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# Smoking cessation and concurrent alcohol and/or substance use

PHO Tobacco and Vaping Webinar  
22-Jan-2026

**Dr. Peter Selby** MBBS, CCFP, FCFP, MHSc, DFASAM

PI - INTREPID LAB; Senior Medical Consultant; Senior Scientist – Addictions, CAMH  
Vice Chair, Research; Giblon Professor, DFCM, University of Toronto  
Professor: Psychiatry; and the Dalla Lana School of Public Health, University of Toronto



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# CAMH Land Acknowledgement

CAMH is situated on lands that have been occupied by First Nations for millennia; lands rich in civilizations with knowledge of medicine, architecture, technology, and extensive trade routes throughout the Americas. In 1860, the site of CAMH appeared in the Colonial Records Office of the British Crown as the council grounds of the Mississaugas of the New Credit, as they were known at the time.

Today, Toronto is covered by the Toronto Purchase, Treaty No. 13 of 1805 with the Mississaugas of the Credit.

Toronto is now home to a vast diversity of First Nations, Inuit and Métis who enrich this city.

CAMH is committed to reconciliation. We will honour the land through programs and places that reflect and respect its heritage. We will embrace the healing traditions of the Ancestors, and weave them into our caring practices. We will create new relationships and partnerships with First Nations, Inuit and Métis and share the land and protect it for future generations.

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Shkaabe Makwa

# Acknowledgements

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CAMH - Senior Scientist support

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# Disclosures

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## **Speaking Engagements (Content not subject to sponsors approval)/Honoraria:**

American Society of Addiction Medicine, Lung Health Foundation, Government of Singapore, Ontario College of Family Physician, Quitpath Yukon, Queen's University, ECHO, Winter Dental Clinic, Vitalité Health Network New Brunswick, Canadian Public Health Association, Canadian Public Health Association, Health Canada, Canadian Network for Respiratory Care, Horizon Health Network, The E-Cigarette Summit UK, Canadian Society of Addictions Medicine

**Consulting Fees:** None

**Other: (Received drugs free/discounted for study through open tender process)**

Johnson & Johnson, Haleon and Pfizer Inc.

**NO TOBACCO or VAPING or ALCOHOL or FOOD INDUSTRY FUNDING**

# Learning Objectives

By the end of this session, participants will be able to

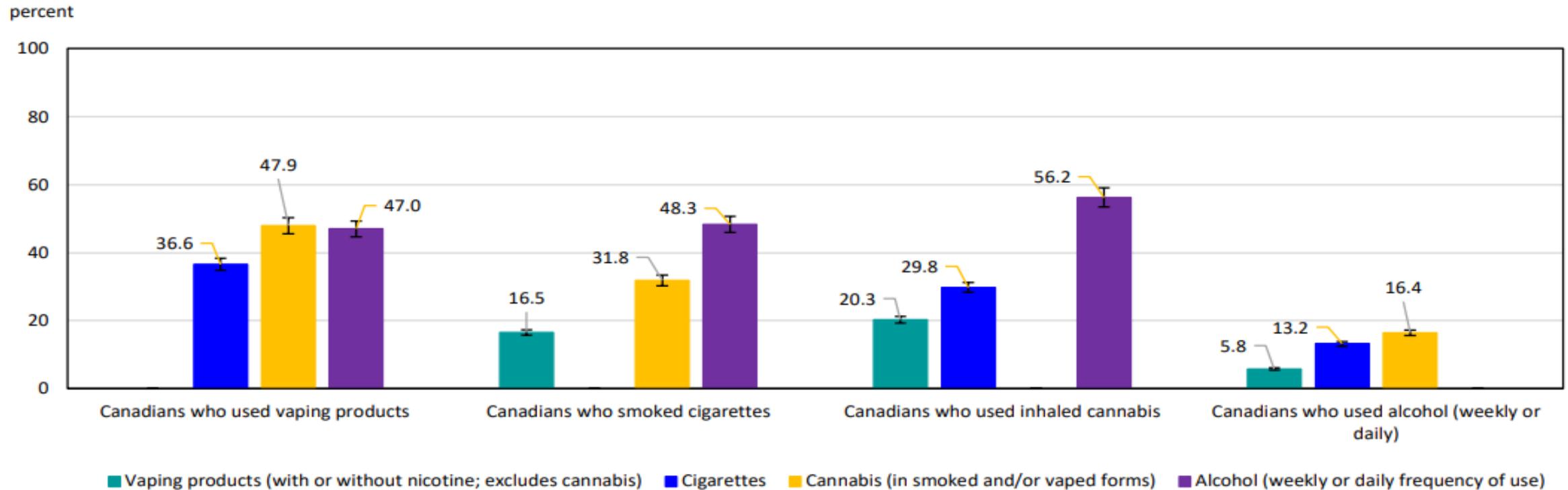
1. Explain the biopsychosocial determinants of co use of alcohol and other substances with tobacco and nicotine
2. Describe the health effects of co-use
3. Situate the role of co-use on smoking cessation outcomes
4. Explore concurrent versus sequential treatment of tobacco use in those with alcohol or other substance use disorders

# 1

**Explain the biopsychosocial determinants of co use of alcohol and other substances with tobacco and nicotine**

# Prevalence of Tobacco and Other Substance Co-Use in Canada (2020)

Prevalence of substance use among Canadians aged 15 years and older who reported use of the examined substances, 2020



