A tale of two epidemics: drugs harm reduction and tobacco harm reduction in the United Kingdom

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Abstract

Purpose – *The purpose of this paper is to compare the response to HIV/AIDS and drug use (drugs harm reduction) with tobacco harm reduction.*

Design/methodology/approach – *Analysis of historical and contemporary sources, combined with personal knowledge of key stakeholders in the history and development of both fields.*

Findings – *Both drugs harm reduction and tobacco harm reduction share a similar objective – to reduce health risks for people who are unwilling or unable to stop using their drug of choice. Both also share a broader public health aim of helping people to make healthier decisions. Drugs harm reduction – as a response to HIV/AIDS – included the adoption of a wide range of radical harm reduction interventions and was a public health success. It became an established part of the professional Public Health agenda. In contrast the Public Health response to e-cigarettes and tobacco harm reduction has ranged from the negative to the cautious. A recent Public Health England report is exceptional for its endorsement of e-cigarettes.*

Originality/value – *Highlights contradictions in Public Health responses to drugs and tobacco; and that public health interventions can be implemented without and despite the contribution of professional Public Health.*

Keywords *Drugs, Harm reduction, Public health, Tobacco, AIDS, E-cigarettes*

Paper type *Viewpoint*

Those familiar with the history of drug policies will be aware of the relatively rapid adoption of drugs harm reduction in the UK, which occurred in the space of a few years at the end of the 1980s and the beginning of the 1990s. The introduction of the HIV test in 1985, and first data indicating that HIV was highly prevalent among Scottish injectors, raised awareness of the potential for the spread of HIV infection (Stimson, 1990). From tentative discussions in 1986 grew the acceptance of radical approaches to reducing drug-related harms. In a short time "harm reduction" became a guiding public health strategy and for some a social movement. A "war on drugs" became overshadowed by a "war on AIDS" (Berridge, 1996), succinctly summarised by the Advisory Council on the Misuse of Drugs statement that "the spread of HIV is a greater danger to individual and public health than drug misuse". (Advisory Council on the Misuse of Drugs, 1988). Drugs harm reduction soon became part of the professional Public Health landscape[1]. The strategy accepted that many people injecting drugs were unable or unwilling to stop injecting: hence the aim was to help them to reduce their risk of infection with HIV.

Another epidemic has not received so much attention by those who support harm reduction. The lessons learned from tackling HIV have not been applied to smoking. Smoking tobacco is the world's second favourite drug, after alcohol. Although the prevalence of smoking is decreasing in richer countries, it is increasing globally. It is estimated that there were nearly one billion smokers

Received 8 March 2016
Revised 29 April 2016
Accepted 19 May 2016

in 2012 (Ng *et al.*, 2014), an estimated 5.7 million premature deaths in 2010 (Lim *et al.*, 2012), an estimated 100 million premature deaths in the twentieth century, and that on current trends the number will be one billion in this century (Tobacco Atlas, 2016).

The idea of "tobacco harm reduction" has lagged behind harm reduction for drugs and alcohol. It is not that the idea has been neglected – rather that there has been until recently no obvious popular and practical mechanism by which it could be implemented in the UK. The tobacco harm reduction proposition is straightforward: smokers risk disease and premature death; most smokers say they want to stop smoking and many have tried; many find it hard to stop and many are unable or unwilling to give up nicotine. The provision of safer ways of delivering nicotine enables people to continue using nicotine but to avoid the health risks of smoking. E-cigarettes provide a vehicle for tobacco harm reduction.

Given the support that given to harm reduction in relation to drug use (Ashton and Seymour, 2010; Atun *et al.*, 2015), including such programmes as providing clean needles and syringes and prescribing methadone, it might have been expected that Public Health leaders would have embraced e-cigarettes and tobacco harm reduction. Rather it has been the opposite: the response has ranged from the extreme negative to the ultra-cautious. Indeed some of the same Public Health leaders who initiated drugs harm reduction and who continue to support it have not supported tobacco harm reduction. Clearly harm reduction is rather selectively applied.

