

## The continuing problem of social control *or* Thank you for smoking...!: A brief reflexion

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The vexed question of *social control* has occupied the musings of historians, sociologists, and welfare theorists in various ways for several decades now (eg., Mead 1925; Parsons 1951; Piven & Cloward 1972; O'Connor 1973; Janowitz 1975; Platt 1977; Cohen 1979; Donzelot 1979; Giddens 1982; Meier 1982; Offe 1984; Edwards 1988). Theorists and practitioners alike have raised important questions about the nature of the social services, *what* social welfare workers do, *why* they do it, and *whose interests* are truly being served. Central to these discussions has been the perceived 'dual' nature of the social welfare profession, a duality that straddles an ambiguous (and often contradictory) divide between competing outcomes: *care* or *control*, *freedom* or *restriction*, *empowerment* or *disempowerment*, and *rewards* or *punishments*. The concept of social control, itself, has come under fierce criticism, [see, for example Robert van Krieken's excellent critique, *Sociological Review*, 1991], and its usefulness as a theoretical paradigm has been seriously challenged. However, this brief article cannot do justice to the erudite critiques previously canvassed, so readers are encouraged to have a look at some of these for themselves to gain a balanced perspective on why the concept of social control has limitations, especially in relation to other important sociological concepts such as *class*, *power* and *culture*. [see Higgins 1980; Thompson 1981; Foucault 1982; Cohen, 1985; Gerstenberger 1985; Gordon 1986]. For the purposes of the current discussion, the idea of social control will be used as the organising tenet to stimulate further debate, despite Van Krieken's disparaging yet humorous reference to the concept as '*a Disneyland relic of our sociological childhood*'.

This short paper will briefly reflect on some aspects of social control with respect to a contemporary and controversial public health issue: namely, cigarette smoking. We should state from the outset that we, ourselves, are *not* smokers and have no vested interests in the cigarette industry.

As a general observation, the encroachment of 'the state' into the lives of its citizens waxes and wanes according to the historical epoch within which it is located including the dominant political philosophy of the times. Thus, the Whitlam era of the early 1970s brought substance to the ideals of social democracy through the introduction of a platform of sweeping social and cultural reforms, which, while increasing intervention in the workings of the economy and, thus, within citizens' lives, brought to bear positive changes to society as a whole, eg. withdrawal from the Vietnam war, the introduction of a national health system, free tertiary education, expansion of cultural and community programs, increased public housing, increased immigration, refugee intakes, and so on. Since that period, successive Australian governments, regardless of their political colour, have reduced their direct involvement within the lives of their citizens, essentially returning control (and therefore personal responsibility, liability, and 'blame') back to its citizens. If we look at trends in federal government policy during the last few decades concerning health, education, welfare, income security, labour market deregulation, public telecommunications, and

occupational superannuation, the dominant political trend is to move away from government intervention and control whilst allowing market principles to regulate wage rates (WorkChoices), utilities (power supply, electricity and gas distribution), public assets (Telstra, SEC), private investment in infrastructure (CityLink), and placing responsibility for retirement provisions back onto the citizen (compulsory occupational superannuation). The Howard federal government, whilst promoting policies that reflected free market and libertarian principles, paradoxically, was increasingly intrusive into the lives of its citizens, especially the most disadvantaged and vulnerable. A clear example of this was the increased policing of income security compliance obligations, ie. ensuring that CentreLink recipients upheld their obligations as an indicator of their “worthiness” to receive payments from the public purse. Another contemporary example was the unprecedented intrusion into the lives of indigenous Australians in the Northern Territory, on the face of it, to “manage” the social and health problems of remote Aboriginal communities. It will be interesting to observe how the newly-elected Rudd Government (November 2007) will address similar, contemporary issues.

As students of the human services, we are introduced early in our careers to the disquieting assertion that, in our professional roles, we act as *agents of social control*. One of the authors of the current paper recalls, as an undergraduate student at the former Gippsland Institute of Advanced Education (GIAE) in Churchill, Victoria, feeling affronted by the unpalatable notion that, whilst ‘we social welfare workers’ purported to protect the interests of our respective clientele, in reality, the underlying impetus was probably less altruistic and, perhaps, even mildly sinister. Were we part of a greater machinery (willing or otherwise) that imparted to our disempowered and vulnerable clients, socially constructed and sanctioned rules of behaviour *in order to elicit a particular and desired result*? It was incredulous that our (noble) efforts to instigate positive change within individuals and, more broadly, at a societal level, could be viewed as anything but *inherently good*. Whilst, perhaps, we now have a far more critical view of the human services, including the political economy that underpins it, happily, some of that freshness of spirit remains intact! All has not been eroded, despite the exigencies of professional practice and academia over a number of years!

However, the harsh reality *is* that in our professional roles, we *do* look for empirical changes in the behaviour, knowledge, attitudes, and, perhaps even the *values* of our ‘target groups’, the people who we serve whether these be individuals, families, groups, or some other constituency. With positive change comes positive reinforcement and rewards, whatever shape these take. Equally, the opposite holds true in attracting sanctions and punishments, however subtle and condescending these may be. This then, represents the insidious aspect of *social control*; the surreptitious attempts to *modify* how our clients *think*, and to then reward them for it.

