The London Drug & Alcohol Policy Forum

A public lecture by

Prof Gerry Stimson
Emeritus Professor, Imperial College London
Visiting Professor London School of Hygiene and Tropical Medicine

Introduced by

Prof David Nutt
Edmond J. Safra Professor of Neuropsychopharmacology
Imperial College London

CITY OF LONDON

KNOWLEDGE ACTION CHANGE

London Drug & Alcohol Policy Forum

A tale of two epidemics: drugs harm reduction and tobacco harm reduction

Gerry Stimson

Guildhall, London, 14th April 2016

#harmreduction

KNOWLEDGE ACTION CHANGE

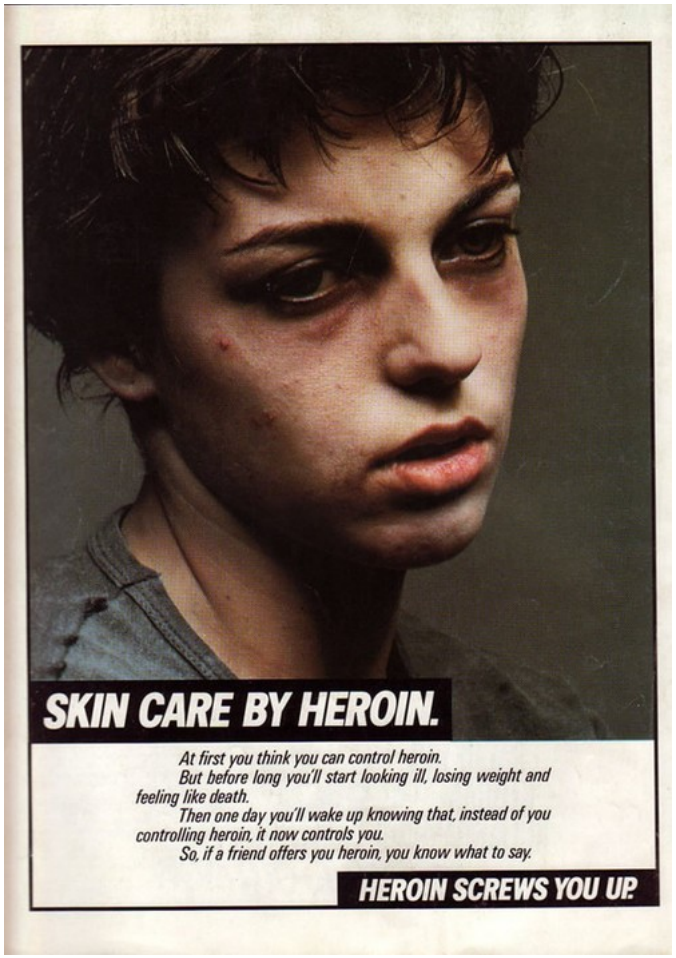
Imperial College London

30 YEARS AGO

April 1986 – public health and drugs harm reduction

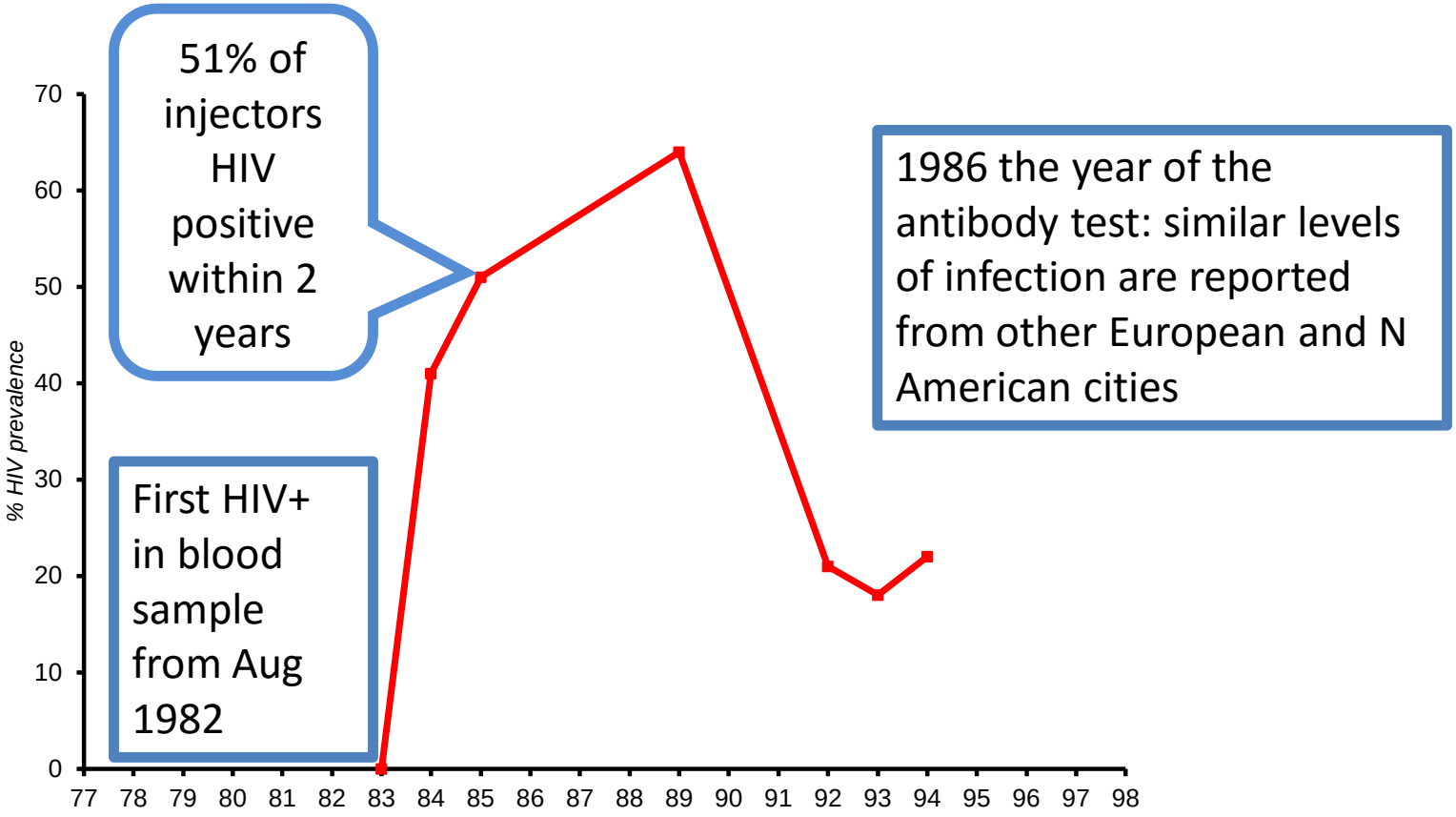
Gerry Stimson 14 April 2016

Context – ‘heroin screws you up’ anti-heroin campaign – 1985-6



1986: The UK discovers the HIV epidemic.