The "tobacco control endgame" and a "drug free world"

Both drugs and tobacco harm reduction have developed in the shadow of a vision of a drug- or tobacco-free world. Drug control and tobacco control have shared an ambition of a world without drugs or a world without tobacco. International and national strategies have focused on reducing supply and demand through an abstinence focused, zero-tolerance model. The concepts of reducing both supply and demand are found in both the international drug and tobacco control conventions. The drug control conventions were implemented by criminalising drug trafficking and possession. The tobacco control convention, dealing with a legal product, has been implemented with a focus on strong persuasive measures to help prevent and stop smoking (World Health Organization, 2015). This includes age restrictions, bans on advertising, the raising of price through tobacco taxes, graphic health warnings, smoke-free laws, anti-smoking campaigns and the deliberate stigmatisation of smokers. There is a multitude of quitting methods – but the main health service approaches to smoking cessation involve medications (such as Nicotine Replacement Therapy, pharmaceutical drugs), and cessation advice. The aim is also to make it harder for tobacco companies to sell tobacco – including the introduction of unbranded packs (sometimes erroneously called "plain packs"), taxation and limits on where tobacco products may be purchased. The Framework Convention on Tobacco Control (FCTC) is now supported by 180 countries (World Health Organization, 2016). The cluster of demand and supply focused interventions that makes up tobacco control foresees an "endgame" where tobacco use ceases and tobacco companies cease to exist (Smith, 2013). The convention does not differentiate between different tobacco products. The focus on supply and demand reduction means that until recently there has been little interest globally in tobacco harm reduction. Harm reduction is in fact included in FCTC alongside demand and supply reduction but is not mentioned in its implementation (see e.g. World Health Organization, 2015).

Drugs control and harm reduction

Despite the zero-tolerance and drug free ambitions of drug control, over several decades there developed both theoretical ideas about and the implementation of practical harm reduction interventions. In the UK these can be traced back to the 1920s and the pragmatic approach to prescribing opiates such as heroin and morphine, and in the 1960s the indigenous counter-culture literature on the pleasurable use of drugs whilst avoiding risk (Stimson, 1994). But, in the UK, drugs harm reduction flourished from the 1980s with HIV/AIDS prevention. The public health challenge was that many people were doing things which might increase their risk of HIV infection. The pragmatic response was to provide people with information about sexual and drug

use risks, and with help to change their behaviour – such as methadone prescribing and needle and syringe programmes. The harm reduction emphasis was on "safer" rather than safe, the comparator always the undesired behaviour.

Liverpool was one the first cities to introduce needle and syringe exchange, in 1986, and the "Mersey model of harm reduction" enunciated by John Ashton and Howard Seymour was soon emulated in other parts of the UK (Ashton and Seymour, 2010). By 1987 the government had initiated pilot needle exchange schemes in England and Scotland, and across the UK there was an expansion of access to methadone treatment, and of outreach and peer education projects (Stimson, 1995). Guiding ideas were that drugs services had to re-orient themselves to be proactive in reaching drug users (rather than waiting for them to come to services), and re-orient from abstinence to maintenance. Reaching out, making contact and keeping drug users in contact became the priority, as too was the idea of avoiding being judgemental about drug use, and avoiding stigmatisation – both of which were seen as barriers to engagement. There was also a vision, held by many of the new band of drugs workers, that this was a collaborative endeavour between them and drug users to fight the spread of HIV infection.

Secretary of State for Health Norman Fowler, advised by Donald Acheson, the Chief Medical Officer, persuaded Margaret Thatcher and cabinet of the need for radical and pragmatic approaches to prevent the spread of HIV infection. Opponents urged caution and suggested that supplying needles and syringes would increase the number of people injecting drugs; that it would undermine drug policy, that it would condone drug use, send the wrong message to young people, and that abstinence was the best option. One of the contradictions that the government had to deal with was that it had run an anti-heroin campaign in 1986 and then in 1987 embarked on a needle exchange strategy. Within two years of the government inception of the national needle exchange pilot projects, drugs harm reduction was endorsed by the Advisory Council on the Misuse of Drugs in its report on AIDS and Drugs Misuse. There followed an extensive rollout of harm reduction services across the UK (Stimson, 1995). Russell Newcombe coined the term "harm reduction" in 1987 (Newcombe, 1987). Despite many changes since in the rhetoric and focus of drug policy, drugs harm reduction remains part of the UK response to drugs, although subsequently overshadowed by an emphasis on recovery.

