Re: Vaporised Nicotine Products Bill 2017

Submission to The Senate Committee from Adjunct Associate Professor Renee Bittoun

My Qualifications to submit to this inquiry:

Given my long and unbroken history as a pioneer on the topic of nicotine addiction in Australia I believe that I am in a unique position to give this submission.

As a health professional I have been engaged with nicotine addiction and smoking cessation since the late 1970s.

I started the first public hospital smokers' clinic in Australia in 1979 at St. Vincent's Hospital Sydney.

I was intensively involved with the first national "Quit for Life" campaigns in the 1980s. My contribution, amongst my other contributions, was to help devise the award winning "Sponge" Ad and to conduct a supporting smokers clinic during these campaigns.

Prior to the now accepted concept, I toured Australia widely for decades advocating that nicotine was an addictive substance and that there were nicotine addicts who would need help.

For decades I have taught and continue to teach university level Courses about nicotine dependence and treatment. The now many hundreds graduates from these courses are considered "tobacco treatment specialists".

I am the founding and continuing Editor in Chief of The Journal of Smoking Cessation, which commenced its life more than 10 years ago in Australia and which is now an international peer-reviewed journal emanating from Cambridge in the UK.

I am the President and also one of the founders of the Australian Association of Smoking Cessation Professionals (AASCP), a national group of health professionals dedicated to helping smokers quit using evidence –based interventions.

I have published research papers, texts and continue to carryout research in the field.

I consult, teach and currently work intensively with Indigenous Health groups, Mental Health groups, smokers with chronic illnesses, smokers from non-English speaking backgrounds and other groups of particularly concern regarding smoking in Australia today.

I continue in the role of tobacco treatment clinician in hospital clinics dedicated to the hard-to-treat smoking patient.

I was the first academic appointment on the topic of nicotine addiction in Australia.

I have no conflicts of interest –no pharmaceutical company funding, have never and do not take funding from tobacco industry or its subsidiaries and am not engaged in clinical trials regarding electronic (E) cigarettes.

I give this opinion, however, as a private individual, and do not represent the groups with which I work.

Principal Points of this Submission:

- Australia enjoys one of the world's lowest rates of smoking among adults and adolescents due to strong campaigns that have seen prodigious drops of smoking prevalence in my lifetime and career.
- These changes in the decreasing incidence of smoking (ie. never starting) have dramatically decreased the tobacco disease epidemic in this country.
- We have been able to "de-normalise" tobacco smoking to a great extent.
- There is a poor understanding of the nature of nicotine addiction and its treatment.

The addictive nature of nicotine

- **All nicotine comes from the tobacco plant**:- nicotine is extremely difficult to synthesize.

- The salient and addictive ingredient in cigarettes is nicotine, which is inhaled in tobacco smoking.
- The salient and addictive ingredient in E cigarettes is nicotine, which is inhaled.
- Inhaling this drug is important. The speed of delivery of a drug into the body leads to its "addictiveness". Hence there is a "hierarchy" of addiction to a drug depending on its mode of delivery. Inhaling a drug (directly into the arterial blood via the lungs) speeds up the delivery, and is the most profoundly addictive form of drug delivery (eg versus intravenous or tablet form).
- Nicotine wears off very quickly in many people (about 40 to 120 minutes half-life). Hence the need to re-use frequently during the waking day.
- Thus there is a profound difference between Nicotine Replacement Therapy (NRT) (which also contains nicotine derived from the tobacco plant), inhaled tobacco smoking and inhaled E cigarette delivery of nicotine. NRT is rarely dependence producing (there are no patch addicts) due to the slow and low level of nicotine delivery and slow wearing off.
- By contrast with NRT, rapid delivery of inhaled nicotine by E cigarettes is potentially very addictive.
- Some (not all) smokers become addicted to nicotine. There is a strong inherited genetic trait for nicotine addiction.
- Addictions are not benign. Addictions are defined by the obsessional usage of the drug, by withdrawals that can be profoundly unpleasant (anxiety, aggression, depression, poor concentration) which stimulates re-use (smokers go through withdrawals between cigarettes), and by relapse to using when attempting to stop. Using the drug in the face of known medical and social consequences also defines the addicted drug user/smoker. It is not in the best interest of

the unwell smokers to smoke, but they do. Nor is it in someone who cannot afford it, or in someone who is socially ostracized by it.

- Nicotine addiction can be profound in some and difficult to "cure". Not all smokers respond to treatment, especially pharmacotherapies, in the same way. There are genetic influences in the successful treatment of nicotine addiction . There is not a "one-size-fits-all" model of care.
- Treatment of tobacco smoking and nicotine addiction has been very successful in many patients despite the complexities of medical comorbidities. Given the correct information, tailored treatment and support, many smokers are able to quit, despite being in the "too hard basket".
- Harm-reduction strategies using NRTs has also been effective in reducing harm, are safe, are acceptable to many smokers and may lead to abstinence. In clinical practice we see many smokers reduce their inhalations and their subsequent Carbon Monoxide levels when smoking concomitantly with NRT. This infers a reduction in harm. The measurements are highly motivating to smokers and shows strong impacts on their motivations to move towards reducing their smoking. More research is required to adequately assess the long-term effects of this strategy.
- Advocates of E cigarettes claim their use mimics "hand to mouth" behaviour of smoking, however there is little evidence to support the importance of this behaviour in helping smokers quit.

