Tobacco and the 'downward drift'

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DISCLAIMER: Dr. Els has received funding from the makers of smoking cessation medication in Canada.

Tobacco preferentially kills the poor and the mentally ill. Smoking remains the leading preventable cause of death and disease, both in Canada and globally. It has been established that tobacco smoking costs the Canadian economy an estimated $17 billion per annum, and cigarettes represent the only legal consumer product that will kill one out of two of its regular users when used exactly as intended by the manufacturer. This product represents a historical anomaly, and in conjunction with the social and political origins of downward social, the effect of tobacco has been pronounced.

The inverse relationship between smoking status and social class is not easily explained. Similarly, the increased prevalence of smoking in the mentally ill and the chemically dependent is not fully understood. What is clear, however, is the persistent relationship between smoking and a downward drift in social status. This may be accounted for, in part by poor access to health, lower disposable income (which is further exacerbated by the cost of tobacco), and the high

prevalence and precipitation of mental illness associated with these determinants of health.

The effect of gender on smoking in lower SES is salient as well. Women from unskilled manual labour classes are twice as likely to be persistent smokers when compared with women from professional and managerial classes. Male smokers are less likely to be upwardly mobile than non-smokers, and both men and women with no educational qualifications, are most likely to smoke.

Persons with mental illness, and / or chemical dependence tend to be more likely to smoke, and tend to start smoking at an earlier age as well. The bona fide medical condition of tobacco dependence is more prevalent among persons with lower education and income, blue-collar workers, and manual workers, as compared to professionals and those with higher income and education. Smoking is more common not only among the poor, but also among those who reported economic “difficulties” and “dissatisfaction”, and there is an inverse relationship between socio-economic status (SES) and being a regular smoker. The mentally ill, also over-represented in lower SES groups, smoke at rates 2-4 times greater than the general population, are less likely to quit, tend to be more addicted, and consume almost half of all cigarettes smoked. It is no surprise then that the tobacco industry has focused some of their marketing to the mentally ill and the poor. To add insult to injury, these are the very populations that are almost universally excluded from evidence-based tobacco control interventions. The result of systemic barriers to cessation is considered at least as intractable as the disease of addiction itself, and this is a fact our decision-makers have to face, take responsibility for, and be held accountable.

It is well established that persons from disadvantaged groups are more likely to initiate smoking, and are less likely to seek out and follow smoking cessation

advice. They are consequently less likely to quit smoking, and benefit less from available smoking cessation programs, if at all offered. Persons from lower SES, the chemically addicted, and the mentally ill tend to display higher levels of nicotine dependence, as well as having low self-efficacy to succeed in quitting, and have lower levels of intention to quit. Persons from low SES may also have to contend with more assaults on their health, some external and some self-imposed, that can reduce the body's resistance to and recovery from disease. There has been demonstrated an increased risk of male lung cancer in lower SES groups, as compared with those in higher SES groups.

Economic difficulties and economic satisfaction only partly explain the inverse association between income and smoking. Lower SES individuals tend to have fewer healthy dietary choices in their communities, and also tend to consume more fat and alcohol than recommended. There is a further link with greater levels of physical inactivity during leisure-time, and overall a higher number of unhealthy lifestyle choices, as well as poorer knowledge levels of harm caused by smoking. These all contribute to poorer health outcomes, along with the high co-occurrence of mental illness, represent a vicious cycle responsible for a downward drift and an ever-increasing substantial risk for developing major health problems. Combined with the direct and indirect costs associated with the use of tobacco products, and the lower levels of access to treatment, all result in a net tobacco-related downward drift.

A provincial addiction and mental health strategy without tobacco treatment?

The link between social disenfranchisement, poverty, smoking, and poor health outcomes are well established. Yet, although tobacco is linked with the exacerbation of poverty, the strategies for reducing poverty only pays rudimentary attention to smoking cessation. Furthermore, despite the overwhelming evidence of the detrimental impact of tobacco on the health and

the economy, the political courage and appetite to ban tobacco has been absent. The mobilization of sufficient domestic resources to address the evidence-based treatment of tobacco addiction is grossly lagging across Canada.

Recently, in July 2009, the Ontario Government developed and published a discussion paper, "*Open Minds Healthy Minds Summit: Towards a 10-Year Mental Health and Addictions Strategy*". Although tobacco addiction is the most prevalent addiction, the most lethal addiction, and among the most treatable of all addictions, this report contains almost no mention of tobacco as an addiction. This deficit will affect the poor, the mentally ill, and other smokers in an adverse fashion, by perpetuating their downward drift. Although substance abuse and addictions are identified in this landmark report, the impact is significantly eroded as a result of this deficit.

Addiction is a treatable mental disorder, and the political will and resources have to be mobilized to address tobacco addiction, especially in those who are disproportionately affected. Prevention of uptake is not enough to remedy the contribution of tobacco to death, disease, and disability. Unless adequate attention is given to smoking cessation, we may not be fulfilling our mandate to the public. And in this case, again, mentally ill persons are most affected.