Drugs harm reduction was a public health success. The UK avoided a major epidemic of drugs-related HIV infection of the sort that has been experienced in many countries (Stimson, 1995). The prevalence of HIV infection among people who inject drugs has remained extremely low and stable over many years. The prevalence of HIV infection among people who inject drugs in the UK is around 1 per cent, (Public Health England, 2014) compared with 37 per cent in Russia, 42 per cent in Ukraine, 34 per cent in Vietnam and 43 per cent in Thailand (Strathdee and Stockman, 2010).

The UK was one of several countries that led the way with drugs harm reduction. But despite evidence for the implementation and effectiveness of harm reduction, international agencies including the World Health Organization (WHO) and the United Nations Office on Drugs and Crime played a rear-guard action in preventing the adoption of harm reduction – WHO in the early stages and UNODC pursuing this through to the mid-2000s when the words "harm reduction" were removed from UNODC publications, under US pressure[2]. But the comprehensive HIV prevention package for people who inject drugs – in other words, harm reduction was eventually promoted by WHO, UNODC and UNAIDS. In all, 91 countries now include harm reduction in national policy, while needle and syringe exchange programmes and opioid substitution therapy are available in 90 and 80 countries or territories respectively (Harm Reduction International, 2015).

Tobacco harm reduction

The idea of tobacco harm reduction has a rather different history. Smoking tobacco is the most harmful way of delivering nicotine. In excess of 4,000 chemicals are released, a number of which are carcinogenic, along with carbon monoxide. Attempts to make cigarettes safer, by the introduction of filters in the 1950s and mild cigarettes in the 1970s, were unsuccessful.

Contemporary tobacco harm reduction proponents point to Michael Russell as a pioneer of the idea, for he observed that people smoke for nicotine, but they die from the tar they inhale, and pointed to the health gains that might be achieved if the tar in cigarettes could be reduced whilst maintaining nicotine levels (Russell, 1976).

The idea of tobacco harm reduction was elaborated by the UK Royal College of Physicians in the 2007 report "Harm Reduction in Nicotine Addiction" which argued that "Harm reduction in smoking can be achieved by providing smokers with safer sources of nicotine that are acceptable and effective cigarette substitutes" and further suggested the potential for rebalancing the market in favour of the safest nicotine products (Royal College of Physicians, 2007). At the time this report was written there was in much of Europe no widely available, attractive and viable source of safer nicotine for smokers to switch to. The safer nicotine option for most smokers was Nicotine Replacement Therapy, mainly in the form of patches, gums and tablets. The exception was in Sweden, where snus – a moist pasteurised low risk oral tobacco – is popular amongst men and accounts for Sweden's low rate of lung cancer.

Turning tobacco harm reduction from an idea into a practical alternative to smoking was made possible by the arrival of e-cigarettes, which came onto the UK market around 2007. E-cigarettes comprise nicotine liquid and flavourings, mixed with proplyene glycol and or glycerin heated over a coil to produce an inhalable mist or vapour. There is a wide range of acceptable products, and there has been considerable and rapid product innovation and improvement. Until recently there has been little advertising in the UK (certainly in comparison with other fast moving consumer products). Awareness of e-cigarettes has been mainly by word of mouth, supplemented by social media forums, and information and advice offered at vape-shops (shops selling e-cigarettes and nicotine liquids and flavours).

There has been remarkably rapid uptake of e-cigarettes with latest data indicating 2.2 million currently using them in 2015 – that is 4 per cent of the adult population. That compares with the 19 per cent of the population who smoke cigarettes. There is a further 3.9 million former users of e-cigarettes and 2.6 million people tried an e-cigarette but never went on to use them. In total 8.7 million have tried an e-cigarette (Office for National Statistics, UK, 2016).

ONS data suggest that 836,000 e-cigarette users are no longer smoking. E-cigarettes are now the most common device used by smokers in the UK to help them quit smoking (West, 2016). Accompanying this rise in the use of e-cigarettes has been a decline in the use of NHS smoking cessation services and a decline in the use of NRT.