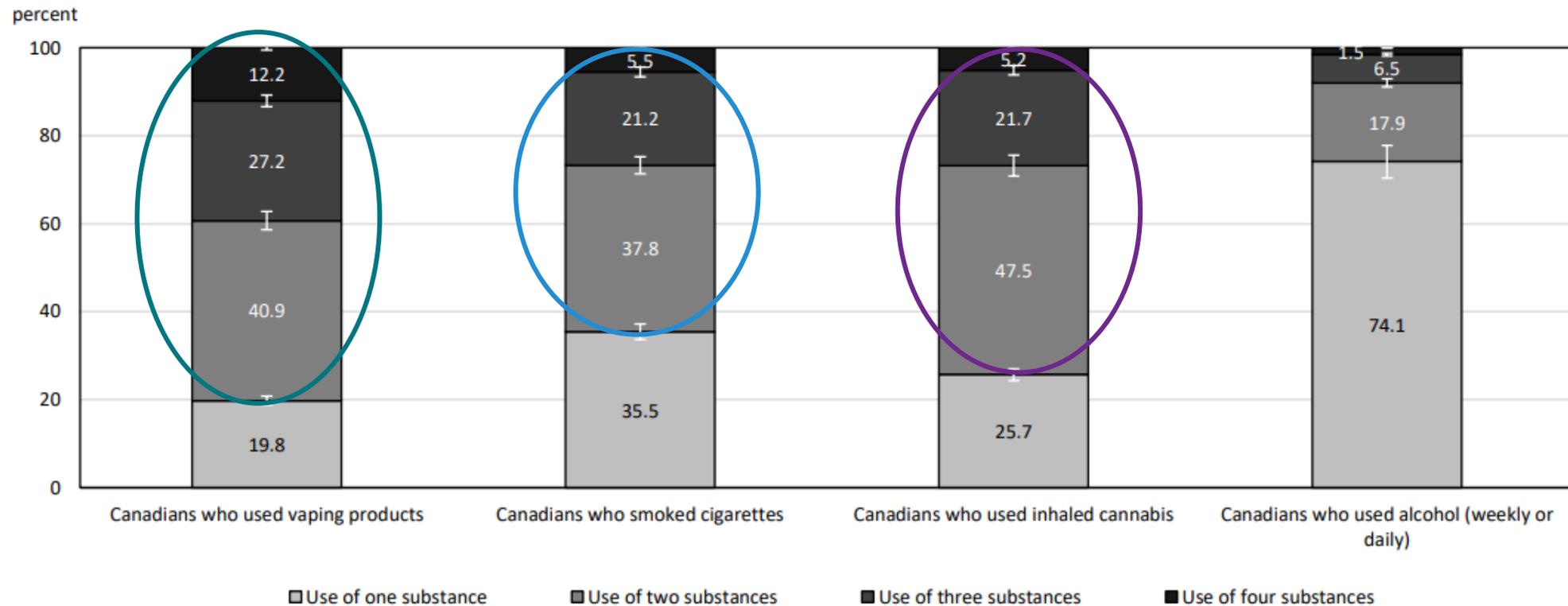
**Notes:** Analyses conducted using weighted data. Respondents with missing data are not included in weighted estimates. Whiskers represent 95% confidence intervals.

**Source:** Canadian Tobacco and Nicotine Survey, 2020.

- Among **3.2 million** Canadians who **smoked cigarettes**, the most common co-used substances were:
  - **Alcohol** (48.3%) and **inhaled cannabis** (31.8%).
- Among **1.5 million** Canadians who **vaped**, the most common co-used substances were:
  - **Inhaled cannabis** (47.9%) and **alcohol** (47.0%).

# Polysubstance Use Patterns Among Canadians (2020)

Number of substances used among Canadians aged 15 years and older who reported use of the examined substances, 2020



Notes: Analyses conducted using weighted data. Respondents with missing data are not included in weighted estimates. Whiskers represent 95% confidence intervals.

Czoli et al., 2023

- **Vaping** is associated with the highest levels of polysubstance use (80%).
- **Cannabis** users report high rates of polysubstance use (74%), with nearly half (48%) using two substances.
- **Cigarette smoking** shows a significant prevalence of two-substance use (38%) and polysubstance use (65%).

# Explaining Co-morbid Substance Use

## Self Medication

- Used to relieve psychiatric symptoms, treatment side-effects and boredom
  - i.e. Schizophrenia

## Addiction Vulnerability Hypothesis

- Psychiatric disorder or shared genes may increase susceptibility to substance use and addiction

## Environmental Factors

- Social network, SES, education etc.