Roy Robertson and colleagues in Edinburgh tested GP patients who were injecting



Robertson,J.R., Bucknall,A.B.V., Welsby,P.D. et al. Epidemic of AIDS-related virus (HTLV-III/LAV) infection among intravenous drug abusers. The British Medical Journal 1986;292:527-529

1986 – alarm, and a harm reduction solution

- April 1986 Government alarm about Edinburgh
- DHSS and Advisory Council on Misuse of Drugs alarm/uncertain

- Sept 1986 McLelland C'tee Scotland reccs distributing needles and syringes

- Oct 1986 Interdepartmental Ministerial Committee on AIDS, chair William Whitelaw

- Dec 1986 Norman Fowler Secretary of State for Health, advised by Chief Medical Officer Donald Acheson and Dorothy Black Senior Medical Officer announces needle exchanges

- Mar/Apr 1987 Needle exchanges launched. Evaluated by my team

- Within 12 months harm reduction emerges as a key UK response to HIV among drug users

It was harder than I suggest, behind the scenes – but no overt opposition in the UK; elsewhere it was and is worse

2 The report's first conclusion is that **HIV is a greater threat to public and individual health than drug misuse**. The first goal of work with drug misusers must therefore be to prevent them from acquiring or transmitting the virus. In some cases this will be achieved through abstinence. In others, abstinence will not be achievable for the time being and efforts will have to focus on risk-reduction. Abstinence remains the ultimate g

AIDS and DRUG MISUSE Part 1

Report by the Advisory Council on the Misu

'We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse... We must therefore… work with those who continue to misuse drugs to help them reduce the risk involved in doing so, and above all the risk of acquiring or spreading HIV.'

UK Advisory Council on the Misuse of Drugs1988; chaired by Ruth Runciman

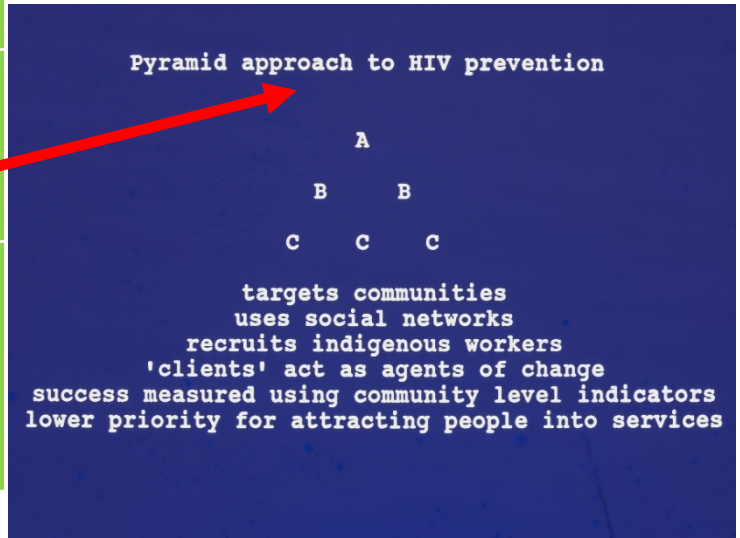
m as a valid goal. In , many drug misusers will not be sufficiently motivated to consider abstinence and that many drug injectors will not be sufficiently motivated to change their route of administration. **We must therefore be prepared to work with those who continue to misuse drugs to help them reduce the risks involved in doing so, above all the risk of acquiring or spreading HIV.** Reaching this less well motivated group will necessitate a more proactive approach and a readiness

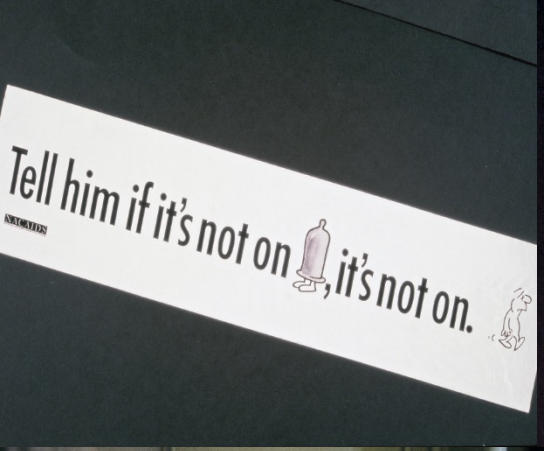
Early in epidemic (1986-7) and quickly (1987-92) UK developed an extensive harm reduction programme

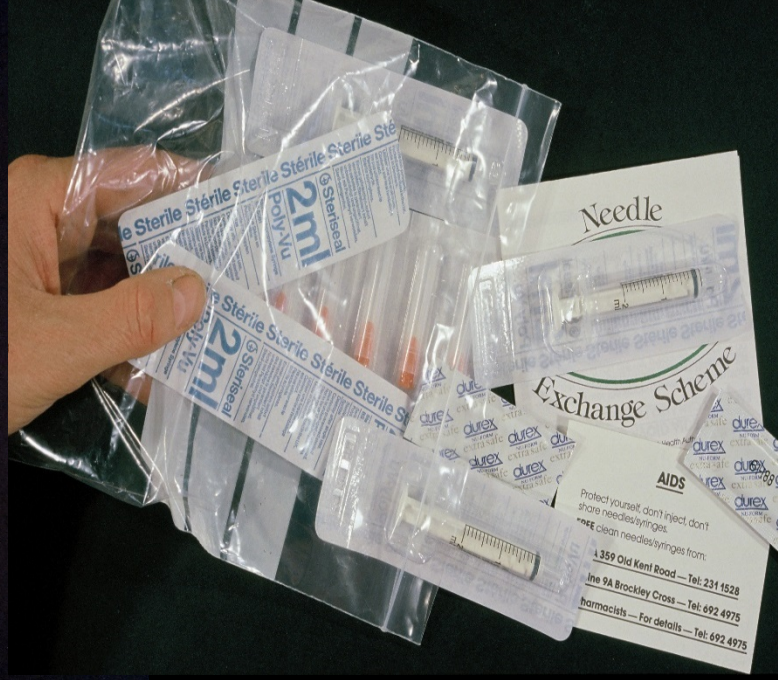
Creating a conducive environment to enable change in drug using etiquette/culture	
Raise awareness, provide information	Social marketing • safer drug use • HIV prevention
Provide resources	• Needles and syringes • Methadone + access to treatment • HIV testing
Make contact	• Outreach • Peer education • Cascade messages
Endorse and remove obstacles	• Key opinion leaders • Government • Media • Change laws etc

Much grass roots action, eventually endorsed by government

Stimson G V. AIDS and injecting drug use in the United Kingdom, 1988-1993: Social Science and Medicine, 41,5,699-716)







Using Drugs

If you are using drugs, this leaflet is for you. It's a simple guide to using drugs more safely and doing less harm to your health. Using any drug can be dangerous. But a lot of the damage can be avoided if you are careful and take some simple steps to look after yourself.

Gerry Stimson 14 April 2016

Meanwhile in the US where needles were banned, Bleachman offered a creative solution

Russell Newcombe, first to use the term ‘harm reduction’ in Druglink, Jan/Feb 1987

Follow him @TheNewImpostor

PLATFORM

HIGH TIME FOR HARM REDUCTION

Russell Newcombe

THOUGH ILLICIT drug use has not yet become typical among most British youths, it has become ‘normalised’ in the sense that the majority of 15 to 20 year olds in urban areas such as London, Edinburgh and Merseyside are likely to have one or more friends who take drugs, and a substantial minority will be taking drugs such as cannabis and solvents on an experimental or recreational basis. A survey in Wirral in 1984-5 found that up to 1 in 10 unemployed male school leavers on some estates were known to be using heroin or similar drugs.[1]

Primary prevention (education which aims to deter youths from trying drugs) is too late for the present generation of drug users and has been found to be ineffective and sometimes counter-productive, findings now widely recognised.[1] However, one of the most carefully designed studies found that education *can* slow the development of more problematic forms of drug use, but may simultaneously increase the rate of ‘safer’ forms of drug use.[1]

Until research reveals an effective primary prevention programme, it would be prudent to direct some of our efforts toward minimising the harm that drug users might do to themselves or others (‘secondary prevention’, ‘harm-reduction’ or ‘risk-minimisation’). The present generation of drug using youths should not be abandoned to inappropriate primary prevention programmes, nor to the many preventable problems (eg, overdose, infections, organic damage, accidents) that can occur because of lack of knowledge about safe use procedures.

