PostScript

LETTERS

Financial implications of cigarette smoking among individuals with schizophrenia

Individuals with schizophrenia are more likely to smoke than those with other Axis I disorders[1] and are 10 times more likely to have ever smoked daily than individuals in the general population.[2] In addition to more frequent medical consequences of smoking[3] as compared to smokers in the general population, smokers with schizophrenia experience negative consequences unique to their mental illness. One often overlooked example includes the substantial financial implications from tobacco use among smokers with schizophrenia—many of whom are dependent on a limited, fixed income.[4 5] Quality of life issues relating to the ability to pay for occasional entertainment desires, or more seriously, adequate housing and nutrition, are already compromised for many with a serious mental illness. This is only worsened by their addiction to cigarettes, the financial cost of which comprises a substantial percentage of their monthly budget.

As part of a larger study on motivational interviewing in smokers with schizophrenia or schizoaffective disorder,[6] participants (n = 78) provided information on public financial assistance in addition to information on tobacco use. All participants were smoking at least 10 cigarettes per day, were psychiatrically stable, and attending outpatient treatment for their psychiatric disorders. They were not currently seeking tobacco dependence treatment (table 1).

Participants spent a median of $142.50 (range $57.15–$319.13) per month on cigarettes. The majority (87.2%) were receiving public assistance at a median benefit of $596 (range $60–$1500) per month. It was therefore calculated that the median percentage of income spent on cigarettes each month was 27.36% (range 6.3–331.3%). In contrast to the general population, where only 10% smoke generic brand cigarettes,[7] 30.8% of participants in the current sample were smoking generic brand cigarettes. Participants reported smoking generic brand cigarettes because of their lower cost, thus recognising to some degree the high financial burden caused by their tobacco dependence. Some reported purchasing cartons through discount mail order programmes or rolling cigarettes themselves from loose tobacco to save money. This illustrates the great lengths these smokers will go to in obtaining cigarettes while struggling with motivation to perform many other daily activities.

It should be acknowledged that the sample was heterogeneous with respect to independence from their family of origin. Participants ranged from having their basic financial needs taken care of by their parents, to those who lived in rooming homes where they were financially independent. These differences may moderate the financial implications of tobacco dependence in this group.

This letter presents yet one more reason clinicians and the tobacco control community should address tobacco use in smokers with serious mental illness: the financial implications of tobacco use in this group are considerable. By spending almost 30% of their public assistance income on cigarettes, the already limited financial resources of smokers with schizophrenia are substantially reduced. The financial burden of smoking for individuals with schizophrenia is serious and often overlooked.

Acknowledgements

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M L Steinberg, J M Williams, D M Ziedonis
Robert Wood Johnson Medical School–UMDNJ, Piscataway, New Jersey, USA

Table 1 Baseline participant characteristics

Variable	Mean (SD) or %	Median (range)
Age	43.78 (8.96)	
Length of psychiatric illness	20.78 (10.56)	
Male sex	67.9%	
Years smoking	26.87 (9.79)	
Global assessment of functioning (GAF)	50.12 (8.10)	
History of substance use disorder	53.2%	
FTND	5.98 (2.06)	
Smoking more than 1 pack/day	82.1%	
Longest previous quit attempts (days)		2.0 (0–5110)
Generic brands	30.8%	
"Light" cigarettes	20.0%	
Menthol cigarettes	38.5%	
Money spent on cigarettes per month		$142.50 ($57.15–$319.13)
Participants receiving public assistance	87.2%	
Public assistance benefit		$596.00 ($60–$1500)
Percentage of income spent on cigarettes		27.36% (6.3–331.3%)*

*Reported income does not include money participants may have received from family and friends, thus explaining how many participants spent more on cigarettes than they received in income.

Correspondence to: M L Steinberg, PhD, Division of Addiction Psychiatry, Robert Wood Johnson Medical School, UBHC-D303, 671 Hoes Lane, Piscataway, NJ 08854, USA; marc.steinberg@umdnj.edu

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Public attitudes about tobacco smoke in workplaces: the importance of workers' rights in survey questions

The importance of public opinion in the formation of smokefree places policies is indicated by the efforts of the tobacco industry to obscure issues and counter information.[1 2] Over 30% of New Zealand workers are currently estimated to be exposed to secondhand smoke (SHS) at work.[3] New legislation was passed in December 2003 that will have the effect of banning smoking in nearly all New Zealand workplaces, including bars/pubs.[4]

Using data from two sets of national telephone surveys by UMR Research Ltd and CM Research Ltd[5–7] (table 1) we examined: (1) New Zealand survey responses during 1999–2003 on smoke-free bars/pubs; and (2) response differences between questions.

The UMR surveys show a 21% absolute increase between May 2000 and April 2003 in support for smoke-free bars—7% per year ($p < 0.00001$). The CM Research surveys show an increase from 64% to 80% between 2001 and 2003 in those who agreed that bar workers have a right to a smoke–free workplace—7% per year.

There were substantially different responses about completely smoke-free bars/pubs, depending on the question asked. In 2001, whereas the response to question 1 showed 38% in favour of a complete bar/pub smoking ban, question 2 could be interpreted as showing only 26% support. When the question was about workers rights generally (question 3), 85% gave support, but when the question was about the rights of bar/pub

Table 1 New Zealand public attitudes about smoking in pubs and bars, 1999–2003

Question	Proportion agreeing with the question or statement (%) 1999	2000	2001	2002	2003	Data source
1) Do you support a complete ban on smoking in NZ pubs and bars?		28	38	38	49*	UMR Research
2) Should people be able to smoke in† bars/pubs?						CM Research
Anywhere	27		28		10*	
In set areas	45		44		52**	
Not at all	25		26		34*	
3) People have a right to work in an environment free of tobacco smoke			85		91*	CM Research
4) People who work in pubs and bars‡ have a right to work in an environment free of tobacco smoke			64		80*	CM Research

*p<0.001 for trend across years; **p<0.01 for trend across years.
†The question in 2003 included the additional word ''hotels''; ‡the question in 2003 included the additional word ''nightclubs''.

workers (question 4), only 64% gave support. This general pattern was repeated in 2003.