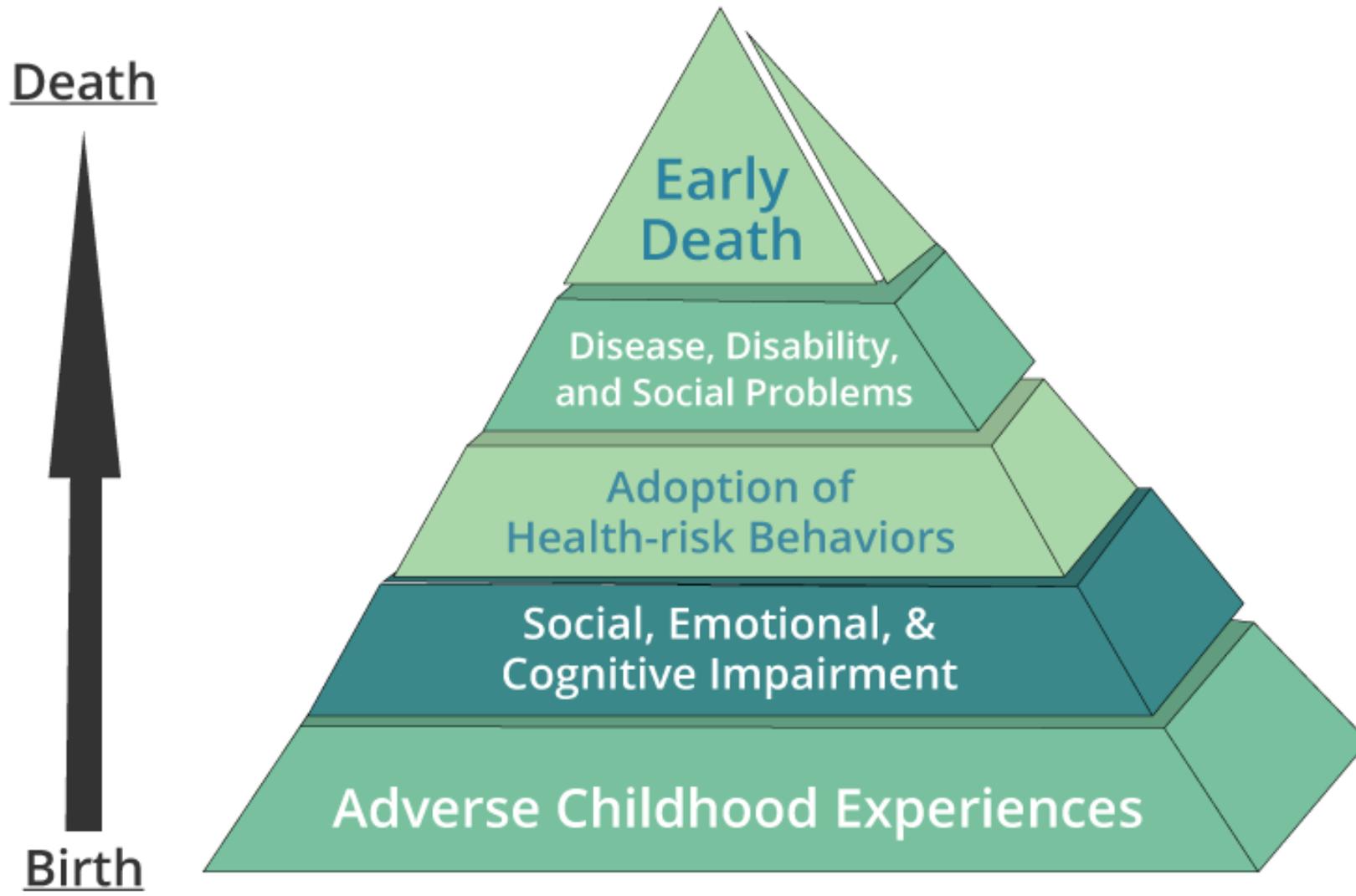
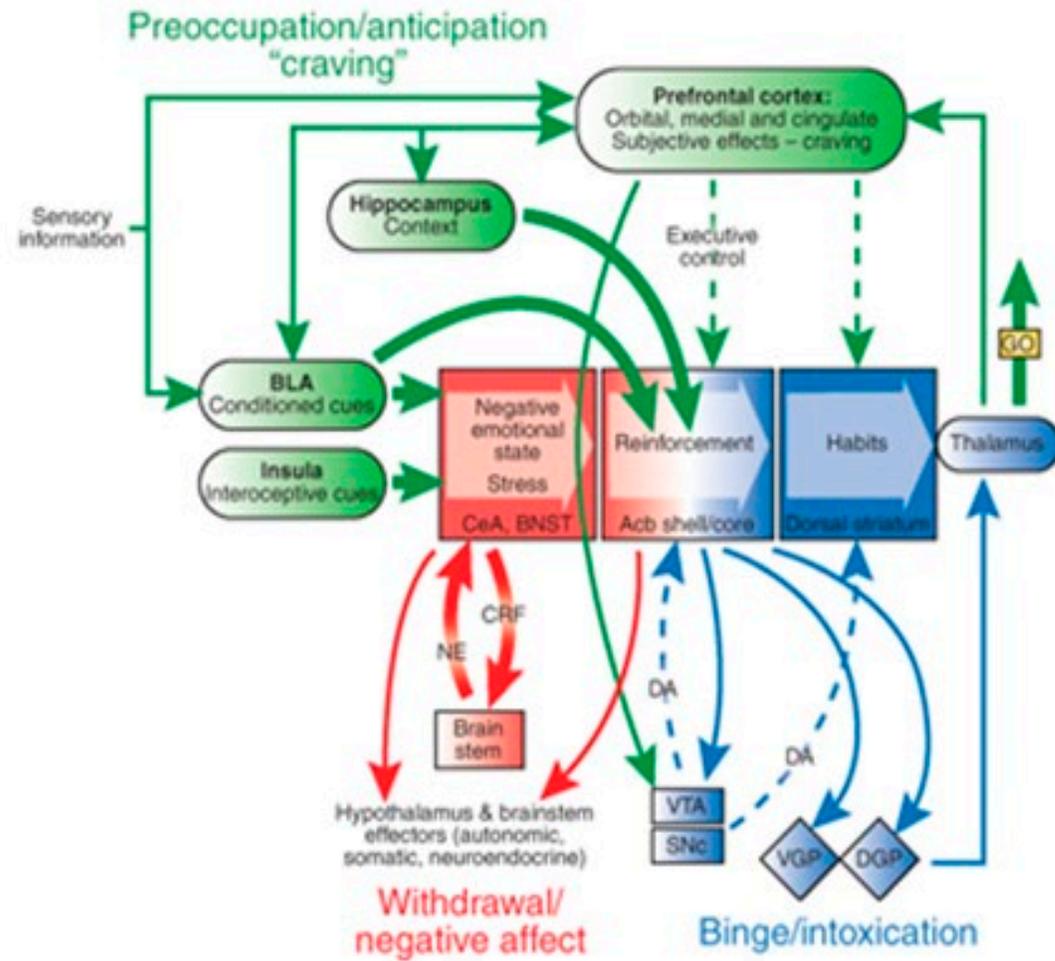
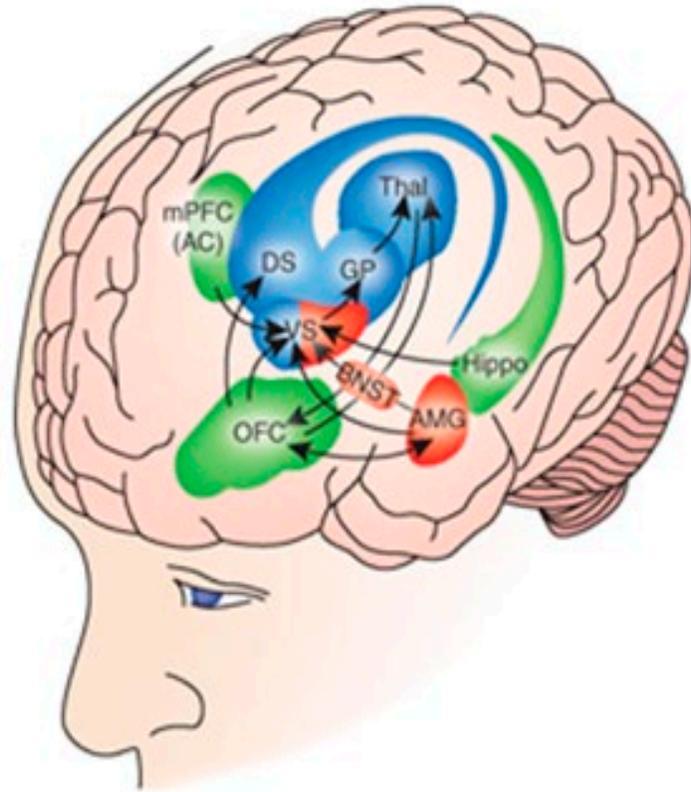


