

## Accepted Manuscript

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PII: S0306-4603(18)31376-5  
DOI: <https://doi.org/10.1016/j.addbeh.2018.11.047>  
Reference: AB 5819  
To appear in: *Addictive Behaviors*  
Received date: 28 November 2018  
Accepted date: 30 November 2018

Please cite this article as: Sharon Cox, Caitlin Notley , Response to Campbell et al., (2018) - Health risk perceptions and reasons for use of tobacco products among clients in addictions treatment. Ab (2018), <https://doi.org/10.1016/j.addbeh.2018.11.047>

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**Response to Campbell et al., (2018) - Health risk perceptions and reasons for use of tobacco products among clients in addictions treatment**

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Campbell et al. (2018) paper focuses on an important issue, smoking amongst those seeking treatment for substance use disorder (SUD). The paper examines rates of use, health perceptions and reasons for use of tobacco and nicotine containing products in order to examine variables associated with product use. Smoking prevalence rates amongst those dependent on illicit substances is incredibly high (Thurgood, McNeill, Clark-Carter & Brose, 2016), and higher than other minority groups (Chang et al., 2011), having shown little change over time, and with little indication of future decline. Understanding how best to facilitate tobacco cessation for adults with SUD is a priority.

In line with research focused on other vulnerable groups there is some evidence of a desire to quit smoking (Twyman, Bonevski, Paul & Bryant, 2014), as well as some current use of alternative tobacco and nicotine products (Baggett, Campbell, Chang & Rigotti., 2016). 26.5% of participants' report e-cigarette use in past 30 days. The two top reasons for this are using e-cigarettes 'at times when can't smoke' and 'to quit/reduce tobacco'. This suggests that this group are willing to engage with attempting positive behavioural change, but have lacked support to do so (Gentry, Craig, Holland & Notley, 2017). The discussion of the Campbell et al., article states that reviews agree that more randomised control trials (RCTs) are needed to ascertain whether e-cigarettes are an effective tobacco cessation method (e.g., Kalkhoran & Glantz, 2016). They also conclude that the continual use of nicotine is another issue which requires consideration.

For the time being, the weight of evidence of the effectiveness of e-cigarettes as a tobacco cessation aid is dwarfed in comparison to RCTs of behavioural, pharmacological and nicotine replacement therapies (NRTs). Our scientific assumption is that e-cigarettes should be subject to the same research process and rigour as these treatments in order to 'prove their worth', regardless of the fact that e-cigarettes are not necessary seen as a medical 'treatment'. There are two fundamental, both practical and humane, reasons as to why this perspective deserves to be challenged.

The first relates to the potential to reduce harm sooner. Compared to combustible tobacco, e-cigarettes are a far less harmful alternative (McNeill et al., 2018), and studies in mid-to long-term users show a reduction in toxicant and carcinogen exposure when users completely switch (e.g., Shahab et al., 2017). There is also evidence that they can double quit rates (Hartmann-Boyce, Begh & Aveyard, 2018). From conceptualisation, through to data dissemination, RCT's are always lengthy. At the same time, smoking continues to cause premature death and disease, which is particularly unevenly distributed amongst populations experiencing multiple health inequalities. Traditional tobacco cessation aids (NRTs; behavioural support) and policies (taxation, point of sale advertising bans) can be considered to have had little impact on the most deprived. Therefore, because e-cigarettes offer considerable potential to reduce harm, even under pessimistic scenarios (Levy et al., 2018), their use for smokers should always be encouraged.

The second issue is one that needs wider consideration amongst the tobacco research community. Traditional methods of investigation too often mean those presenting with multiple confounding variables are excluded. In the event that studies do focus on minority groups, the most vulnerable and deprived populations do not easily fit with the requirements of RCTs for standardised intervention delivery, fidelity, and sometimes onerous data collection and assessment procedures. Longer follow up times are particularly difficult for the most deprived; as an example the homeless are often transient and moving between areas. Those who are dependent on illicit substances may drift in and out of treatment services and may intentionally or unintentionally be difficult to contact. A further point of consideration is that because of high levels of tobacco dependence in those with comorbid mental health needs, there may be an extensive period of 'dual-use' (use of both tobacco and an e-cigarette), thus any effects on cessation with an e-cigarette may seem inferior at follow-up compared to healthy adults.

E-cigarettes, or other reduced risk nicotine products, are unlikely to be the solution to smoking amongst the groups raised here alone. It is more likely that a combination of nicotine containing products, combined with support, will be required to fulfil a complex mix of physiological, social and

ritualistic urges and desires. This may mean that many within health, medicine and research need to renegotiate their position on long-term nicotine use.

It may be considered unethical to expect those who are dependent on substances, have comorbid mental health difficulties and/or may not be securely housed to conform to the same protocols as those without such difficulties in order to quit tobacco. Poorer communities do not have the same freedom to 'buy and try' from the vast range of reduced risk products as those higher up the social economic scale, and as such can be considered more reliant on evidence being passed into health practice sooner. While research on the effectiveness of e-cigarettes as a tobacco cessation aid must continue, it is deeply misguided and perpetuates harm to not encourage their use for all smokers until we have this information. The public health approach of acting for the greater good to reduce harm should dominate over the short term principle of 'do no harm'. If the scientific community and policy makers overly focus on the so called 'gold standard' of RCT evidence, minority groups will not have their voices and needs heard, and will keep on smoking.

**Conflict of interest:**

SC has provided expert consultancy to the Pacific Life Insurance group on tobacco and reduced risk product prevalence and use rates.

CN has no conflicts of interest.

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This is a commentary in response to an article and no highlights are required.

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