This paper looks at the four main components of a harm-reduction strategy: the rationale, content, implementation and evaluation.

Rationale

Primary prevention approaches assume that the use of illicit drugs is morally wrong because it is illegal, and/or because it is unhealthy. Therefore, abstinence is the ultimate goal, and success is measured by a reduction in the incidence of drug use.

The rationale of secondary prevention rests on three different insights about the nature of drug use.

► Secondary prevention approaches recognise the frequently unmentioned (or disregarded) fact that most people like to get ‘high’ — to change their mental states and processes by chemical or other means — and that in this regard humankind is unlikely to change its ways. Rather than viewing drug use simply as a ‘deviation’ to be rectified, the secondary prevention approach concedes that there are many ‘normal’ motives underlying drug use, including curiosity, group membership, recreation, stimulation, relaxation, relief of boredom, and coping with depression or anxiety. In many cases, even ‘dependent’ drug use can be reconstrued as just another example of the basic human desire to repeat pleasurable activities.

► Harm-reduction is also based on evidence that most illicit psychoactive drugs — if used by scientifically determined or culturally prescribed methods — are probably far less harmful to health than many products to which people are licitly exposed, such as tobacco, alcohol, prescribed pharmaceuticals, processed and high-fat foods, polluted air, contaminated water, pesticides, radiation and nuclear waste. The message that drugs are unhealthy is likely to be regarded by many people in industrialised societies as akin to warning soldiers on the battlefield that chewing gum can cause indigestion.

► The necessity for a harm-reduction strategy stems from the growing realisation that unless society changes its repressive laws and policies toward drug users, most will remain ‘underground’, out of the reach of agencies which deal with problem drug use. A harm-reduction strategy would be based on a caring and non-judgemental approach, encouraging more teenagers experimenting with drugs to discuss their experiences with concerned adults.

Dr Newcombe is at the Misuse of Drugs Research Project at the University of Liverpool, and co-author of the project’s report on drug misuse in Wirral. He can be contacted at the University, phone 051-709 6022, ext. 2630.

Content

Harm-reduction materials need to be based on scientific knowledge, meaning that their content needs to be constantly reassessed.

Programmes could include instruction on the psychological and physical effects of licit and illicit drugs; safest methods of administration and quantities of use; obtaining help for drug-related problems; and alternative (non-drug) methods of controlling mental states.

The focus would be on controlled use (rational choice, care and moderation) rather than abstinence (‘just saying no’), the crucial assumption being that “abstinence is very much out of character with the reality of modern life”.[1]

Anti-AIDS advice on the use of heroin and other injectable drugs provides a clear example of the logical ‘flow-chart’ structure of harm-reduction messages (see box). Rather than encouraging more harmful drug use, such an approach provides a series of ‘safety nets’ to catch various types of drug user, minimising potential harm to the user and the community.

Another important example is instructing potential sniffers about the risks of experimenting with solvents.[1] Over 40 per cent of solvent-related deaths reported in 1971-81 were due to indirect causes, such as accidents and injuries due to sniffing in dangerous situations, or suffocation from over-large plastic bags.[6] Also, some inhalants are inherently more dangerous than others. Giving instruction about these avoidable hazards to current and potential solvent users, while taking great care not to encourage the practice, could do much to reduce injury and death.

Harm-reduction programmes might also reduce the relatively high incidence of accidental overdosing by drug users recorded at some urban hospitals. For instance, many accidents and deaths might be avoided if polydrug users were given early instruction never to use alcohol with other depressant drugs such as sedatives or opiates — it is reported that one-third of all illicit drug overdoses in the UK in 1985 occurred in combination with alcohol.

Implementation

Implementation of harm-reduction programmes also needs to be based on scientific knowledge, this time of how to maximise the probability of success — but there are some formidable practical problems to be overcome.

Research suggests the majority of young people have neither tried nor plan to try illicit drugs. Some believe this makes it unwise to risk stimulating their interest by giving information about the effects and methods of using drugs. Others argue that, given certain conditions (eg, unemployment, hedonistic values), virtually all young people are susceptible to experimentation with drugs, so harm-reduction programmes should be given to everyone approaching the age of first drug use.[1]

Structure of anti-AIDS advice on heroin

HEROIN can cause many problems, so it is best to avoid this way of getting high:

▼

BUT if you are going to use heroin, then smoke (or snuff) rather than inject;

BUT if you have decided to inject, do not share your needles or other injection equipment;

▼

BUT if you are going to share needles and syringes, make sure you follow the correct procedure for cleaning injection equipment;

▼

ALSO if you are injecting heroin, make sure you regularly obtain fresh supplies of needles, syringes and condoms.

PLATFORM

For many youngsters, the ‘just say no’ campaign has come too late or failed: in some urban areas, heroin and other illicit drugs have become a ‘normal’ part of teenage experience. In areas like these, Russell Newcombe argues it’s ‘high time for harm-reduction’.

There is no doubt that it would be advisable to learn from past mistakes by treading cautiously in the first stages of implementing a harm-reduction programme. One solution is to initially give harm-reduction education only to young people already using drugs or most likely to use drugs in the future.

The missing link has been how to identify the young people most at risk of using drugs, before they actually start. However, in recent research early, frequent and heavy use of alcohol and tobacco, planning to try drugs or having pro-drug attitudes, and having large numbers of friends who smoke or drink, have been found to be strong indicators of later illicit drug use.[3]

Accordingly, groups of young people found to be smoking or drinking earlier or more heavily than others could be targeted (along with current users) for a harm-reduction programme. Regular surveys of the drinking and smoking habits of young people from the age of about 9 or 10 years would be needed.

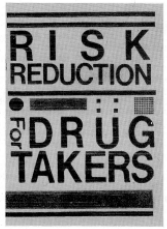
However, there may be problems in conducting programmes with different objectives within the same school or group of youths. Youngsters are likely to talk to each other about any ‘special classes’, spreading harm-reduction information to the low-risk group. If targeted youths become aware they are thought to be potential drug users, this may have the effect of a ‘self-fulfilling prophecy’. Some teachers and parents may regard targeting as unethical. Lastly, identifying the majority of at-risk youths may turn out to be difficult in practice.

One way of overcoming some of these difficulties would be to target larger groups, rather than specific individuals. Since illicit drug use appears to be more widespread among young people in areas of social deprivation, all the young people in some schools and townships might usefully be regarded as ‘at risk’ of drug use.

It may be advisable to transfer responsibility for harm-reduction programmes from teachers to specialist instructors with some basic training in the medical and social sciences. Alternatively, teachers with appropriate experience could be trained on courses of about six months’ to a year’s duration. Harm-reduction programmes may be better separated from (rather than integrated into) the secondary school curriculum, a change in approach in conflict with the view of most contemporary health educationists.

Introduction of harm-reduction programmes may meet with strong opposition from many parents, teachers, youth workers and community groups. It would therefore be prudent to conduct a series of meetings and discussions with representatives of these groups, whose cooperation and good will is essential to the effectiveness of any drug education programme. Ideally, secondary prevention programmes for young people should be conducted in tandem with programmes for adults, allowing adults to make more informed judgments about the approach.

One possible compromise between targeting high-risk young people for harm-reduction programmes and the objections to such programmes, would be to split the project into two phases. Confidential surveys of young people throughout the school could identify actual and potential users, but only on leaving school would those identified be given harm-reduction instruction.



An experimental harm-reduction leaflet being evaluated in the Salford area.