Conclusion:

- It is by the very nature of nicotine addiction that some individuals find it difficult to quit. To advocate that they convert to E cigarettes perpetuates the dependency and the life-long consumption of this newer form of "nicotine delivery device".

- Poor understanding of nicotine addiction leads to the interpretation that smokers require E cigarettes as a substitute for smoking in order to quit or reduce harm. There is good evidence that tailored treatments and medical interventions are valid, safe and effective for smoking cessation and harm-reduction.

- We should not introduce a new form of rapidly inhaled nicotine delivery to the Australian people.

Collaboration with the Tobacco Industry

Interactions and collaboration with the Tobacco Industry, or its subsidiaries is contrary to the W.H.O. Framework Convention on Tobacco Control (FCTC) signed by Australia, 2005.

- **All nicotine comes from the tobacco plant**:- nicotine is extremely difficult to synthesize.

- The e-cigarette industry sources its nicotine from tobacco farmers which effectively **is** the tobacco industry.

- The Tobacco Industry/E cigarette industry, like any other business, is there to grow their market.

- It is a reality that the E cigarette industry elsewhere in the world is behaving like the other unhealthy commodity industries, the unhealthy food, alcohol industries, in the adoption of a range of manipulative strategies designed to raise product awareness, create false positive beliefs, expectations and emotional responses and draw citizens and particularly young people into the use of these products.

- Overseas the E cigarette industry replicates the behaviour of bygone eras with the very same images associated with sexual attraction, hipster product names, product content that adds to the attractiveness of these products and a mixture of overt and covert messages to promote the uptake and use of its products and normalize the behaviour.

- While we have heavily regulated many of these commercial behaviours in the case of the combustible cigarettes, we will now find ourselves having to catch up with the E-cigarette industry which is of course, increasingly indistinguishable from the tobacco industry.

- I recall personally advising the Commonwealth Department of Health regarding the Tobacco industry "harm reduction" ploy in the 1990s and presenting evidence that these strategies were not reducing harm but had the potential to increase inhalation of harmful tobacco smoke.

- Though appearing to be conscientious and ethical, the tobacco industry has had a history of failure, starting with large investments in filters, some turning out to be very dangerous. There was, due to manipulative advertising, a wholesale shift to "weaker" cigarettes by smokers under the false impression that weaker are "lighter" "milder" and thus less harmful. This ploy is now prohibited, though many smokers continue today with the idea that smoking these products reduces the harm.

- The tobacco industry is no longer covert but is overtly involved in the development, production and support of e cigarette research. Since the inception of e cigarettes the tobacco industry has encouraged a highly divisive rift in the previously effective and very successful tobacco control community.

- The overt appearance of the tobacco industry at conferences (see BAT (British American Tobacco) at the recent international meeting of the Society for Research in Nicotine and Tobacco (SRNT) Florence 2017 I attended) means a self-assurance and cockiness not seen for many decades. This intrusion into basic scientific and health promotion conferences is divisive and strategically aimed at creating a rift in the very effective cohesive "anti-smoking" community in order, I believe to reduce its effectiveness—especially in Australia! Long held friendships are tested, people are encouraged to take sides, colleagues are not speaking with each other and collaborations are diminishing.

Conclusion: E Cigarette promotion is contrary to national and international W.H.O convention and is unethical. It is naïve to assume that the tobacco industry is not directly involved with E cigarette and will actively promote them.

E Cigarettes as Therapy and Harm-reduction: The Therapeutic Goods Administration (TGA) and its Role:

- The TGA is the most important and respected national body that regularly reviews and oversees the regulation of therapeutic goods.
- Until the TGA approves of E cigarettes as both a therapeutic good for smoking cessation and a harm-reduction strategy based on the evidence it has received then clinicians would be unwise to recommend their usage.
- NRT has been approved of as both a therapeutic good for smoking cessation and for harm-reduction.

Conclusion: There should be strong prohibitive regulations regarding the provision of E cigarettes and their promotion. Recommending the use of E cigarettes may have medico-legal consequences.

The Consumer Issue:

- Addictions are not benign. The very nature of nicotine addiction will drive users of E cigarettes to acquire regular (daily) supplies of E "juice". E cigarettes users will be at the mercy of the E cigarette industry to access their nicotine. Though relatively cheap now, just like other drugs of dependency (licit or illicit), pricing may change. Originally cheaper to

expand the business, market forces will inevitably play a role as demand for profits increase.

- The overt involvement of the tobacco industry can only mean that there is a growing market that they will, as all effective businesses would, want to expand their future market and they will use all the resources and past experience they have. To do this would require the recruitment of new users and they would inevitably be adolescence, who, once dependent will become life-long consumers of this newer nicotine delivery device.

In summary:

Recommendation:

- That health officials, especially those making public health policy, at all levels become better acquainted with the nature of nicotine addiction and effective evidence-based treatment.
- That the introduction of the E cigarette nicotine delivery devise should be prohibited. It is the potential "cigarette of the 21st Century" with its concomitant addicts/consumers and as yet unknown consequences and that the introduction of E cigarettes will potentially re-normalise smoking behaviour.
- That it is naïve to believe that the tobacco industry, given its past history, will not endeavor to expand its market and sale of this highly addictive substance. In particular, the seductive and alluring marketing to gain an adolescent consumer who may become a life-long nicotine addict is reprehensible. No health worker should be complicit in this.

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Some References

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3) Tobacco Harm Reduction; Cochrane Tobacco Addiction Group Cochrane Database of Systematic Reviews. 12, 2016