A significant aspect of the popularity of e-cigarettes is that for the first time stopping smoking is a pleasurable and shared experience, evidenced by the enthusiasm for different flavours and new devices, and the sharing of information on social media sites – something that is not seen with medical interventions such as NRT nor indeed with tobacco cigarettes. One UK e-cigarette forum website has 10,000 visits a day (McLaren, 2016). For some, becoming a vaper is an important transformation in personal identity. Smoking cessation has been repositioned from a medical "treatment" – with its associated displeasure, to one of guilt-free "enjoyment" of nicotine (Jakes, 2016). This perhaps explains why vapers (e-cigarette users) use a language of "switching" rather than of "quitting". "Pleasure" has rarely been so explicit in externally led harm reduction interventions.

Public Health reticence to support e-cigarettes and tobacco harm reduction

The support for drugs harm reduction has not been matched with respect to tobacco harm reduction. The Public Health response to e-cigarettes has been predominantly negative. Concerns have been expressed that e-cigarettes are unsafe, about their potential effect on the renormalisation of smoking, that adverts for e-cigarettes – and their flavours – are aimed at children, about their potential uptake by children and hence a gateway to smoking, about the glamorisation of "smoking" through the portrayal of vaping, that they undermine of tobacco control efforts, and that e-cigarettes are a tobacco industry plot to keep people smoking through the dual use of e-cigarettes and regular cigarettes (McKee, 2013, 2014).

For example, Dame Sally Davies, Chief Medical Officer at the Department of Health said that "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" (New Scientist, 2014). The UK Faculty of Public Health, the lead professional public

health body expressed its alarm at the rapid growth in advertising for electronic cigarettes, that they may be a gateway to smoking for young people, and the potential for this advertising to re-normalise and re-glamorise smoking. It called for a ban on their marketing. It expressed concern that the tobacco industry might be using e-cigarettes to undermine tobacco control and to promote tobacco cigarettes (Faculty of Public Health, 2014). And Martin McKee, a key opinion leader in Public Health similarly claimed that "e-cigarette manufacturers have engaged in intensive marketing that gives every impression of being targeted at young people". And that e-cigarettes renormalize or re-glamorise smoking and undermine smoking prevention policies (McKee, 2014).

The emphasis in these comments is on threats, fears and enemies. It is difficult to tell whether the objections which have been expressed by some Public Health thought leaders represent the majority view, but "product champions" for tobacco harm reduction are rare. Only one of the 150 or so Directors of Public Health in the UK has made a significant pro e-cigarette statement (McManus, 2015). This is a strange silence in comparison with HIV harm reduction.

What explains the antipathy – or lack of enthusiasm – for e-cigarettes and tobacco harm reduction? Why such a different line with respect to tobacco compared with drugs? This must be subject to a lengthier analysis than is possible in this article, but two issues might be considered.

First, drugs harm reduction evolved in a Public Health era strongly influenced by ideas of engaging with and empowering individuals and communities to take responsibility for their health. The response to AIDS in the 1980s benefited from the "new public health" thinking about the need to engage with and enable populations to make positive changes that affect their health (Ashton and Seymour, 1988). These ideas were a key feature the WHO Ottawa Charter for Health Promotion (WHO, 1986), that "Health promotion is the process of enabling people to increase control over, and to improve, their health". The language of the time was of the "empowerment of communities", "community ownership and control", "people as the main health resource" and the community as the "essential voice". These views are still from time to time enunciated. The WHO Constitution states that "Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people" (World Health Organization, 2006). Margaret Chan, Executive Director-General of WHO has referred to "the power of civil society and the activist community to generate the grassroots pressure that can ignite policy change" (World Health Organization, 2008).

In recent decades there has been a shift in thinking to a more macro analysis of health problems and statist top down interventions. The preferred drivers of change are mainly top level interventions (e.g. alcohol, sugar and fat taxes). Tobacco harm reduction (as exemplified by e-cigarettes) does not fit easily with this model – being a bottom up consumer-led health initiative.

Many years of stigmatising smokers has made it difficult to entertain the idea of engaging with vapers. The tobacco control narrative is essentially repressive: hence the remarkable contrast with drugs harm reduction, which has been positive towards drug users and de-stigmatising, whereas tobacco control has used stigmatisation of smokers as a deliberate tactic.