Though such an approach may be more acceptable to some groups of parents and teachers, the obvious shortcomings are that large numbers of youths will already have been using various drugs for several years while at school, and, after they leave, many of those most at risk will be hard to contact through youth work agencies.

Evaluation

Harm-reduction programmes are only worthwhile if the effects on young people are evaluated by carefully designed ‘before and after’ studies and by long-term follow-up studies using control groups.

Such programmes are, by definition, evaluated by the type and number of potential or actual problems drug users (1) experience themselves; or (2) cause others to experience.

For instance, in the first case — problems experienced by the user — programmes might be expected to:

— reduce the prevalence of unsafe frequencies and methods of use;

— reduce the rate of heavy or dependent consumption;

— reduce experimentation with drugs most likely to cause medical problems (eg, tobacco) or social problems (eg, heroin);

— improve abilities to recognise and respond to drug-related problems.

Examination of any of these variables requires that schools and other youth agencies develop drug policies which create an atmosphere in which young people can talk truthfully about their use of drugs.

Reduction in harm caused to the community could be monitored through:

— the number of acquisitive offences com-

University, 1986.

2. See for example: Advisory Council on the Misuse of Drugs. *Prevention*. London: HMSO, 1984. But it is important to remember that most methodologically sound research supporting this verdict is concerned with North American drug education programmes, and that countless programmes have never been properly evaluated.

3. Blum R.H. *Drug education: results and recommendations*. Lexington, Mass.: Lexington, 1976.

4. Carroll R.J. *Shifting gears: making secondary prevention strategies ‘primary’ in the substance abuse field*. Pennsylvania, USA: Eagleville Hospital, 1985.

5. See ISDD Research and Development Unit. *Teaching about a volatile situation*. London: ISDD, 1981.

6. Anderson H.R., Dick B., MacNair R.S., *et al*. An investigation of 140 deaths associated with volatile substance abuse in the United Kingdom (1971-1981). *Human Toxicology*: 1982, *1* (3), p207-221.

7. Many teachers and youth workers believe that young people are now far more knowledgeable about drugs than older generations — not surprising given increasing press coverage and the high-profile media prevention campaigns aimed at youths. Formal instruction about drugs from trained teachers could not therefore be expected to arouse an already primed curiosity. If this is the case, then the targeting strategy discussed later may be unnecessary.

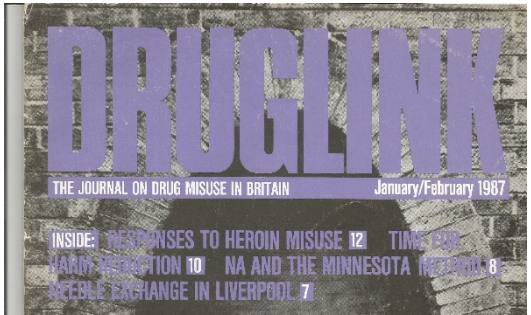
8. See: Pritchard C., Fielding M., Choudry N., *et al*. Incidence of drug and solvent abuse in ‘normal’ fourth and fifth year comprehensive school children — some socio-behavioural characteristics. *British Journal of Social Work*: 1986, *16*, p1-11.

Kandel D.B. Epidemiological and psychosocial perspectives on adolescent drug use. *Journal of the American Academy of Child Psychiatry*: 1982, *21* (4), p328-47.

Parker H., Newcombe R.D. & Bakx K. Alcohol, tobacco and illicit drug use among young people in Wirral. Liverpool: The University, 1986.

It is my view and increasingly the view of others who work with drug users or young people that it is high time for harm reduction.’

AIDS was the impetus – but HR rolled out also to overdose prevention, pill testing, safer drug use



Why was HR accepted in the late 1980s?

- Supportive drug policy and explicit HR strategy
- Supportive AIDS policy
  - political co-operation and consensus
  - 'war emergency' mood
  - AIDS prevention as a social movement
- Financial resources
- Infra-structures to deliver harm reduction - community based agencies
- Support across political spectrum
- HR Legitimised on back of general AIDS awareness campaigns – AIDS affects us all – safer sex > safer drug use

Stimson G V. AIDS and injecting drug use in the United Kingdom, 1988-1993: Social Science and Medicine, 41,5,699-716)

ihra
INTERNATIONAL HARM REDUCTION ASSOCIATION
Promoting harm reduction on a global basis

Helping change the culture of drug use

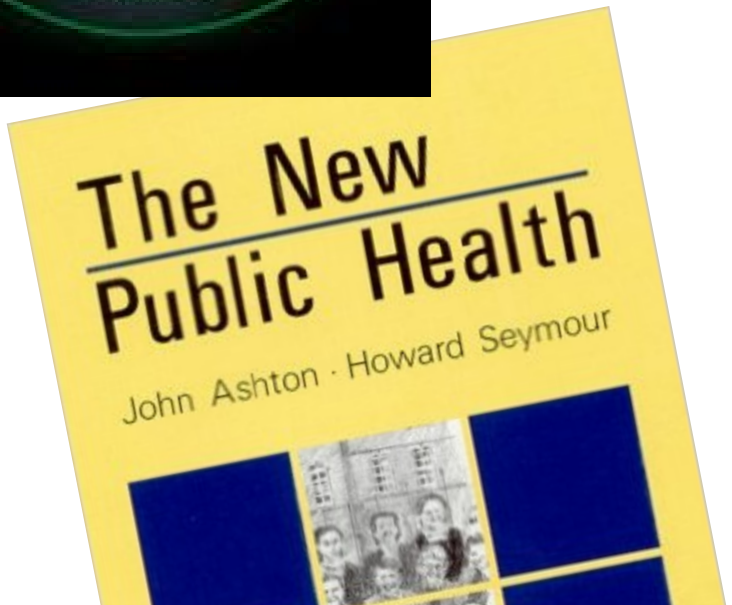
Engagement with 'affected' populations – 'nothing about us without us'

