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Tobacco smoking and vulnerable groups: overcoming the barriers to harm reduction

Scholarly commentary

Tobacco use in high-income countries correlates with socio-economic disadvantage; groups vulnerable to disadvantage who also have high smoking prevalence include people who are homeless or in the prison system, those who have a mental illness or a drug or alcohol addiction, and the indigenous people of North America and Australasia (Twyman et al., 2014). In addition, pregnant women and young people are often regarded as vulnerable groups because of the importance of halting the tobacco epidemic in future generations (Notley et al., 2015). A recent systematic review found that barriers to smoking cessation included smoking for stress management, lack of support from health and other service providers and high prevalence and acceptability of smoking in vulnerable communities (Twyman et al., 2014). However, while similar findings have been reported in many other studies and reviews, they have not resulted in widespread implementation of effective interventions to address continuing high rates of smoking in these groups. We need greater understanding of why tobacco control strategies have not reached or impacted upon vulnerable groups; but to reduce smoking-related health inequalities quickly, we also need alternative approaches.

One potentially promising approach to supporting smoking cessation in vulnerable groups may be tobacco harm reduction. This involves replacing very harmful tobacco products with far less risky alternatives that contain nicotine, the addictive constituent in smoked tobacco, but without many of the harmful constituents of cigarettes. Although the idea of addiction is contested and fraught with moral judgement (Bell and Keane, 2012), particularly for groups which are already the focus of stigma (Graham, 2012), higher levels of addiction in vulnerable populations (Siahpush et al., 2006) suggest that they might disproportionately benefit from a harm reduction approach involving the continued use of nicotine. In addition to

nicotine, less risky products may provide alternative sources of social identity and pleasure (Notley et al., 2018, Cox and Jakes, 2017, Barbeau et al., 2013), replacing aspects of smoking which quitters might miss as much or more than the nicotine itself. Key current alternative products include e-cigarettes or vaping products, which existing evidence suggests are substantially less harmful to health than continued tobacco smoking (National Academies of Sciences, 2018, McNeill et al., 2018). In the UK, a recent UK Parliamentary Select Committee Report on e-cigarettes endorsed their use in vulnerable groups e.g. patients in mental health units (Science & Technology Select Committee, 2018). However, other countries, including Australia and the US, have been, and may increasingly be, more concerned with young people's potential exposure to e-cigarettes than with the benefits to smokers (Green et al., 2016), whilst others, despite having many poor smokers, have taken a hostile approach (Cousins, 2018).

It is not yet clear to what extent e-cigarettes will be effective in vulnerable groups (Gentry et al., 2018), nor how they will impact on health inequalities (Lucherini et al., 2018, Thirlway, 2018), not least because some barriers to e-cigarette use may affect vulnerable groups disproportionately. These include initial start-up costs and other difficulties in accessing and operating devices and refills, the masculine environment of vape shops which may be off-putting to women smokers, legal limits on nicotine concentrations and concerns about health risks and continuing addiction, often linked to the regulatory environment (Thirlway, 2016, Cox et al., 2018, Gentry et al., 2018, Ward et al., 2018, Dawkins et al., 2018, Yong et al., 2017). Health care professionals have been reluctant to support e-cigarette use during pregnancy due to safety concerns, and tobacco smoking has historically been part of the culture of inpatient psychiatric services (Trainor and Leavey, 2016). Many of these barriers can be addressed by public health policy, driven in the UK by the Public Health England evidence review of e-cigarettes (McNeill at al 2018) but also put into practice by smoking cessation services supporting e-cigarette use (e.g. Leicester Stop Smoking Service). South London and Maudsley NHS Foundation Trust and Norfolk and Suffolk Mental Health Trust have adopted 'e-cigarette friendly' services. In the UK, the Mental Health and Smoking Partnership has produced resources including advice on

e-cigarettes for mental health settings (Smoke Free Action, 2018b). Similarly, the smoking in pregnancy challenge group (Smoke Free Action, 2018a) has been at the forefront of developing evidence-based advice for pregnant women and healthcare professionals to promote engagement with e-cigarettes as a reduced harm alternative to continued cigarette smoking. The extent to which such initiatives are successful in addressing high rates of smoking in vulnerable populations is an emergent area for international research, where contextual factors including policy and culture fundamentally influence the implementation of reduced harm approaches to nicotine addiction.

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