Second, reducing the prevalence of smoking has been central to the work of Public Health staff and strategy to reduce smoking has been dominated by a package of tobacco control interventions. Public Health experts are wary of anything that might seem to undermine the reduction in smoking that has been achieved in the UK. The statist level thinking about intervention – exemplified in a wish to see the end of the tobacco industry – makes it difficult to countenance that some of the companies who now provide a solution to smoking were the same companies that created the problem. Hence the profound suspicion of the motives of tobacco companies.

Public Health England and e-cigarettes: 95 per cent less risky than smoking tobacco

Given the antipathy to e-cigarettes by both the Chief Medical Officer and prominent Public Health leaders, the surprise towards the end of 2015 was a review of the evidence about e-cigarettes published by Public Health England that stated that e-cigarettes were at least 95 per cent less harmful than smoking regular cigarettes (McNeill *et al.*, 2015). Public Health England is the coordinating body for public health services, and provides high-level analysis and positions on public health issues. The "95% less harmful" communication was coupled with other positive

statements about e-cigarettes, including that e-cigarettes pose no identified risks to bystanders, that e-cigarettes have the potential to help smokers quit smoking, and that smoking cessation services need to become e-cigarette friendly. It is perhaps no coincidence that the key experts who helped steer this report are knowledgeable about HIV/AIDS harm reduction interventions.

The PHE report faced a backlash including a critical editorial and comment in the Lancet (*Lancet*, 2015), and an editorial in the BMJ (McKee and Capewell, 2015) backed up by a media campaign hostile to PHE. E-mails revealed as a result of a Freedom of Information request indicate that this backlash and media campaign was orchestrated by a few people with links to the CMO (Puddlecote, 2016). The repetitive anti-e-cigarette narrative is no coincidence: it is the output of personal relationships and organisational networks.

PHE steered through the controversy and managed to create, for the first time, a consensus on the public health potential of e-cigarettes that was supported by a wide range of tobacco control and Public Health organisations (Public Health England, 2015). The PHE report and consensus statement represents an important shift. Key organisations now accept publicly (even though some of their members do not do so privately) that e-cigarettes are significantly less harmful than smoking.

Further support for tobacco harm reduction came in April 2016, from the Royal College of Physicians. This follow-up to their 2007 report analysed harm reduction developments since the introduction of e-cigarettes, and concluded that harm reduction has huge potential to prevent death and disability from tobacco use, and that "in the interests of public health it is important to promote the use of e-cigarettes, NRT and other non-tobacco nicotine products as widely as possible as a substitute for smoking in the UK" (Royal College of Physicians, 2016). It is interesting, in terms of the argument in this commentary, that this report emanated from the Royal College of Physicians and not the Faculty of Public Health.

Two epidemics, two public health responses

There is a striking contrast between, on the one hand, the drugs harm reduction model of "enabling" and "engaging" populations, of facilitating behaviour change, and of de-stigmatisation and on the other the tobacco control model of repression, sanctions and stigmatisation. One embraces people, the other is predominantly hostile to consumers. Some Public Health leaders are deeply suspicious of vapers and seem to enjoy vilifying them (Capewell, 2015), with the former President of the Faculty of Public Health (the Public Health professional body) insulting vapers on Twitter (*Daily Mail Online*, 2014). It would be unusual to find health experts attacking other key populations.

Vaper (electronic cigarette) advocates are extremely knowledgeable – from personal experience and familiarity with the science. But there are few opportunities for vapers to contribute their knowledge and experience. Many e-cigarette advocates feel that Public Health leaders are aloof and distant – and that they have little moral authority on this issue. It may be that the art of listening to key populations has become less prominent, or that Public Health has not found a way to listen to e-cigarette users. In part this may be a legacy of fearing tobacco-related consumer groups. Contrast AIDS and drugs harm reduction where engagement with affected populations had the highest priority – summed up in the slogan "nothing about us without us" (Stimson *et al,* 2013). "Community engagement" in the context of AIDS meant reaching out to key hard to reach populations. There are no such initiatives with e-cigarettes: no assertive outreach providing e-cigarettes in places where smokers congregate, no outreach to prisoners and people in other closed institutions, where involuntary abstinence is currently enforced, or to disadvantaged populations.