Partnership ethos

Destigmatisation

A supportive public health vision

Courageous public health leaders



The *Ottawa Charter for Health Promotion* WHO, 1986

A public health vision

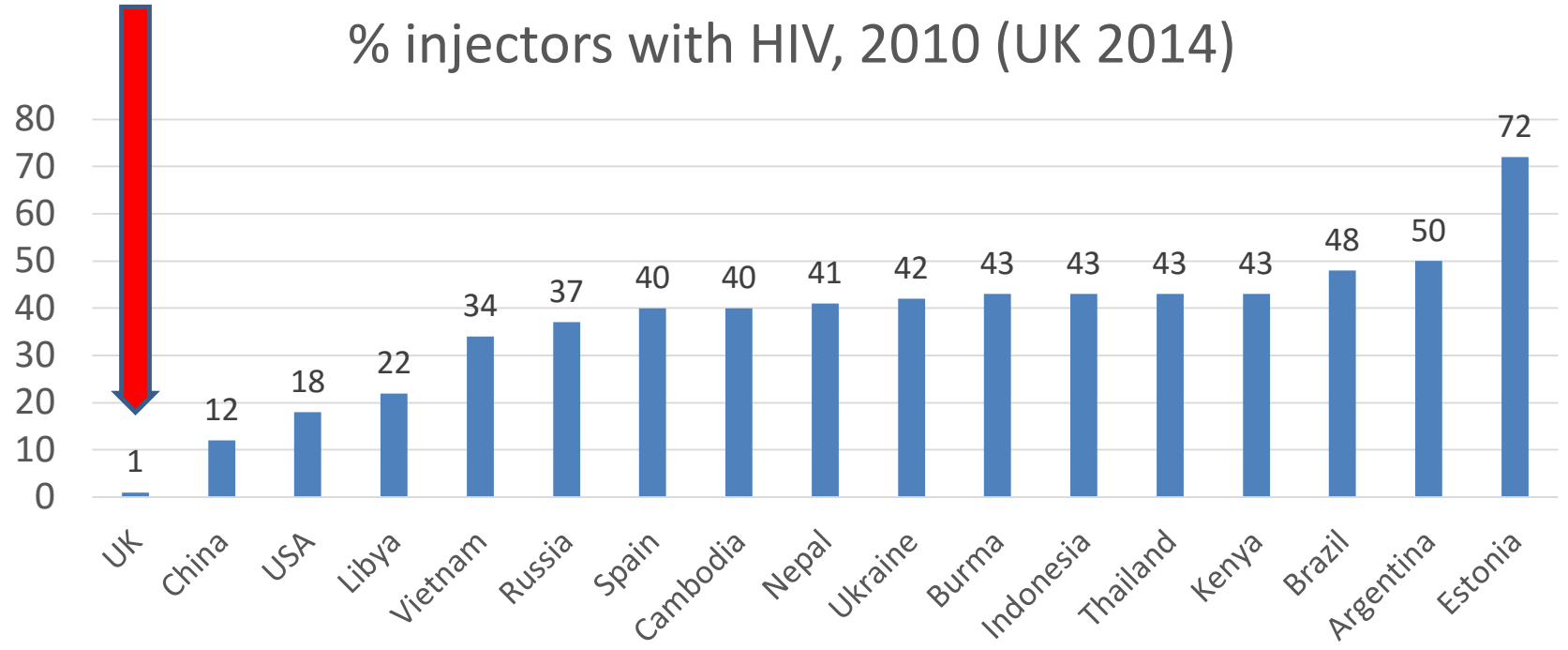
Strategies for health promotion

Advocate:

Enable: … individuals must become empowered to control the determinants that affect their health

Mediate: …success will depend on the collaboration of all sectors of government (social, economic, etc.) as well as independent organizations (media, industry, etc.).

Harm reduction for drugs/HIV – a UK public health success – the right approach helped prevent HIV infection



Epidemiology of HIV Among Injecting and Non-injecting Drug Users: Current Trends and Implications for Interventions. S Strathdee et al Curr HIV/AIDS Rep. 2010 May; 7(2): 99–106; and (UK) PHE Shooting Up: Infections among people who inject drugs in the UK, 2014

Harm reduction works

30 YEARS LATER

Public Health got it right with drugs harm reduction but gets it wrong with tobacco harm reduction

The tobacco harm reduction proposition:

- Nicotine is the second most popular drug
- Smokers risk disease and premature death
- Most smokers say they want to stop smoking
- Many have tried to stop
- Many find it hard to stop and many are unable or unwilling to give up nicotine – they like it
- Smoking tobacco is the most harmful way of delivering nicotine
- Providing safer ways to deliver nicotine enables people to continue using nicotine but to avoid the health risks of smoking

Tobacco harm reduction - origins

Pioneer - Mike Russell

"Smokers cannot easily stop smoking because they are addicted to nicotine…. People smoke for nicotine but they die from the tar"

1976 BMJ 1: 1430-1433

4000 chemicals in tobacco smoke

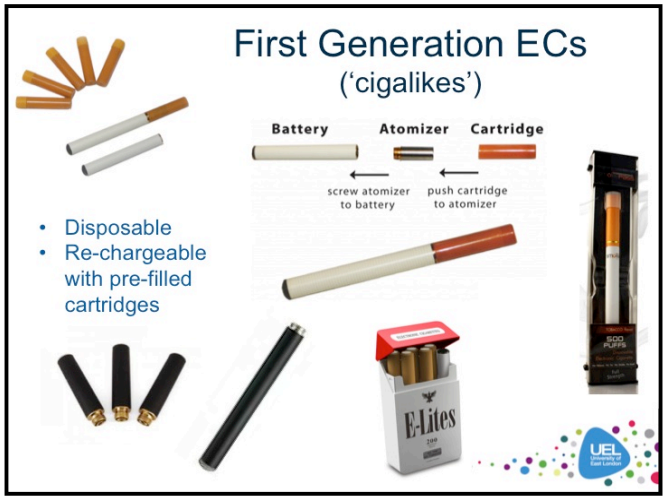
'Rebalancing the market in favour of the safest nicotine products would provide choice, encourage safer nicotine use, and reduce morbidity and mortality.' p240

Harm reduction in smoking can be achieved by providing smokers with safer sources of nicotine that are acceptable and effective cigarette substitutes.' p241

2007

At the time apart from NRT (and snus) no attractive and viable sources of safer nicotine

E-cigarettes the game changer



- A low risk way to deliver nicotine
- Came on UK market in 2007
- Rapid innovation
- 'Biggest disruption to tobacco consumption since Bonsack invented the cigarette rolling machine in 1880' *

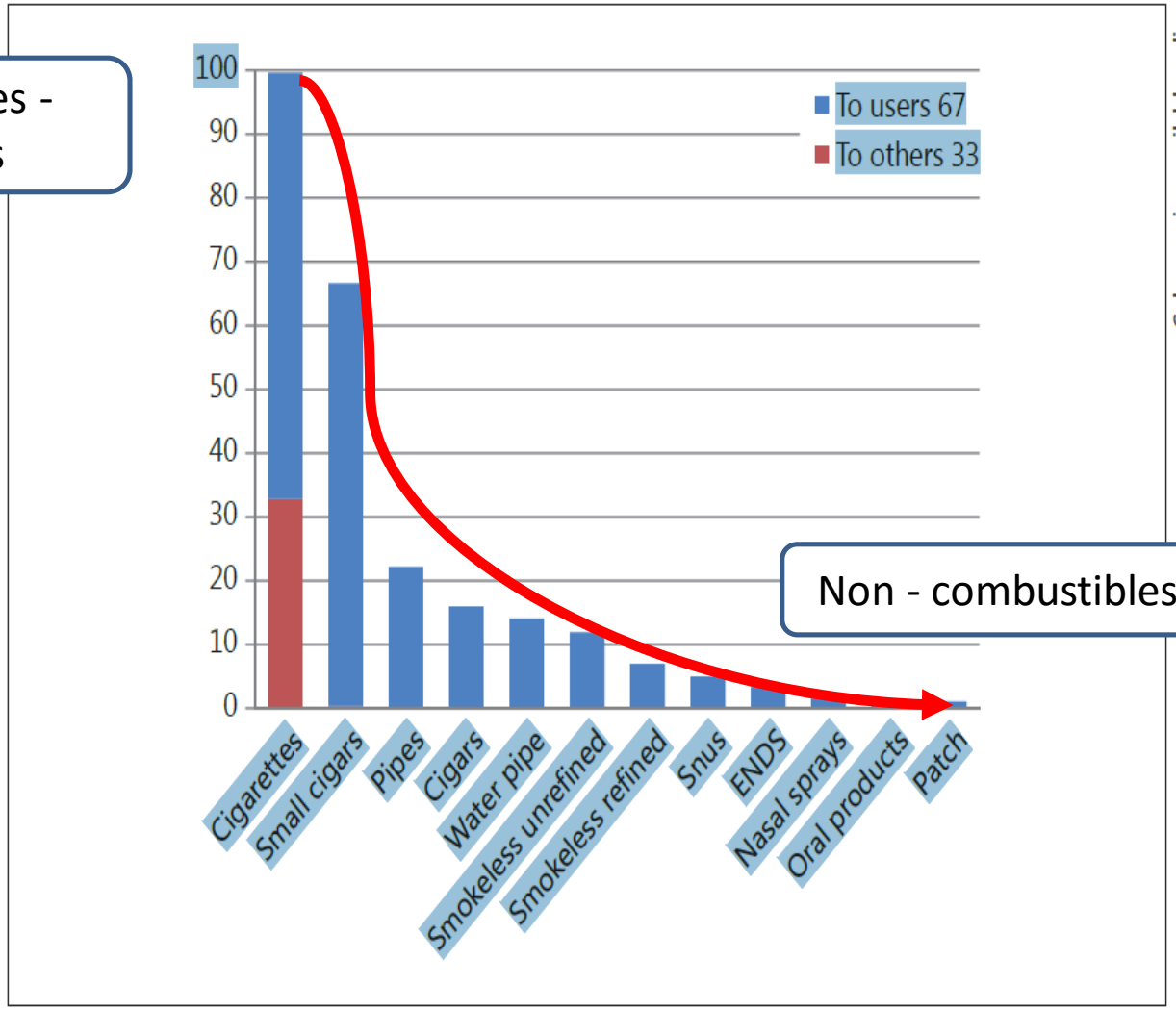
* Stimson, G. V, Thom, B., & Costall, P. (2014). Disruptive innovations: The rise of the electronic cigarette. *The International Journal on Drug Policy*