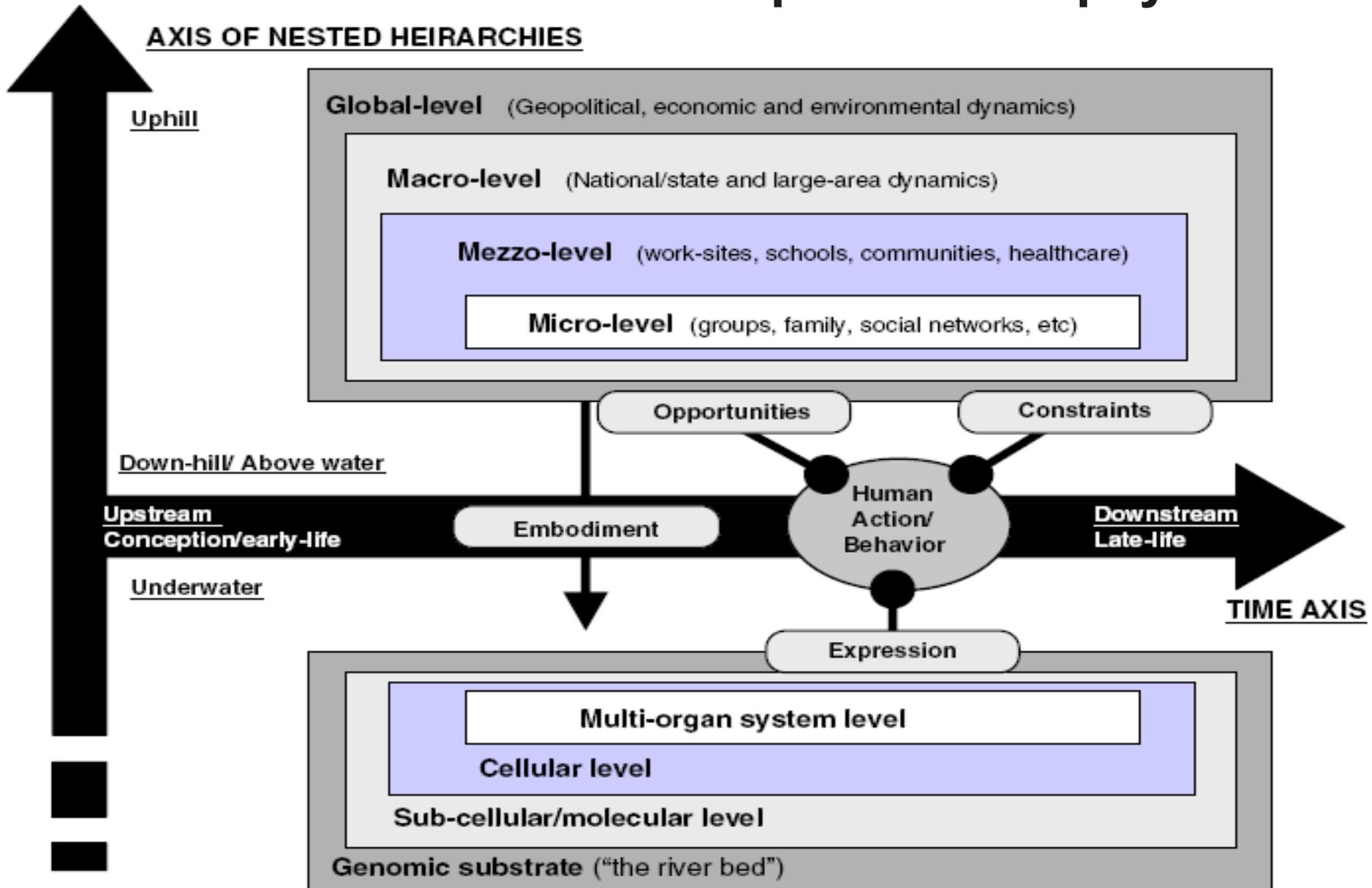
Figure 2. Potential influences throughout the lifespan of adverse childhood experiences.

# 3 Stages of Addiction Cycle: Neuroadaptation



Neuropsychopharmacology

# Determinants of addiction are developmental biopsychosocial



# 2

**Describe the health effects of co-use**

# Health effects of co-use: Alcohol and Tobacco



Increased risk of mouth and throat cancer



Increased risk of liver cancer



Increased risk of tobacco-related diseases i.e. heart disease & lung disease



Increased risk of death from tobacco-related complications

# Cannabis and Tobacco Co-Use



Co-use may occur as:

## 1. Simultaneous Use

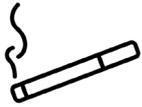
- Blunts: cannabis wrapped in cigar paper
- Spliffs: cannabis mixed with loose leaf tobacco

## 2. Concurrent Use

- Sequential or “chasing”
- Substitution
- Asynchronous (both used, but not in close temporal proximity)

**Cannabis use nearly doubled among patients seeking smoking cessation treatment, increasing from 20.2% in 2015 to 37.7% in 2021.**

# Health Effects of Cannabis and Tobacco Co-Use



## Dependence & Relapse

- Co-use worsens **dependence** on both substances
- Co-use increases the likelihood of relapse during cessation attempts for both substances



## Respiratory

- Co-use leads to greater **respiratory symptoms** compared to using either substance alone
- Mixing increases exposure to harmful chemicals like carbon monoxide and **raises THC inhalation**



## Mental Health

- **Mood and Personality Disorders:** Bipolar disorder, narcissistic, borderline, paranoid, and schizotypal personality disorders
- **Anxiety Disorders**

# Health Effects of Opioid Use Disorder

## High Prevalence and Mortality Risk

- Nicotine-Opioid Co-Use Rates:
  - **80%** of individuals with OUD smoke cigarettes.
  - Co-use is higher in untreated individuals (**92–95%**).
- Smoking increases the **4x higher mortality rate** of OUD patients vs. non-smokers.