The PHE report is an historical landmark and may well come to be seen as the parallel – in policy impact – of the 1987 ACMD report on AIDS and Drugs Misuse. Excessive caution held up the Public Health response to e-cigarettes. Invocation of the precautionary principle prevented good public health analysis of risks and benefits. "Better safe than sorry" has potential for harm when it discourages otherwise healthy options. HIV/AIDS harm reduction would never have started if the precautionary principle had been invoked in 1986/1987.

What can Public Health do, now?

This analysis suggests that there is a good future for tobacco harm reduction but a small role for Public Health. This health movement to safer nicotine products is unusual. Unlike other public

health interventions it is not only "ground up" but also has not come about as the result of planned intervention or as a result of state investment in harm reduction resources. It has come about as a result of individual smokers deciding to purchase an alternative way of using nicotine. This is a consumer-led health initiative.

The switch to e-cigarettes has been at no cost to the taxpayer: it is a no-cost intervention with major benefit: The UK health service estimate of value of a "successful quit" is put at £74,000, based on average 1.2 life years saved and £60,000 per life year. The 836,000 people who use e-cigarettes and no longer smoke represent a value of £62 billion. From a harm reduction perspective e-cigarettes are a gift to the health of the public. It is unlikely that any formal Public Health initiative could claim so much impact in such a short time, in terms of reach – the 8.7 million who have tried e-cigarettes, successful converts – the 2.2 million current users of e-cigarettes – or with such success – the nearly one million e-cigarette users who no longer smoke cigarettes.

There is a new landscape of smoking cessation. It could well be argued that in the space of a few years the drive away from smoking has shifted from experts and that e-cigarette makers, vaping stores, vaping forums and vapers have become new leaders in the fight against smoking (Stimson, 2016). Vapers are the equivalent of AIDS peer education workers. If this is indeed the case then it is perhaps an example of public health objectives being managed without the involvement of Public Health professionals.

So, what is the potential role of Public Health in this new landscape? This analysis has highlighted the negative view that Public Health experts have taken with regard to e-cigarettes. There are two conclusions. First, how much greater the uptake and impact of e-cigarettes might have been had Public Health been early endorsers. Second, that compared with tackling HIV/AIDS the Public Health role in tobacco harm reduction is surprisingly small and comparatively easy. There is no need to develop costly programmes and spend large amounts of the public budget. The task comes cheap. Smokers, of their own accord are doing exactly what Public Health experts exalt people to do – take responsibility for their own health. The Public Health role is minimal: stop sowing doubts, recognise the limits of tobacco control and the potential for tobacco harm reduction, promote good science and analysis, endorse what vapers are doing, and encourage them to pass on to their peers the message that e-cigarettes are – as Public health England states – at least 95 per cent less harmful than smoking tobacco cigarettes.

Acknowledgement

Declaration of interest: the author has strong personal views in favour of drugs and tobacco harm reduction. The author helped invent, disseminate, develop and evaluate drugs harm reduction from 1986 and has advised UK government departments, WHO, UNODC, World Bank and GFATM on harm reduction. As head of the International Harm Reduction Association the author's task was to convince multi-lateral agencies of the public health and human rights case for harm reduction. In the author's retirement he advocates for tobacco harm reduction. The author was a member of the NICE guidelines group on tobacco harm reduction, and is a member of the BSI and BSI/CEN standards group on e-cigarettes. The author helps run a website, a news service and an annual conference on nicotine. The author helped found and is the chair of the charity New Nicotine Alliance which represents the views of e-cigarette users. In 2012 a company of which the author is the director sought and received a small development grant from Nicoventures for testing the feasibility of the use of a licensed nicotine product in a disadvantaged population. A version of this paper was delivered at Guildhall, London 14 April 2014 at a meeting hosted by the London Drug and Alcohol Policy Forum www.youtube.com/watch?v = sCKXhOnO8aE

Notes

1. Public Health in this paper refers to professional and organised public health: public health refers to the health of the public.
2. Letter from Antonio Maria Costa, Executive Director, UNODC, to Robert Charles, Assistant Secretary, International Narcotics and Law Enforcement Affairs, US Dept of State, 11 November 2004.

References

Advisory Council on the Misuse of Drugs (1988), *AIDS and Drug Misuse Part 1*, Department of Health and Social Security, London.

