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Co-use measurement is also required in treatment interventions

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Key words	6 key words	Tobacco, Cannabis, co-use, treatment, intervention, measurement
Concise statement	A statement of one or two sentences of the key point that is being made. This should stand alone as a meaningful statement and not include meta-phrases such as 'This commentary discusses'	Clinical treatment interventions need to include assessment of co-use of cannabis and tobacco. We need a better understanding of which factors, including legal status of cannabis use, impact on co-use measurement for both practitioners and individuals using such interventions.
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McClure and Hindocha (1) make the argument for improved measurement of tobacco and cannabis co-use in both clinical studies and population level surveys, proposing a tiered system of questions for the research field. In this commentary we expand on how clinical treatment interventions and services may approach co-use measurement.

Despite being commonly co-used tobacco and cannabis are usually separated for treatment purposes as well as in research studies. Treatment options for individuals wishing to address their tobacco and cannabis use have been explored, but few options exist for co-treatment as yet (2,3,4). We need to better understand what approach is taken within clinical practice and in the digital health domain for those seeking smoking cessation treatment and for those seeking cannabis cessation or reduction treatment with respect to co-use. First, little is known about how smoking cessation services consider co-use of cannabis in either assessment or interventions. We need to establish whether and how cannabis use is measured. Then, we need to understand more about what areas of good practice exist already, what practitioners may require in terms of assessment tools, knowledge of cannabis and the wide array of cannabis products and delivery systems available, and the impact of these on someone's tobacco quit attempt. Practitioners would likely benefit from guidance on detailed assessment of co-use of cannabis, including guidance on asking questions of what in some areas is illicit drug use, and support in advising clients on optimising their quit attempt. Co-use measurement would also equip them to monitor co-use at service level; the tiered domain of questions proposed by McClure and Hindocha would aid this process. The UK based Nacional Centre for Smoking Cessation and Training (NCSCT) has recently published a briefing for smoking cessation practitioners on addressing cannabis use, but more evidence is required to inform clinical practice and to describe the prevalence amongst tobacco cessation treatment seekers (5).

From the other perspective, we must also consider how services addressing cannabis use, which may include primary care, substance misuse services as well as digital treatment options may address tobacco use. As highlighted by McClure and Hindocha (1), without comprehensive co-use measurement, such services may miss the opportunity to assess and treat tobacco dependence, which may also impact on treatment outcomes for cannabis use. This hidden population of tobacco

users who don't identify as 'smokers' is increasingly recognised in the literature (6). Cannabis cessation outcomes appear worse amongst tobacco users (7) and the impact of co-administration versus concurrent co-use on these outcomes is as yet unknown. Despite high prevalence of smoking within the client population, services addressing substance misuse are not necessarily ready to address tobacco use effectively (8).

Second, and most importantly, we need understand more about how someone who uses both substances finds questions about co-use across different geographical and health service contexts. Legal frameworks in a particular country or state will influence not only how socially acceptable cannabis use may be, and whether use incurs any form of penalty and how serious this penalty might be, but also the impact of disclosure of cannabis use on employment, on insurance and on the duty of reporting to child protection services. Perhaps paradoxically, whilst an increasing number of US states are decriminalising cannabis use, some states still require healthcare professionals to report parental substance use to authorities (9). We need to investigate therefore how acceptable is screening for and documenting cannabis use within a smoking cessation service, or other service such as primary care, and which groups may be most reluctant to disclose this. Concurrent to a client's perspective, we also need to know what additional support practitioners and services may need when asking about cannabis use. Previous research has found practitioners poorly equipped to screen and manage cannabis use (10,11). In areas where cannabis use remains illegal, we need to understand what guidance is required for practitioners to ask and record use, what advice they feel able to provide and how to tailor this to particular groups, and in areas where use is legal, what knowledge do practitioners require in order to be able to advise clients with confidence.

As McClure and Hindocha (1) highlight, clients in smoking cessation services should be routinely asked about cannabis use, as those accessing services to address cannabis use should be asked about tobacco use, and interventions including those in digital format should routinely ask about co-use whichever substance they are targeting. Without adequate measurement and a greater understanding of how to implement such measurement, clinical services will remain unable to adequately address the complexity of co-use. As the title indicates, if you don't know about it, you can't manage it.

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