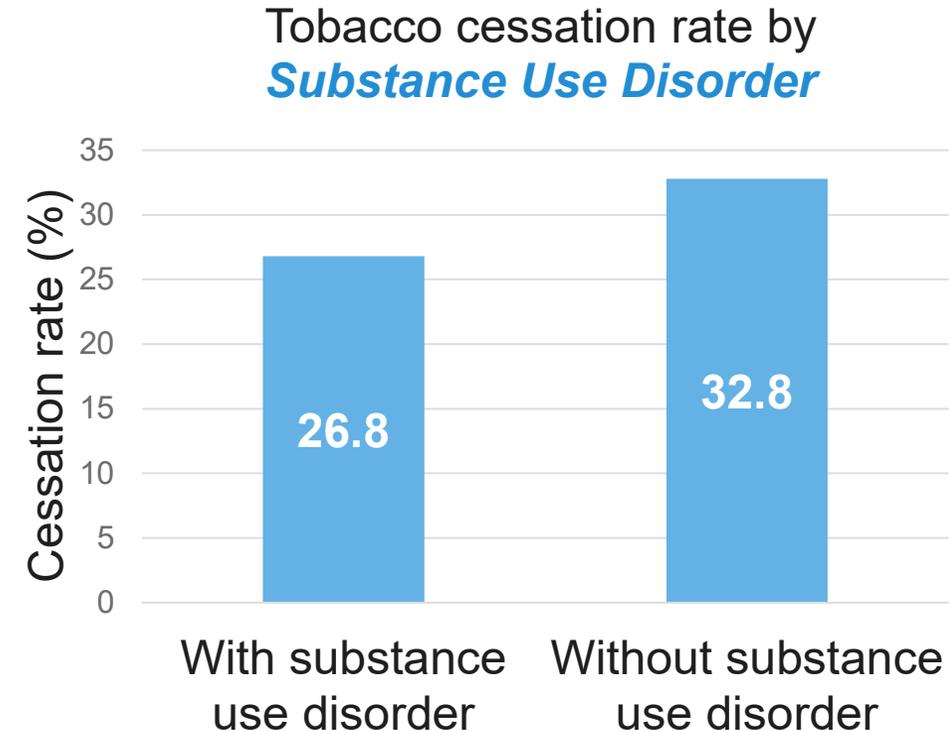
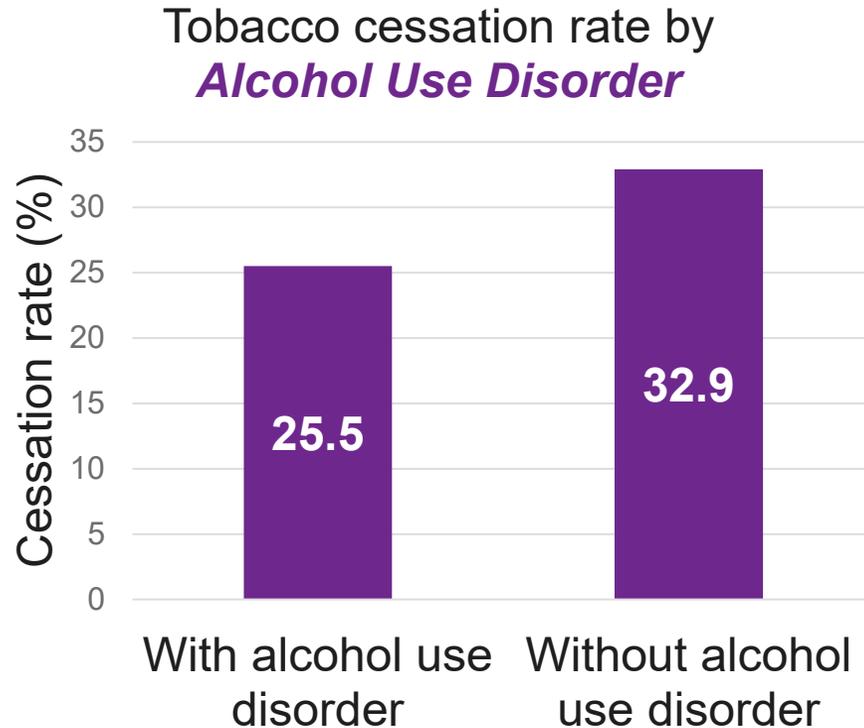
## Health Implications

- Increased **relapse risk** to opioids and **adverse neonatal outcomes** in pregnancy (i.e. low birth weight and longer + higher-dose morphine treatment needed for neonatal abstinence syndrome.)
- Smoking exacerbates **chronic pain**, requiring higher opioid doses.

# 3

**Situate the role of co-use on smoking cessation outcomes**

# Tobacco Cessation Rates in the STOP Program (2023-Present): Alcohol and Substance Use Impact



***Smokers without alcohol or substance use disorders achieved higher cessation rates, based on 7-day point prevalence cigarette abstinence at 6 month follow-up.***

# The effects of alcohol use on smoking cessation treatment with nicotine replacement therapy: An observational study

Benjamin K.C. Wong <sup>a b</sup>, Scott Veldhuizen <sup>a c d</sup>, Nadia Minian <sup>a d e f g</sup>, Laurie Zawertailo <sup>†</sup>, Peter Selby <sup>a d f h i</sup>  

**Higher levels of alcohol use/hazardous drinking were associated with lower rates of smoking abstinence at 6 months.**

Group	7-Day PPA at 6 Months (Adjusted)
Non-Drinkers	30.3% (29.4–31.1)
Low-Risk Drinkers	30.2% (29.4–31.0)
AUDIT-10 < 8	29.0% (28.1–29.9)
AUDIT-10: 8–14	27.3% (26.0–28.6)
AUDIT-10 ≥ 15	24.4% (22.3–26.5)

# Effects of alcohol use on smoking cessation

## Systematic Review (Amsterdam & Brink, 2023)

- Studies Included: Naturalistic and experimental, each with  $\geq 40$  tobacco smokers and a recorded drinking status.
- Alcohol use was found to be consistently associated with lower quit rates and higher relapse.



20/27  
studies

Alcohol use  
linked to **failed  
quit attempts**  
(lapses &  
relapses)



19/20 long  
term studies

**Shorter  
abstinence  
duration** in  
heavier  
drinkers.



13/13  
experimental  
studies

Alcohol  
exposure/cues  
**increase urge**  
to smoke.

# Cannabis Use Among Adults in Cigarette Smoking Cessation Treatment in Ontario, Canada: Prevalence and Association With Tobacco Cessation Outcome, 2015–2021

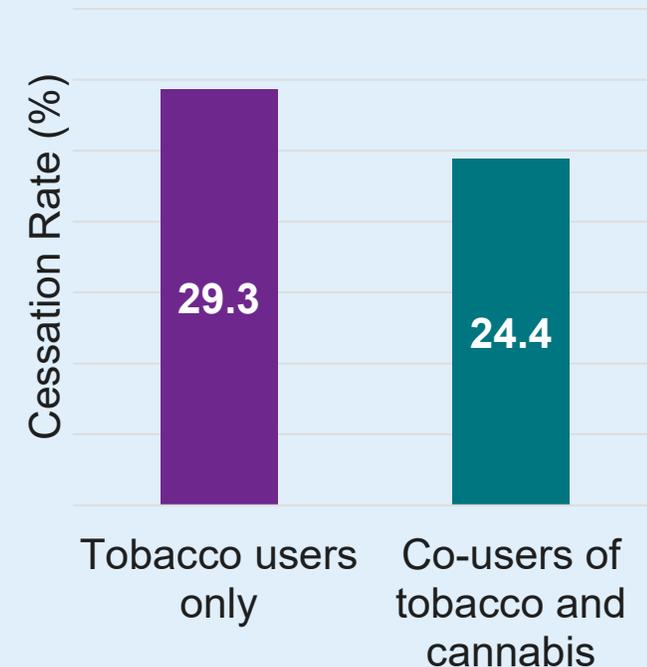
Sabrina Voci, PhD, Scott Veldhuizen, PhD, Anna Ivanova, MPH, Osnat C. Melamed, MD, MSc, Peter Selby, MBBS, MHSc, and Laurie Zawertailo, PhD

Voci et al. 2024

## Key Findings:

- Data from **83,206 adults** enrolled in STOP program.
- Cannabis use among patients nearly doubled since 2015 (**20.2% to 37.7%**).
- Co-use was associated with **lower** self-reported **cigarette smoking abstinence at 6-month** (**24.4% vs. 29.3%**; **OR = 0.78**; **95% CI = 0.75, 0.81**).
- After adjusting for covariates, the association weakened but remained significant (**OR = 0.93**; **95% CI = 0.89, 0.97**).