Ashton, J.R. and Seymour, H. (1988), *The New Public Health*, Open University Press, Milton Keynes.

Ashton, J.R. and Seymour, H. (2010), "Public health and the origins of the Mersey model of harm reduction", *International Journal of Drug Policy*, Vol. 21 No. 2, pp. 94-96.

Atun, R.A., Lebcir, M., McKee, M., Habicht, J. and Coker, R. (2015), "Impact of joined up HIV harm reduction and multi drug resistant tuberculosis control programmes in Estonia: system dynamics simulation model", *Health Policy, 2007*, Vol. 81 No. 2, pp. 207-17.

Berridge, V. (1996), *AIDS in the UK: The Making of Policy, 1981-1994*, Oxford University Press, Oxford.

Capewell, J. (2015), "President's Letter: my thanks to internet trolls, libertarian bloggers and hobbits", *Society for Social Medicine Summer Newsletter*, Vol. 6 No. 3, p. 1.

Daily Mail Online (2014), "Health chief steps down after crude 'e-cig' rant on Twitter: Professor stands aside after online attack on supporter of quitting aide", *Daily Mail Online*, 13 September , available at: www.dailymail.co.uk/news/article-2754917/Health-chief-steps-crude-e-cig-rant-Twitter-Professor-leaves-post-online-attack-supporter-quitting-aide.html#ixzz42FZlDm2x (accessed 7 March 2016).

Faculty of Public Health (2014), "UK Faculty of Public Health – policy paper on electronic cigarettes", Final 23 June, available at: www.fph.org.uk/uploads/UK%20Faculty%20of%20Public%20Health%20-%20Policy%20paper%20on%20electronic%20cigarettes%20-%20FINAL%2023%20JUNE%202014.pdf (accessed 7 March 2016).

Harm Reduction International (2015), "The global state of harm reduction, 2014", available at: www.ihra.net/contents/1524 (accessed 7 March 2016).

Jakes, S. (2016), "The pleasure principle", available at: http://nnalliance.org/blog/39-the-pleasure-principle (accessed 7 March 2016).

Lancet (2015), " E-cigarettes: public health England's evidence-based confusion", *Lancet*, Vol. 386, p. 829.

Lim, S.S., Vos, T., Flaxman, A.D., Flaxman, A.D. *et al.* (2012), "A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the global burden of disease study 2010", *Lancet*, Vol. 380 No. 9859, pp. 2224-60.

McKee, M. (2013), "E-cigarettes and the marketing push that surprised everyone", *British Medical Journal*, Vol. 347, p. f5780, doi: 10.1136/bmj.f5780.

McKee, M. (2014), "Electronic cigarettes: proceed with great caution", *International Journal of Public Health*, Vol. 59, pp. 683-5, doi: 10.1007/s00038-014-0589-z.

McKee, M. and Capewell, S. (2015), " Evidence about electronic cigarettes: a foundation built on rock or sand?", *British Medical Journal*, Vol. 351, p. h4863.

McLaren (2016), Visits to E-Cigarette-Forum.com. Website visits United Kingdom, personal communication, 2015.

McManus, J. (2015), "How and why I changed my mind on e-cigarettes", available at: https://jimmcmanus.wordpress.com/2015/11/15/how-and-why-i-changed-my-mind-on-e-cigarettes/ (accessed 7 March 2016).

McNeill, A., Brose, L.S., Calder, R., Hitchman, S.C., Hajek, P. and McRobbie, H. (2015), "E-cigarettes: an evidence update. a report commissioned by Public Health England", PHE publications gateway number: 2015260 2015, available at: www.gov.uk/government/publications/e-cigarettes-an-evidence-update (accessed 7 March 2016).

New Scientist (2014), "Don't let vaping, obesity and boozing become norms", Interview with Sally Davis, available at: www.newscientist.com/article/dn25319-dont-let-vaping-obesity-and-boozing-become-norms/ (accessed 7 March 2016).

Newcombe, R. (1987), "High time for harm reduction", Druglink, January/February.

