Letters to the Editor

Is it Time to Consider the Sociology of Nicotine Addiction? Smoking and Social Disadvantage.

Dear Editor,

It was with great enthusiasm that I attended a recent public seminar entitled "Inequities and Addictions: An exploration of the relationship", held at the University of South Australia as a forerunner to the national APSAD Alcohol and Drug Conference in Adelaide, Australia in November of this year (1). Of particular interest was the presentation by Professor Martin Jarvis of the Department of Epidemiology and Public Health, University College of London, on the relationship between smoking and social inequality. During his presentation, Professor Jarvis emphasised the lack of convincing evidence for a social theory of addiction to nicotine despite the known higher prevalence of smoking and addiction by the more socially disadvantaged smokers among the population. He and others at the seminar gave several examples of such disadvantaged groups, such as the known statistics that 83% of prisoners in the UK smoke, that 90% of homeless people smoke, and that approximately 75% of people with serious mental illness smoke. All agreed that the more severe the deprivation, the higher smoking prevalence appeared to be. However, he and other speakers were hesitant to explore the social context associated with smoking by such disadvantaged groups, other than to quote the statistics.

This brief letter to your readers invites debate on the issue in an attempt to learn more about this problem from a social perspective. It also seeks to engage those who require cold hard facts and figures, evidence that seems more convincing to policy makers than evidence derived from our innate knowledge and understanding of the human condition. To give an example, we can all empathise with the notion of equity does not involve treating everyone equally, or the start, as has been successfully done in the UK according to Professor Jarvis. By doing so, we are acknowledging that social policy lead to a situation in which widening health inequalities mean that such disadvantaged groups are left behind, does this matter? I would urge readers to argue that, yes, it does matter and that we need to be advocating for strategies that reduce poverty and make treatment more readily available to disadvantaged groups. Providing free nicotine replacement therapy to such groups as part of the National Health Scheme (NHS) might be a good place to start, as has been successfully done in the UK according to Professor Jarvis. By doing so, we are acknowledging that social equity does not involve treating everyone equally, or the notion that one rule fits all. Rather, it involves the provision of greater support to those with greater needs.

It would appear that policies attempting to solve the problem of high rates of smoking among disadvantaged groups must look at solving problems of institutional poverty and the existential suffering that comes with unemployment and absence of meaningful activity and sense social contribution, stigma and social exclusion. These concerns arise in addition to the clear weight of evidence that exists about the physical health inequalities that exist for such disadvantaged groups when compared with others in the community (5). Other social concepts also need further exploration. Two such concepts are: the effects of institutional environments and the phenomenon of smoking by minority groups as an expression of power. The first of these was explored extensively within the South Australian public psychiatric system (6). The latter concept was demonstrated in a study of alcohol abuse by Palm Island Aborigines (7) and smoking by Aborigines (8).

Professor Jarvis ended his talk with the question, “If absolute improvements in life expectancy as a result of current tobacco policy lead to a situation in which widening health inequalities mean that such disadvantaged groups are left behind, does this matter?” I would urge readers to argue that, yes, it does matter and that we need to be advocating for strategies that reduce poverty and make treatment more readily available to disadvantaged groups. Providing free nicotine replacement therapy to such groups as part of the National Health Scheme (NHS) might be a good place to start, as has been successfully done in the UK according to Professor Jarvis. By doing so, we are acknowledging that social equity does not involve treating everyone equally, or the notion that one rule fits all. Rather, it involves the provision of greater support to those with greater needs.


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Toxic effects of food, drink and chemicals - continued from page 9

The Complementary Medicine Association is a federal body members of which include health and medical practitioners interested in orthomolecular medicine.

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For the views of other organizations, you can access the RANZCP Position Statement (no 24) at www.ranzcp.org.au and those of the Mental Health Research Institute of Victoria Inc (MHRI) at www.mhri.edu.au.

The Mental Health Council of Australia (www.mhca.org.au) does not include a representative who practises, or is a consumer of, the orthomolecular medicine techniques for psychiatric disorders.

I hope that all stakeholders will be encouraged to consider the important role of foods, drinks and chemicals in producing symptomology associated with mental illness, and, as a corollary, the need to assess the function of foods, drinks and chemicals as in relation to intervention strategies including fasting, single food challenging, eliminating some foods and drinks, monitoring diet, clinical assessment of toxic chemicals in the body and the use of supplementary nutrients.

Sincerely yours with very best wishes,

Doug McIver
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