***Co-use is associated with significantly lower smoking cessation rates, underscoring the need for targeted interventions.***



# Effects of Cannabis Use on Smoking Cessation

## ➤ **Barrier to Tobacco Cessation**

- **Increases** smoking **initiation**, nicotine **dependence** and **relapse** risk.
- Worsens **withdrawal symptoms**.

## ➤ **Impact on Smoking Behavior**

- Reinforces smoking-related cues, **increasing cravings**.
- Creates a **synergistic effect**, complicating cessation strategies.

## ➤ **Policy Implications**

- Edibles may reduce co-use and smoking behavior
- Public health campaigns and regulatory interventions (e.g., discouraging mixing) are critical.

# Effects of cannabis use on smoking cessation

## Evidence Gaps

- Mixed findings: Some studies show no impact, others report adverse effects
- No prospective studies evaluating the impact of cannabis severity on cessation outcomes.
- Limited biochemical verification of cannabis use
- Lack of targeted recommendations for individuals co-using cannabis and tobacco.

## Research Priorities

- Conduct prospective studies to examine cannabis' role in cessation outcomes.
- Develop interventions tailored to co-users of cannabis and tobacco.

Walters et al., 2023; Goodwin, 2020

# Smoking Cessation Outcomes and Challenges in OUD

## Key Outcomes and Barriers

- **<8% cessation success** despite pharmacotherapy.
- Tobacco use promotes methadone escalation; methadone increases cigarette consumption.
- Medications yield **one-quarter the success rate** of the general population.

## Challenges

- Poor adherence, Low self-efficacy, high stress, and withdrawal symptoms.
- Smoking used as a coping mechanism during withdrawal.

## Unique Dynamics

- Cigarette consumption peaks during opioid effects.
- Tapering opioid doses reduces smoking.

# 4

**Explore concurrent vs. sequential treatment of tobacco use in those with alcohol or other substance use disorders**

# History taking: quantity, frequency and pattern of use with tobacco

- Onset relationship: which started first?
- What's their drug of choice? First to come, last to go.
- Concurrent or sequential use.
- Effect on pattern and quantity of use.
- Effect on quit attempts.
- Relationship to thoughts, feelings, behaviours



# Treatment options for co use

## Settings

- **Withdrawal management** settings and not specifically seeking TUD treatment
  - Goal should be withdrawal management-
    - Management of withdrawal with NRT
- **Inpatient settings/residential** treatment programs ( McKay Manor is a poster child)
  - Focus only on tobacco
  - Focus on tobacco in a tobacco free treatment setting
- **Harm reduction**

Scan to access resources from



**Project VECTOR**



**Lower-Risk Nicotine Use Guidelines**

# Cannabis and Tobacco Co-Use

# Efficacy of Tobacco and Cannabis Intervention for Co-Users

## Systematic review and Bayesian Meta-analysis (Walsh et al., 2020)

- 20 studies (12 RCTs, 8 uncontrolled)

### Key Findings:

- **Cannabis cessation:** **Weak evidence** for intervention efficacy (RR = 1.48; CrI = 0.92–2.49).
- **Tobacco cessation:** **No clear effect** (RR = 1.10; CrI = 0.68–1.87).
- Multi-substance interventions were more effective for cannabis cessation.
- **Cannabis reduction achieved** (RR = 0.25; CrI = 0.03–0.45); no effect on tobacco reduction.
- Feasibility and acceptability supported in uncontrolled studies.

*Single and dual-substance interventions show limited efficacy for cessation but are feasible for co-use treatment.*

# Practical approaches to Tobacco and Cannabis Co-Use

Review by Nguyen et al., 2024

## Concurrent Treatment

Simultaneous treatment of tobacco and cannabis is **feasible and acceptable**, with no evidence of compensatory use.

## Behavioral Therapy

**CBT** is the most common

Others: MI, CM. Techniques: Identifying triggers, setting quit dates, craving management, withdrawal coping

## Pharmacotherapy

NRT: Combination (patch + gum/lozenge) or single-agent  
Emerging Therapies: Varenicline;  
N-acetylcysteine and cannabidiol for dual cessation

## Format and Duration

In person, remote, or hybrid  
5 to 12 weeks

# Sequential and Simultaneous Treatment approaches: Cannabis and Tobacco Co-Use

Participants: 67 adults seeking outpatient CUD treatment.

## Study Design

- **SIM:** Immediate Tobacco intervention (TI) (Weeks 1–12)
- **SEQ:** Delayed TI (Weeks 13–24)
- **TI:** Web-based counseling + NRT

## Results

- SIM: **62%** initiated counseling, **50%** quit attempts, **41%** started NRT.
- SEQ
  - **39%** quit attempts, **18%** initiated NRT before TI.
  - Only **30%** completed TI

Simultaneous interventions support co-use cessation but do not affect cannabis outcomes.

Sequential interventions need **motivation-focused strategies** to prevent dropouts.