The question of social control and its corollary, ‘*whose interests are being served?*’ was brought into stark relief one evening recently whilst returning home to Melbourne after a day’s work in Warragul. Tuned in to the ubiquitous ABC, one’s attention was seized by a lively discussion ensuing between radio journalists and a guest, the latter who was an apologist for smokers’ rights. The guest’s contention was that, in recent years, cigarette smokers have been increasingly ‘persecuted’ [*our words*] by political

interest groups intent on discriminating against and shaming people for a largely free choice they have made and, in many instances, continue to make. In his opinion, smokers have been harshly dealt with by a bevy of political spin-doctors and powerful lobby groups buoyed by swathes of public health funding.

The guest speaker, from the outset, *clearly acknowledged the serious harms* known to derive from cigarette smoking and, to his credit, made no attempt to minimize these accepted medical facts. He calmly asserted the following about smoking-related diseases:

- Approximately 15% of all deaths (approximately 20,000 deaths) in Australia are due to tobacco smoking each year.
- Tobacco smoking is the largest single preventable cause of death and disease in Australia.
- Smoking is a key risk factor for the three diseases that cause most deaths in Australia: ischaemic heart disease, cerebrovascular disease and lung cancer.
- Smokers are at increased risk of developing chronic obstructive pulmonary disease and reduced lung function.

Yet, this was not the point of his argument. The speaker's motivation was *not to defend smoking, nor to justify an untenable ideological position*. Indeed, he decried the plethora of risks that smoking poses to all and sundry, and quite correctly canvassed people against it. Rather, his concern centred around the accepted axiom of an adult person's civil and political right to make choices about his or her life, in full knowledge and acceptance of the consequences of their (rational) actions; a rational action being one that is made in the light of all available knowledge with a substantial understanding of the benefits and risks involved with that decision. He argued that changes in public attitudes and policy towards smoking have had unforeseen negative consequences for smokers and that these consequences have had a disproportionate impact upon those who choose to smoke.

In 2007, smokers represent a relatively small proportion of the general Australian population, around 25%. This compares with the period of high consumption during the 1950s when the rate of smoking amongst Australian adult males was in the order of 70%. Since then, public health campaigns and the anti-smoking lobby have been highly successful in getting their key message across, with impressive results. A significant decrease in smoking has been seen across most Western nations over the previous few decades. We all agree this is, indeed, a very good thing.

Yet, the speaker's argument was essentially libertarian, being based upon a loose confluence of the philosophical traditions of John Stuart Mill and Jeremy Bentham. His argument encompassed key tenets of utilitarianism, liberty, and freedom to live without state interference so long as no harm was promulgated towards others. We can reasonably accept this argument in relation to passive smoking, yet it fails when people smoke alone, away from the possibility of harming others. .

To this, the speaker added a further important dimension that added weight to his thesis. Namely, that, historically, smoking has not been adopted uniformly across all strata of society. . Certain sub-groups within society have a much higher propensity to smoke. For example, people with mental illness are amongst those who smoke the most frequently and heavily. On average, smoking is three times more prevalent among people with schizophrenia, as compared to the general population. Smoking rates among the mentally ill are not declining commensurate with the general population (QUIT Victoria 2006). An Australian study conducted at the Centre for Young People's Mental Health in Parkville, Victoria, found that 75% of the sample were smokers. Another study conducted in an outpatient setting in Melbourne reported that 76% of those surveyed were smokers.

Indigenous people also smoke at a much higher rate compared with the general population. The estimated rate of 51% represents more than double the Australian average. In addition, people in less wealthy [socioeconomic groups](#) also have significantly higher rates of smoking compared to median income persons. Finally, past surveys have demonstrated that people with [less](#) education smoke more than those who have higher levels of education (QUIT Victoria 2006).

The point being made here is that people who smoke cigarettes are likely to hail from lower socioeconomic backgrounds, which means they are probably living in poverty with substandard private rental housing and limited tenure, work in occupations that are semi-skilled or unskilled and are highly stressful, have a chronic mental illness, and come from marginalized indigenous communities.

Consequently, it is only a small conceptual step to suggest the dramatic changes we have seen in public health policy regarding smoking closely mirror dominant 'middle class' ideologies that have been imposed upon already disadvantaged groups whilst pursuing politically-driven health agendas. No reasonable person would argue against the various harms related to smoking: there are, indeed, no safe levels for smoking. These facts remain undisputed. However, what is amenable to further critical analysis is the process by which contemporary smoking policies and laws have evolved and the differential impact these policies and laws bring to bear upon disadvantaged and vulnerable groups.