These survey data indicate that attitudes on smoking in bars/pubs can change significantly over two or three years. Factors that may have contributed to this change included: (1) media coverage concerning draft smoke-free environments legislation (introduced in 1999); (2) advocacy activities; (3) mass media campaigns on the hazards of SHS.

The difference between the results for questions 1 and 2 could be explained by the difference between a question that is about the proposed policy (Do you support a complete ban?) compared to one which was focused on smokers' rights (Should people be able to smoke?). The difference could also be explained by the provision of a compromise option (''in set areas'') within question 2. Differences in the survey methodologies could possibly also have contributed to the different responses between questions 1 and 2.

Questions 3 and 4 show the difference that extra context can give—when the workers' smoke-free rights were located specifically in bars/pubs, there was less support for them. A similar change was shown in a 1996 Western Australian survey for ACOSH (Australian Council on Smoking and Health), which showed that 85% ''opposed smoking in the workplace'', but only 56% opposed smoking in pubs.[8]

The New Zealand experience suggests (1) that the equality of bar/pub workers' rights with other workers' rights needs to be emphasised by health advocates, (2) that including a context of the rights of those harmed by SHS in survey questions concerning attitudes to smoke-free environments will produce different results from questions without that context, and (3) that a compromise option, within questions about smoking restrictions, decreases the apparent support for completely smoke-free settings.

G W Thomson, N Wilson
Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago, Wellington South, New Zealand

Correspondence to: George W Thomson, Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago, Box 7343, Wellington South, New Zealand; gthomson@wnmeds.ac.nz

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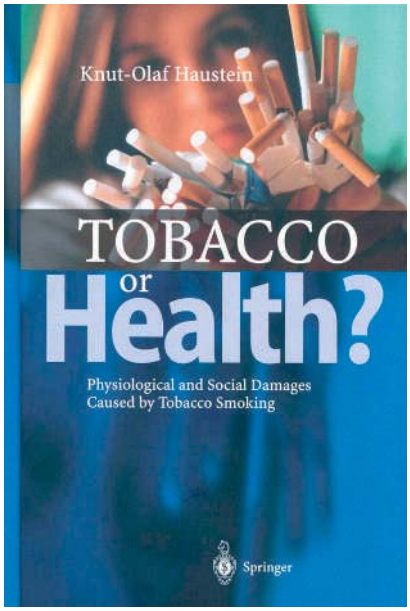

BOOK REVIEW

Tobacco or health? Physiological and social damages caused by tobacco smoking

By K-O Haustein, Springer-Verlag, 2002, 446 pages, US $99, ISBN: 3540440313 (translated from the German original)

Tobacco or health?

Writing a single volume on the most researched topic in biomedical history is no small undertaking. Numerous volumes on specific disease consequences of smoking have been published by medical authors from around the world. But I know of no comprehensive review that does as thorough a job as this book. In 14 central chapters, the author thoroughly reviews the literature on a wide and growing list of subjects related to tobacco use and its consequences. Though the author is clearly aiming the book at clinicians and medically literate readers, the directness of the content with plentiful figures and tables helps to keep the sections in each chapter concise.

The author clearly has a pharmacological background and the text is sponsored by Pharmacia, makers of Nicorette. Though chapters 4, 10, and 11 reflect this emphasis, there is sufficient content in all areas with recent journal findings plentiful. A massive seventh chapter entitled ''Other organ systems'' is a unique mix covering everything from psychiatry to psoriasis. The book contains over 2400 references covering both tobacco's role in disease and immediate preventive challenges: providing smoking cessation, addressing secondhand smoke, and predatory tobacco industry marketing.

Appealing features are the book's thoroughness and forward research focus, with particularly strong chapters on the pharmacology of nicotine dependence and secondhand smoke. Because the book is so evidence oriented, it covers certain social aspects of tobacco control only very briefly. Summary points at the ends of each chapter are useful but often too prescriptive, providing little insight to the varied contextual factors which make the social dynamics of tobacco control issues so difficult.

Annoyance

I must admit, I even enjoyed the clear annoyance that the German author expresses in his last chapter towards European politicians, tobacco industry research funding, subsidisation of tobacco growing, tobacco constituent regulations, tobacco taxing policies, lack of tobacco advertising regulations, and the tobacco industry's misinformation campaigns on the consequences of smoking.

Others may find these comments too subjective. Nonetheless, the author does make his point; there is a lot of awakening necessary to speed the present slow pace of tobacco control measures in Europe.

Overall, I rate this book not only a useful introduction to various medical research findings, but an important challenge to physicians to address tobacco as a drug product. Thus far, research and the use and abuse of tobacco have been largely controlled by the tobacco industry. This is reminiscent of the early days of limited ''patent'' drug regulation in the USA by the Food and Drug Administration. While withholding biomedical findings from the public is one aspect of the fraud of the tobacco industry, product manipulation and misrepresentation alone would seem to warrant stronger regulation given the resulting toll documented here. This book makes it clear that the science of tobacco as a drug can no longer be left to the industry and stresses many emerging issues that scientists and physicians must soon address. The message is that health is the social option the world should no longer forgo and, as the evidence suggests, must act upon now.

S Hamann
Tobacco Control Policy Research Network;
slhamann@hotmail.com