# Alcohol and Tobacco Co-Use

# Pharmacotherapies for Smoking Cessation among individuals with AUD

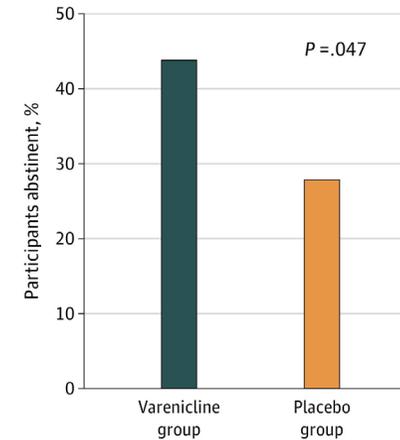
Systematic Review and Meta-analysis (Guo et al., 2021)

Outcomes	Risk with Placebo	Risk with Medicine	Relative Effect (95% CI)	No. of Participants	Certainty of the Evidence (GRADE)	What Does This Mean?
Varenicline	38 per 1000	199 per 1000 (90-385)	OR 6.27 (2.49-15.78)	259 (3 studies)	⊕○○○ Very low	Varenicline shows <b>significant short-term effect</b> .
Naltrexone	246 per 1000	273 per 1000 (221-334)	RR 1.11 (0.90-1.36)	951 (3 studies)	⊕⊕⊕○ Low	Naltrexone shows <b>no significant impact</b> on abstinence.
Topiramate	87 per 1000	129 per 1000 (60-257)	OR 1.56 (0.67-3.64)	223 (2 studies)	⊕⊕○○ Low	Topiramate <b>lacks strong evidence</b> for effect.
Bupropion	179 per 1000	300 per 1000 (110-598)	OR 1.97 (0.57-6.83)	58 (1 study)	⊕⊕○○ Low	Bupropion shows <b>no significant impact</b> and has limited studies.

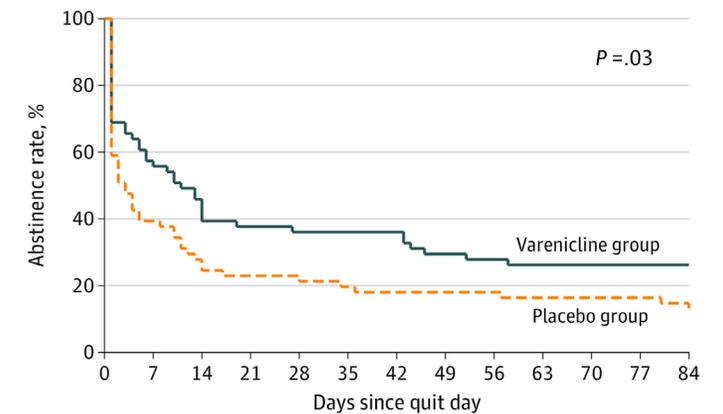
# Effect of Varenicline and Nicotine Patch on Smoking Cessation in Heavy Drinkers

- Double-blind RCT (N=122), 12-week intervention.
  - Treatment Arms:
    - **Varenicline (1 mg BID) + Nicotine Patch**
    - Placebo + Nicotine Patch
- **Higher abstinence** at weeks 9–12 (**44.3% vs 27.9%**, OR=2.20; p=.047).
- **Lower relapse risk** (HR=0.62; p=.03).
- No effects on alcohol consumption
- Tolerability: Generally well-tolerated; some increased adverse events in the varenicline group.

**A** Continuous smoking abstinence, weeks 9-12



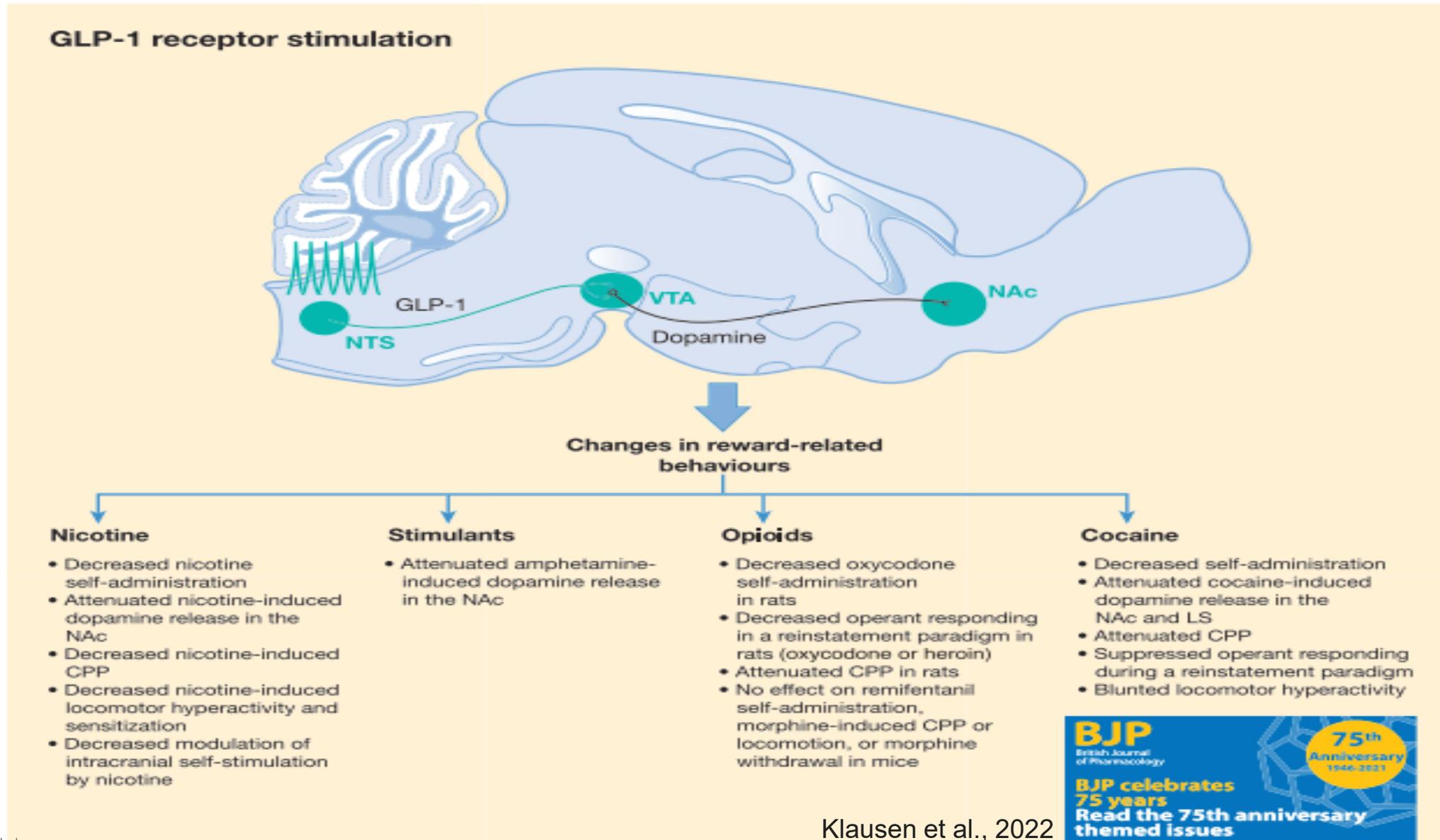
**B** Smoking abstinence rates, weeks 0-12