As a case in point, the introduction of anti-smoking laws in 2006, banning smoking from public mental health facilities, are likely to generate unforeseen impacts upon the management of patients within inpatient treatment and rehabilitation facilities. Due to the very high rates of smoking amongst the mentally ill, this will almost certainly pose a significant operational issue that managers and clinicians will need to contend with. Social workers involved with managing the care process for patients within psychiatric units are obliged to uphold compliance of the new anti-smoking laws, irrespective of the wishes of patients or their own personal views. The fact is, since the new laws were introduced some twelve months ago, there have been some problems in implementation within psychiatric inpatient units where things can be volatile at the best of times. It is difficult to inform a floridly psychotic patient that he/she can't have a cigarette and then attempt to explain why. Sometimes, short-term compromises in policy are necessary to effect positive changes over the longer-term. Perhaps it is more prudent to allow mentally unwell people to smoke during times of

acute illness and stress, and then when they are well again, modify their smoking behaviours through education, emotional support, and positive incentives. The introduction of nicotine patches during inpatient stays will be beneficial for only a proportion of cases. These are not universal or immediate solutions to chronic smoking habits. Once a person is admitted to an inpatient unit, smoking must cease immediately, rather than being gradually reduced. It is well-known that a gradual decrease in cigarette consumption with a range of psychological, social, and emotional supports will have a better chance of long-term cessation as compared to the proverbial 'cold turkey approach'.

An often overlooked aspect of tobacco use is its social character. Often one of the few occasions where isolative patients may engage in social interaction without feeling unsafe or threatened within a mental health facility is during the informal 'smoko', which historically has occurred in a garden area outside the inpatient unit.

It is worthwhile asking the question why the excessive consumption of alcohol has not been subjected to the same, very high standard of control to which tobacco consumption has been subjected. The main rationale is probably linked to the fact that there are safe levels of alcohol consumption, whereas there is no safe level of cigarette consumption. Notwithstanding this, that alone does not proffer a convincing argument when the plethora of social ills directly related to excessive alcohol consumption are well-known, severe, and far reaching: domestic abuse, degradation of culture, violence against women and children, destruction of life through motor vehicle accidents, loss of jobs, income, social status, and self-esteem. Yet, there has been no serious attempt to control alcohol consumption to the same extent as tobacco.

As a concluding comment, government policy and its associated machinery (viz: legislation and executive departments) does indeed have a critical role to play in shaping citizens' knowledge, attitudes, values, and behaviours. Some policies are far more pervasive and influential depending upon where it sits on the public policy agenda of the day. Social and welfare workers, especially those in the direct employ of government departments are expected to uphold legislative imperatives, rules, and the spirit of government policy. If not, then they themselves risk running foul of the authorities who control their employment and their careers. Some government employees are compelled to agree to uphold a code of conduct without fail. The introduction of state policies and laws in relation to cigarette smoking (across a variety of settings) gives testament to the limited scope for personal action and choice for individuals and the key roles which social and welfare workers are expected to play in relation to regulating individual choice and human behaviour. The issue of social control, and all which that means for a contemporary society, remains a key sociological concept for understanding power and authority.

## References

- Cohen, S. (1979) 'The Punitive City: Notes on the Dispersal of Social Control', *Contemporary Crises*, 3: 339-63.
- Cohen, S. (1985) *Visions of Social Control*, Cambridge: Polity Press.
- Donzelot, J. (1979) *The Policing of Families*, London: Hutchinson.
- Edwards, A. (1988) *Regulation and Repression. The study of social control*, Sydney: Allen & Unwin.
- Foucault, M. (1982) 'The Subject and Power', 208-26 in H.L. Dreyfus & P. Rabinow, *Michel Foucault: Beyond structuralism and hermeneutics*, Brighton: Harvester Press.
- Gerstenberger, H. (1985) 'The Poor and the Respectable Worker: On the introduction of social insurance in Germany', *Labour History*, 48: 69-85.
- Giddens, A. (1982) *Profiles and Critiques in Social Theory*, London: Macmillan.
- Gordon, L. (1986) 'Family violence, feminism and social control', *Feminist Studies*, 12(3): 453-78.
- Higgins, J. (1980) 'Social Control Theories of Social Policy'. *Journal of Social Policy*, 9(1): 1-23.
- Janowitz, M. (1975) 'Sociological theory and social control', *American Journal of Sociology*, 81: 82-108.
- Mead, G.H. (1925) 'The genesis of the self and social control', *International Journal of Ethics*, 35: 251-77.
- Meier, R.F. (1982) 'Perspectives on the Concept of Social Control', *Annual Review of Sociology*, 8: 35-55.
- O'Connor, J. (1973) *The Fiscal Crisis of the State*, New York: St.Martin's Press.
- Offe, C. (1984) *Contradictions of the Welfare State*, London: Hutchinson.
- Parsons, T. (1951) *The Social System*, New York: Free Press.
- Piven, F. F. & Cloward, R. A. (1972) *Regulating the Poor. The functions of public welfare*, London: Tavistock, 1972.
- Platt, A. (1977) *The Child Savers*, Chicago: University of Chicago Press.
- QUIT Victoria webpage. <http://www.quit.org.au/> accessed 9<sup>th</sup> August 2007.

Thompson, F. M. L. (1981) 'Social Control in Victorian Britain', *The Economic History Review*, 34(2): 189-208.

van Krieken, R. (1991) 'The Poverty of Social Control: explaining power in the historical sociology of the welfare state', *Sociological Review*, 38(1) 1991: 1-25.

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