The elephant in the room?

Critical elements of tobacco addiction treatment are, as with other addictions and mental illnesses, are ensuring availability, accessibility, and affordability of evidence-based interventions. For tobacco addiction treatment, the interventions are proven to be effective across a broad range of populations. The mentally ill and the poor also *want* to quit smoking, and are capable of doing so. They do have a voice and a choice, but the barriers to treatment are often insurmountable. Routine combinations of pharmacotherapy and psychosocial

interventions have been shown to be safe and effective in reducing morbidity, mortality, and cost. Yet, the majority of smokers are either unable to access or afford available treatment for tobacco addiction treatment.

In Canada there are six medications and a multitude of psychosocial options available for the treatment of tobacco addiction. Nicotine and other medications are required to have poor consumer acceptability, may not provide sufficient biochemical support, are trapped in artificial short-term regulatory paradigms incongruent with the true nature of addiction as a chronic disease, and continue to suffer through lengthy and expensive regulatory approval processes. These options, albeit proven to be safe and effective for a broad range of smokers, are also limited in terms of location of sale, dosage, length of use, and in the absence of universal coverage under listed benefits, are typically not affordable to the majority of mentally ill or the poor.

The harsh reality is that despite the lofty advances in science, the political appetite does not allow for equity of care. The elephant in the room is not the *absence* of effective treatments, but rather our governments' failure to mobilize pro-poor (and pro-mentally ill) health (especially tobacco cessation) systems. The absence of tobacco addiction treatment, integrated into a comprehensive and integrated strategy, is reflective of policy incoherence, and the mentally ill and the poor will pay the dearest price for such. In Ontario, the absence of mentioning tobacco in the 10 year mental health and addictions' strategy fails especially the poor and the mentally ill. Unless remedied, it will continue to perpetuate the disenfranchisement and the poor will continue to suffer ill health and die and early death as a consequence. Unless equity is achieved with other addictions, and with other populations, the downward drift will continue.

Perhaps the recent decision in Ontario (and other provinces) to directly sue tobacco companies for alleged wrongdoing would allow for the recovery of past, present and ongoing tobacco-related damages. Perhaps the proposed $50 billion

sought for cost recovery and damages could be used to remedy this inequity and insult to the poor and the mentally ill. Perhaps now would be the time for advocacy groups, looking after the interests of the mentally ill and the poor, to respectfully request (perhaps even demand that) all levels of Government recognize tobacco addiction as a real mental condition, amenable to treatment, disproportionately affecting the mentally ill and the poor. Mental health and addiction services may be moving closer to the rest of the health system, but the tobacco treatment silo remains excluded, flying in the face of best scientific evidence. Unless strategies include tobacco addiction as a bona fide condition, and as a prominent political priority to which adequate health resources are channeled, we will continue to see more of the same. This is the seed of devastation the tobacco industry has sown in eroding longevity, health, wellness, and the economy. Do understand: this is entirely preventable and is not the way it has to be. Tobacco addiction is an area of public health that is crying out for attention and for a change in health policy direction.

What can we do next[1]?

A variety of mechanisms can remedy the current inequities to the poor and the mentally ill. Ideally our tax policy should ensure cigarettes cost much more than any medicinal nicotine and has marketplace advantages over any tobacco product. This would allow for starting the process of phasing out all combustible forms of tobacco.

The use of nicotine is symptomatic of addiction to tobacco, as well as self-medication of psychiatric conditions. This is to relieve the effects of a myriad of conditions including schizophrenia, bipolar disorder, Tourette's, ADHD and depression. Unless these are taken into consideration, policy and practice will not reflect what is best for those with mental illness, and will fail to protect against

[1] From: Sweanor, Els, Ling: Briefing note on Policy Recommendations, 2009.

continued use of cigarettes. To that extent, mental health policy needs to offer special services to deal with nicotine dependence in these populations, and deal effectively with the option of longer-term substitution therapy.

Currently, national policy to date has had the unintended consequence of giving cigarettes a virtual monopoly on long-term nicotine delivery, and smokers need to be given alternative choices. Perhaps it is time for the establishment of a 'Nicotine Regulatory Body' as has been proposed elsewhere. That would allow for the appropriate regulation of the most dangerous drug delivery devices, i.e. cigarettes on the market.

Tobacco addiction is a prevalent chronic and a treatable disease, but one that remains under-treated. As part of any pro-poor health system, it is imperative that in the 21st century the Canadian health system develops and delivers a state-of-the-art smoking cessation program, as part of a comprehensive mental health and addictions strategy. Smoking cessation is one of the most cost-effective health interventions in terms of preventing disease. With greater availability of products and services we can empower Canadians, especially those with mental illness and addictions, to make healthier decisions and to be able to follow through on such decisions.

Further reading:

http://www.newswire.ca/en/releases/mmnr/smr/WhitePaperTobaccoAddiction.pdf