Ng, M., Freeman, M.K., Fleming, T.D., Fleming, T.D., Robinson, N., Dwyer-Lindgren, L., Thomson, B., Wollum, B., Sanman, E., Wulf, S., Lopez, A.D., Murray, C.J.L. and Gahidou, E. (2014), "Smoking prevalence and cigarette consumption in 187 countries, 1980-2012", *JAMA*, Vol. 311, pp. 183-92.

Office for National Statistics, UK (2016), "Adult smoking habits in Great Britain, 2014", *Statistical Bulletin*, p. 7.

Public Health England (2014), "Shooting up: infections among people who inject drugs in the UK, 2014", available at: www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk (accessed 7 March 2016).

Public Health England (2015), "E-cigarettes: an emerging public health consensus", available at: www.gov.uk/government/news/e-cigarettes-an-emerging-public-health-consensus (accessed 8 March 2016).

Puddlecote, D. (2016), "Correspondence between McKee and Davies Aug 15 to Oct 15", available at: www.scribd.com/doc/296112057/Correspondence-Between-McKee-and-Davies-Aug-15-to-Oct-15 (accessed 7 March 2016).

Royal College of Physicians (2007), *Harm Reduction in Nicotine Addiction: Helping People Who Can't Quit. A Report by the Tobacco Advisory Group of the Royal College of Physicians*, Royal College of Physicians, London.

Royal College of Physicians (2016), *Nicotine Without Smoke: Tobacco Harm Reduction*, Royal College of Physicians, London.

Russell, M. (1976), "Low-tar medium-nicotine cigarettes: a new approach to safer smoking", *British Medical Journal*, Vol. 1, pp. 1430-3.

Smith, E.A. (2013), "Questions for a tobacco-free future", *Tobacco Control*, Vol. 22 No. S1, pp. i1-i2, doi: 10.1136/tobaccocontrol-2013-051066.

Stimson, G. (2016), "Public health should step aside, vapers are now leading the way against smoking", available at: https://health.spectator.co.uk/public-health-should-step-aside-vapers-are-now-leading-the-way-against-smoking/ (accessed 26 April 2016).

Stimson, G.V. (1990), "AIDS and HIV: the Challenge for British drug services. (Fourth Thomas James Okey lecture)", *British Journal of Addiction*, Vol. 85 No. 3, pp. 329-39.

Stimson, G.V. (1994), "Minimising harm from drug use", in Strang, J. and Gossop, M. (Eds), *Heroin Addiction and Drug Policy: The British System*, Oxford University Press, Oxford, pp. 246-56.

Stimson, G.V. (1995), "AIDS and injecting drug use in the United Kingdom, 1988-93: the policy response and the prevention of the epidemic", *Social Science and Medicine*, Vol. 41 No. 5, pp. 699-716.

Stimson, G.V., Dorn, D. and Lines, R. (2013), "Re: E-cigarettes and the marketing push that surprised everyone", *British Medical Journal*, Vol. 347, doi: http://dx.doi.org/10.1136/bmj.f5780.

Strathdee, S.A. and Stockman, J.K. (2010), "Epidemiology of HIV among injecting and non-injecting drug users: current trends and implications for interventions", *Current HIV/AIDS Reports*, Vol. 7 No. 2, pp. 99-106.

Tobacco Atlas (2016), "Smoking death toll", available at: www.tobaccoatlas.org/topic/smokings-death-toll/ (accessed 7 March 2016).

West, R. (2016), "Impact of e-cigarettes on smoking cessation in England. Smoking in England, STS150530", available at: www.smokinginengland.info/sts-documents/ (accessed 7 March 2016).

World Health Organization (1986), "Ottawa Charter for Health Promotion", available at: www.who.int/healthpromotion/conferences/previous/ottawa/en/ (accessed 7 March 2016).

World Health Organization (2006), "'Preamble' Constitution of the World Health Organization", available at: www.who.int/governance/eb/who_constitution_en.pdf (accessed 7 March 2016).

World Health Organization (2008), "Launch of the Final Report of the Commission on Social Determinants of Health", statement to the press, Geneva, 28 August, available at: www.who.int/dg/speeches/2008/20080828/en/index.html (accessed 7 March 2016).

World Health Organization (2015), "WHO report on the global tobacco epidemic, 2015: raising taxes on tobacco", available at: apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf (accessed 7 March 2016).

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