Gerry Stimson 14 April 2016

Photos courtesy Lynne Dawkins and Dave Dorn - VTTV

Nicotine products are not equally harmful - continuum of harm for different nicotine containing products

Combustibles - cigarettes



Non - combustibles

Differences in harm reported by David Nutt et al using expert ranking of harms; e-cigarette evidence since replicated manifold by lab and clinical studies

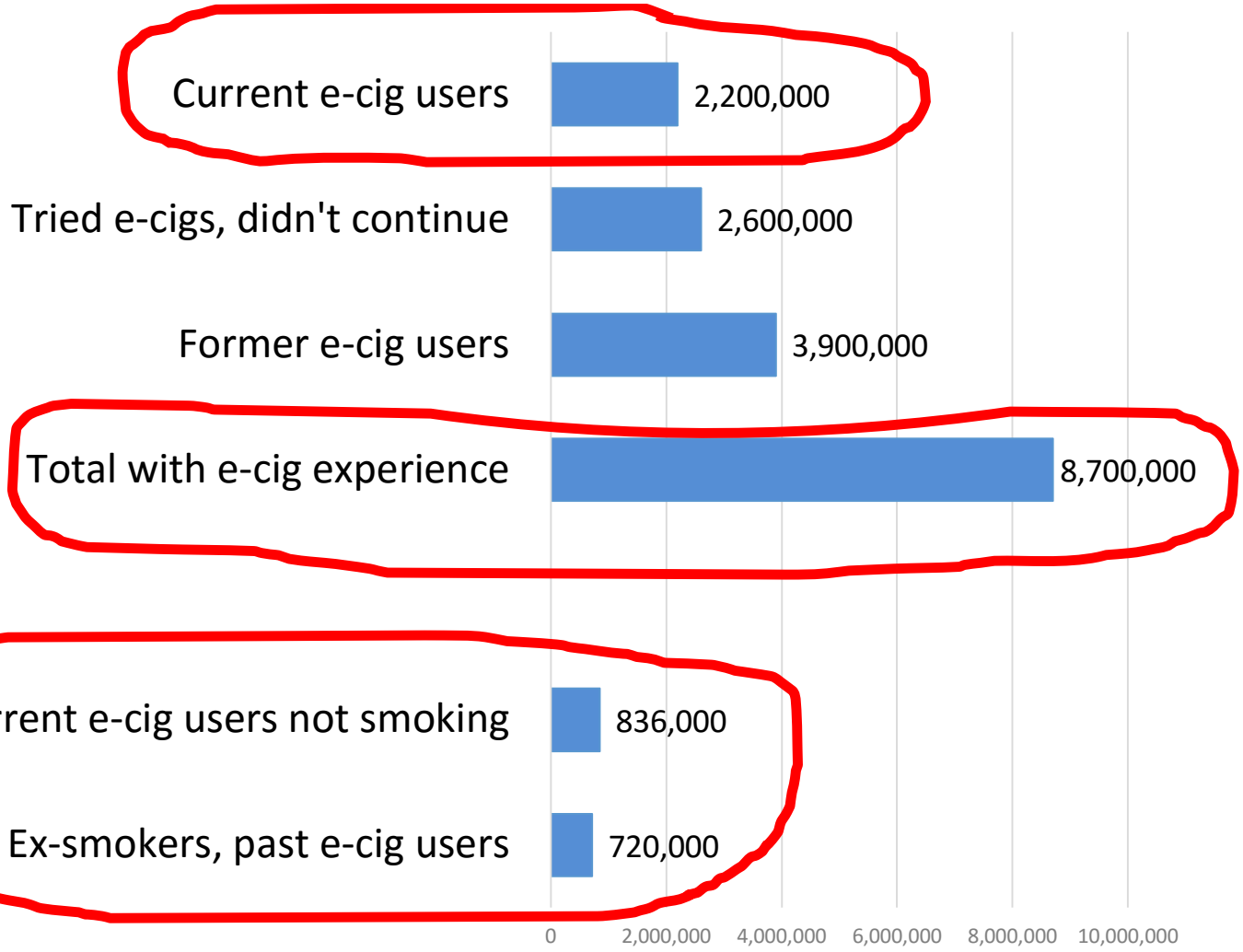
ENDS = Electronic Nicotine delivery Systems

There will be an increasing range of non-combustible nicotine products – in addition to e-cigs and Swedish snus (banned in EU except Sweden); tobacco heating products, hybrid e-cigs with tobacco flavour ….

Rapid rise of e-cigarette use in Britain 2015

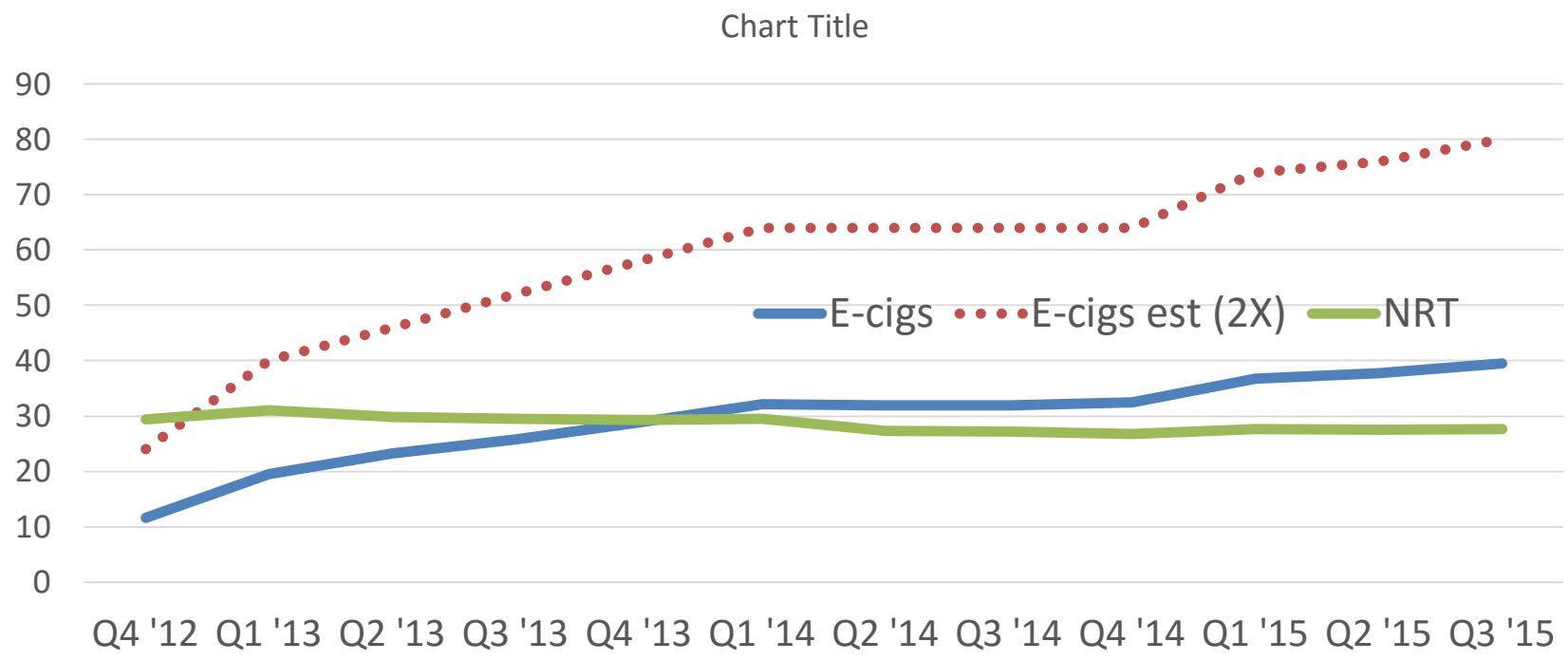
Office for National Statistics

Unlikely that any Public Health initiative could have so much impact in such a short time, in terms of reach - 8.7 m have tried e-cigs; successful converts – 2.2m current users; or with such success - the nearly 1m e-cig users who no longer smoke cigarettes + +



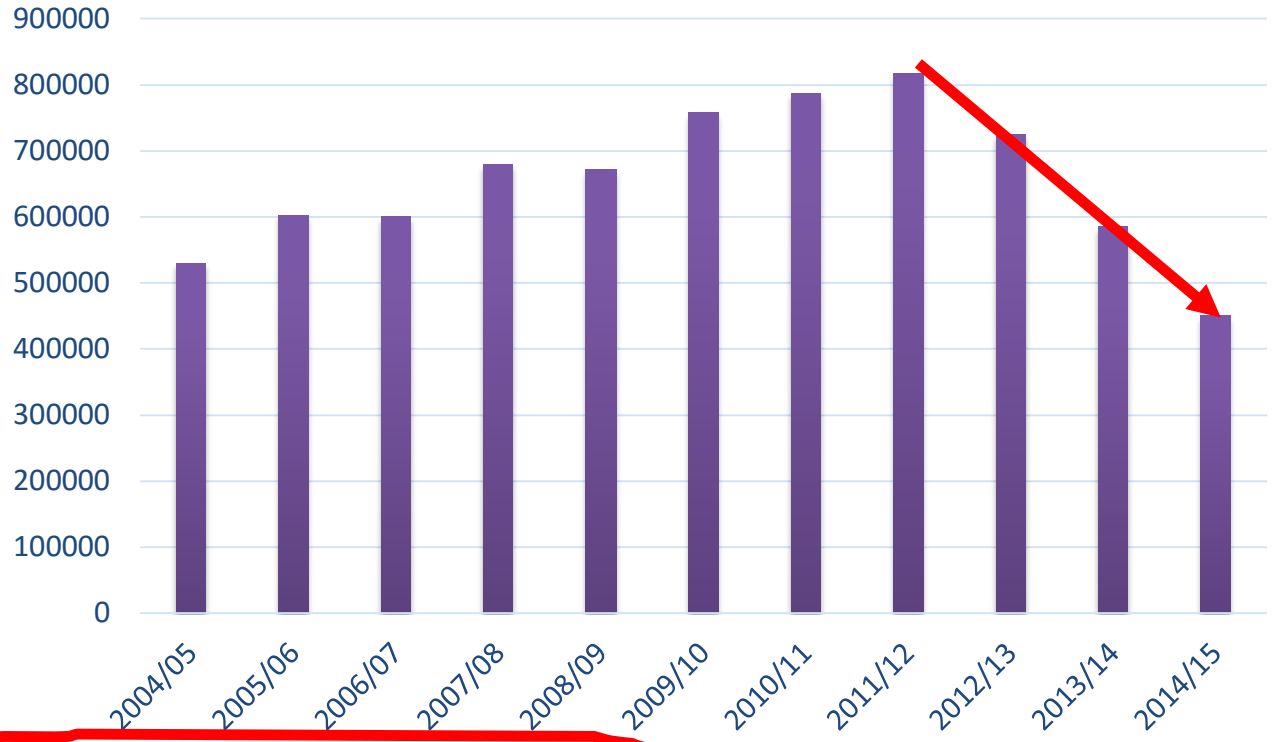
E-cigarette sales overtake NRT

(£M sales/Qr)



Source: Nielsen – this measures e-cigarette retail store data and not vape shops and online. Stock analysts estimate total volume would be 2X.

Smoking cessation services lose business - customers declined by 45% since 2011-12



Total cost 2014-5*	**£118m****
Cost per successful quit	**c £513****

*Cost per quit increases as clients decrease; service cost £235 in 2012-13, £344 in 2014-15.
**Prescribing costs est. based on 2013-14 reduced by £10m lower in 2014-15 England

Clients [i]	**450,582**
Successful quits [ii]	**229,688**

	Total cost	Per successful quit
SSS service [iii]	**£79m**	**£344**
Prescribing (c 50% NRT)[iv]	**(£49m) £39m adjusted**	**(£212) £169 adjusted**
Total	**(£128m) £118m adjusted**	**£513**

[i] Setting quit date
[ii] Quit smoking at 4 week follow-up, not smoked since two weeks after the quit date
[iii] 2014-15 Table 4.12
[iv] 2013-14 Table 4.10. data unavailable for 2014-15. Will be less in 2014-15
Source: Health and Social Care Information Centre, Statistics on NHS Stop Smoking Services in England; April 2014 to March 2015; April 2013 to 31 March 2014. Missing data = costs are understated

From ‘quitting’ to ‘switching’ and ‘pleasure’

- ‘Smoking cessation’ repositioned from medical ‘treatment’ to pleasurable experience
- From stigma and guilt to guilt-free enjoyment of nicotine
- Vaping and pleasure - a recreational alternative to smoking - Sarah Jakes http://nnalliance.org/blog/39-the-pleasure-principle
- For some, becoming a vaper an important transformation in personal identity; for some, a hobby (gadgets etc)
- Vaping and fun: Vapefest (there are no NRTfests)
- Normalisation of nicotine use – nicotine as a life style product

Self-help, mutual help

- DIY approach to switching from smoking
- Vapers helping vapers
- Vapers helping smokers - Chris Russell http://substanceuseresearch.org/christopher-russell-ph-d/
- Vapers are experts
- Vapers are advocates
- Vapers do it for free– unpaid!
- Doing exactly what PH experts extol:

WHO Ottawa Charter on Health Promotion - individuals must become empowered to control the determinants that affect their health

Visits to E-Cigarette-Forum.com
Website visits United Kingdom, 2015

3,607,461 total visits

10,000 average daily visits

(International total = 33,792,766)

1.	England	**3,191,126**
2.	Scotland	**233,292**
3.	Wales	**113,688**
4.	Northern Ire	**50,032**
5.	(not set)	**16,511**
6.	Isle of Man	**2,812**

Data courtesy of Neil Mclaren and Oliver Kershaw

Vapers become advocates

Gerry Stimson 14 April 2016

A VOICE FOR VAPERS

VAPERSINPOWER.co.uk

A Registered Political Party

SUPPORT

UK New Nicotine Alliance

Promoting and supporting tobacco harm reduction

Registered charity in England and Wales # 1160481

Majority Against Vaping Ban

in Wales

E-cigs save lives

ARTICLE 20 OF THE TPD

HOW WILL IT AFFECT ME?

JOIN US IN SAYING NO TO ARTICLE 20 OF THE TOBACCO PRODUCTS DIRECTIVE

NO Bottles over 10ml

LESS Choice of e-liquid

NO Tanks over 2ml

NO Refillable Tanks

NO Nicotine above 20mg

NO Advertising

WE NEED YOUR SUPPORT

JOIN OUR PETITION ONLINE AND SHOW YOUR SUPPORT AGAINST ARTICLE 20

article20legalchallenge.com

World Health Organization

HARM SOLD

‘Public health’ response - v1

Meanwhile in a parallel universe – what was the Public Health response to smokers doing the right thing?

Antipathy – or quiescent

No public health vision

Predominantly a ‘threat’, ‘fear’ and ‘concern’ narrative from PH thought leaders. E-cigarettes -

- Undermine anti-smoking policy
- Encourage young people to smoke/become nicotine addicts
- Prolong smoking, delay quitting
- Normalise smoking
- No evidence for effectiveness
- Tobacco company plot
- Abstinence the best option
- Instead seek professional help

Some Public Health leaders deeply suspicious of and vilify vapers*; Pres. of the Faculty of Public Health insulted vapers on Twitter**.

* Simon Capewell (2015) President’s Letter: My thanks to Internet Trolls, Libertarian Bloggers and Hobbits. Society for Social Medicine Summer Newsletter ** Daily Mail Online (2014).

Dame Sally Davies Chief Medical Officer for England New Scientist 28 Mar 2014

- **Why are you against increased use of e-cigarettes?**
  If they were properly regulated as a medicine and we knew what was in them and the dose of nicotine, then they might play a useful role in stopping smoking. But they aren't, so at the moment we don't know their safety or the dose they deliver. They are often aimed at children with their flavourings – not only menthol but cookies and cream and bubblegum. They are sold rather cheaply and many of them are made in China, so I worry about what is in them. We have even got a verb for e-cigarette use: to vape. I am worried about normalising once again the activity of smoking. This matters particularly with children and adolescents.
- **So you are worried this could be a rerun of socially acceptable smoking?**
  Yes. Have you seen the adverts for e-cigarettes? They make them look cool and chic. In the Metrocentre in Newcastle they have a vaping boutique, which looks like a perfume boutique.

Martin McKee

Int J Public Health (2014) 59:683–685

Nicotine is a poison and there are increasing reports, from several countries, of poisoning in young children who swallow nicotine-containing fluid ...which is hardly surprising given their attractive packaging and flavours, such as bubble gum, that seem designed to appeal to children.

...e-cigarette manufacturers have engaged in intensive marketing that gives every impression of being targeted at young people.

...marketing..should not target children and young people or other non-smokers ..and should not 'renormalise' or 're-glamourise' smoking or undermine smoking prevention policies (which implies a ban on their use in enclosed public places).

Faculty of Public Health

http://www.fph.org.uk/people_who_want_to_quit_smoking_should_consult_their_gp

People who want to quit smoking should consult their GP

"A key concern for everyone in public health is that children and young people are being targeted by mass advertising of e-cigarettes. There is a danger that e-cigarettes will lead to young people and non-smokers becoming addicted to nicotine and smoking….

For now, the best thing anyone who wants to stop smoking can do is to talk to their GP or ring the national quitline to get a referral to safe, evidenced-based services. We just don't know enough yet about e-cigarettes to be sure that they are a safe alternative to this proven method of quitting smoking for good."

John Middleton, FPH 2016

Why the PH difficulty with e-cigarettes?

- PH strategy on smoking dominated by tobacco control narrative > to make tobacco use difficult > anti- smokers and industry > tobacco free world
- All tobacco use seen as a problem
- Make tobacco/smoking difficult - price, smoking bans
- Stigmatisation of smokers (contra drugs and HIV de-stigmatisation)
- 'Anti' framework makes it difficult to adopt a 'pro' position on nicotine
- Discombobulated that (a) the market and (b) industry might help solve some health problems
- PH thinking finds it difficult to embrace pleasure
- e-cigarettes not invented or implemented by medicine or PH

Public health response - v2
Public Health England launches strong positive position on e-cigarettes

- PHE evidence review communicates that e-cigarettes at least 95% less risky than smoking regular cigarettes (McNeill et al 2015).
- e-cigarettes pose no identified risks to bystanders
- e-cigarettes have the potential to help smokers quit smoking
- smoking cessation services need to become e-cigarette friendly (as pioneered by Louise Ross in Leicester)

stop smoking service...an e-cig friendly service

http://www.stopsmokingleic.co.uk/category/ecigs/

Key PHE staff who led this (Kevin Fenton and Martin Dockrell) long term advocates for HIV/AIDS risk reduction.

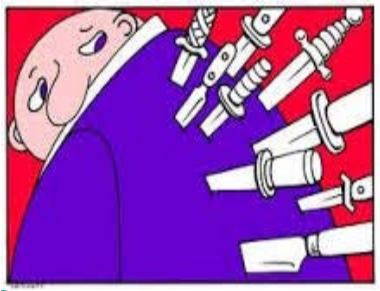
* PHE the coordinating body for public health services; provides high-level analysis and positions.

Public Health England and e-cigarettes

PHE report an historical landmark - parallel to the 1988 ACMD report on AIDS and Drugs Misuse?

PHE consensus statement: key public health agencies accept publicly (though not all members privately) that ‘e-cigarettes are significantly less harmful than smoking’.

BUT a PH cabal launched a coordinated attack to discredit PHE



Public Health England

PH Progress…

BUT - only 1 of 150 Directors of Public Health in the UK has made an unqualified pro e-cigarette statement.

Jim McManus

How and why I changed my mind on e-cigarettes

https://jimmcmanus.wordpress.com/2015/11/15/how-and-why-i-changed-my-mind-on-e-cigarettes/

The New Tobacco Harm Reduction

There is a good future for tobacco harm reduction but a small role for Public Health

Gerry Stimson 14 April 2016

A new landscape of 'smoking cessation'

Provide resources; make contact; raise awareness, provide information	Cost to taxpayer
Research and development, science, product innovation, manufacturing marketing • e-cigarette/tobacco companies	0
Front-line 'staff' and 'outreach workers' • c1 m vapers who have stopped smoking	0
Smoking cessation advice centres • 1500-2000 dedicated vape shops • 1500-2000 stores with significant trade + retail chains	0
• Self-help and mutual help (peer education) • Social media, internet forums, websites	0
COST TO STATE	£0
BENEFIT *	£62bn

* 836,000 people use e-cigarettes and no longer smoke. NHS value a "successful quit" = £74,000, based on average 1.2 life yrs saved @ £60,000 per life year.

The New Tobacco Harm Reduction – a success for the health of the public without help from Public Health

E-cigarettes are a free gift to the health of the public.

E-cigarette makers, vaping stores, vaping forums and vapers are the new front line in helping people switch from smoking (Resources + Raise awareness + Make contact)

Public health objectives delivered without the involvement of Public Health professionals.

At no cost to the taxpayer

Two epidemics, two public health responses – what role for PH in Tobacco Harm Reduction?

Compared with HIV, the Public Health role in the tobacco harm reduction is small, cheap and easy.

Smokers, of their own accord are taking responsibility for their own health.

The landscape of nicotine is changing

The Public Health role, to:

- stop sowing doubts
- recognise the limits of tobacco control and the potential for tobacco harm reduction
- promote good science and analysis
- endorse and reassure

A Tobacco Control Plan for England or a Tobacco Harm Reduction Plan?

http://www.kachange.eu/