No. at risk		0	7	14	21	28	35	42	49	56	63	70	77	84
Varenicline group	61	35	28	24	23	23	23	19	18	17	17	17	17	16
Placebo group	61	26	17	15	14	13	12	12	12	11	11	11	11	9

# GLP1RA Effects on Addiction

# GLP1RA effects on substance-reward related behaviours in preclinical models



# GLP1RA effects on Alcohol

Systematic review of 6 studies (88,190 participants; 43.9% on GLP-1 RAs)

Study	Study Type	Intervention	Study Design	Key Findings
Klausen, 2022	RCT	Exenatide	26 weeks, placebo-controlled	<b>Heavy drinking days:</b> -19.6 (95% CI -27.4 to -11.8); <b>AUDIT:</b> -7.0
Probst, 2023	RCT	Dulaglutide	Placebo-controlled, adjusted for education	Relative effect size: 0.71 (95% CI 0.52–0.97, p = 0.04)
Quddos, 2023	Observational	Tirzepatide	Self-reported alcohol measures	<b>Drinks/week:</b> -1.54 (p ≤ 0.001); <b>Binge episodes:</b> -3.8 (p ≤ 0.001)
Wium-Andersen, 2022	Observational	GLP-1 RAs vs. DPP-4	ITT-adjusted alcohol-related events	<b>Alcohol-related events HR:</b> 0.46 (0–90 days)
Richards, 2023	Observational	GLP-1 RAs	AUDIT and alcohol consumption	<b>AUDIT reduction:</b> -9.5 points (p < 0.001)
Kalra, 2024	Conference Abstract	GLP-1 RAs	Self-reported abstinence	<b>Abstinence/reduced drinking:</b> 42%

*GLP-1 receptor agonists may reduce alcohol consumption, especially in individuals with obesity, but more robust research is needed to confirm efficacy.*

# GLP1RA effects on Tobacco: Emerging Research



Study	Participants	Key Findings	Follow-Up	Safety
Yamine, 2021	<p>N = 84 (<b>Exenatide</b> 2 mg vs. Placebo)</p> <p>Intervention:</p> <ul style="list-style-type: none"> <li>NRT 21mg patch) + brief smoking cessation counselling</li> </ul>	<ul style="list-style-type: none"> <li>Smoking Abstinence: Exenatide <b>46.3%</b> vs. Placebo <b>26.8%</b> (Risk Ratio = 1.70; PP = 96.5%).</li> <li>Reduced craving and withdrawal.</li> <li>Weight: <b>Reduced post-cessation weight gain</b> by 5.6</li> </ul>	6 weeks	Mild GI symptoms (Exenatide: 4.9%, Placebo: 2.3%).
Lengsfeld, 2024	<p>N = 255 (<b>Dulaglutide</b> 1.5 mg vs. Placebo)</p> <p>Intervention: Varenicline + Behavioural counseling</p>	<ul style="list-style-type: none"> <li><b>No difference</b> in smoking abstinence (Dulaglutide: 63%, Placebo: 65%).</li> <li><b>Weight: Reduced post-cessation weight gain</b> (1.5 kg vs. 3kg, p &lt; 0.001).</li> </ul>	12 weeks	GI symptoms common on both (Dulaglutide: 90%, Placebo: 81%).

# GLP1RA effects on Opioid



Observational Study (Wang et al., 2024)

- 33,006 patients with T2D and OUD.
- Semaglutide associated with **lower risk of opioid overdose** vs. other antidiabetic medications (HR: 0.32–0.58).

Retrospective Cohort Study (Qeadan et al., 2024)

- 503,747 OUD and 817,309 AUD patients.
- GIP/GLP-1RA prescriptions linked to **reduced opioid overdose** (aIRR: 0.60) and **alcohol intoxication** (aIRR: 0.50).

## Clinical Study:

- Ongoing RCT (NCT04199728): Testing liraglutide (3.0 mg/day) for 30 days on opioid craving in OUD patients.

# Opioid and Tobacco Co-Use

# Smoking Cessation Treatments, Efficacy, and Challenges in OUD

Treatment	Efficacy		Challenges
<b>Low-Intensity Behavioral Interventions</b>	0% cessation in OUD vs. 13% smokers without OUD	Negligible	<ul style="list-style-type: none"> <li>Insufficient potency</li> <li>Low adherence.</li> </ul>
<b>Motivational Interviewing</b>	5.8–8.3% cessation with MI + nicotine patch.	Modest	<ul style="list-style-type: none"> <li>Comparable to brief counseling.</li> <li>Adherence remains modest.</li> </ul>
<b>Contingency Management</b>	46.7% cessation.	Strong (Short-Term)	<ul style="list-style-type: none"> <li>Short-term effects only.</li> <li>Relapse post intervention.</li> </ul>
<b>High-Dose/Combination NRT</b>	7% cessation with high-dose NRT vs. 0.5% placebo.	Modest	<ul style="list-style-type: none"> <li>Low adherence.</li> <li>Limited long-term effectiveness.</li> </ul>
<b>Pharmacotherapy (NRT, Bupropion, Varenicline)</b>	8.3% cessation with combination NRT vs. 2.2% placebo.	Modest	<ul style="list-style-type: none"> <li>Low adherence.</li> <li>Modest effects compared to general population.</li> </ul>
<b>Extended Varenicline Treatment</b>	3.7% cessation vs. 8.3% with combination NRT.	Low	<ul style="list-style-type: none"> <li>Low adherence.</li> <li>Short-lived effects.</li> </ul>

# Opioid antagonists for smoking cessation

Cochrane Review. David et al., 2013

Treatment	Number of Studies and Sample Size	Measure of Effect (95% CI)	Key findings
<b>Naltrexone vs. placebo (no NRT)</b>	5 RCTs n = 450	RR: 1.00 (0.66-1.51)	<b>No significant benefit for naltrexone over placebo</b>
<b>Naltrexone + NRT vs. placebo + NRT</b>	4 RCTs n=768	RR: 0.95 (0.70-1.30)	<b>No treatment effect for naltrexone as an adjunct to the nicotine patch</b>

***Naltrexone does not improve smoking cessation rates compared to placebo, whether used alone or with nicotine replacement therapy.***

# Summary

1. Developmental Biopsychosocial determinants for all addictions.
2. Co-use is common and negatively affects quit outcomes.
3. Sequential or concurrent treatment.
4. Use Evidence-based, approved interventions.
5. Adopt harm reduction strategies for those unable or unwilling to stop.

# STOP ON THE NET

A completely online program designed to assist adults with quitting smoking.

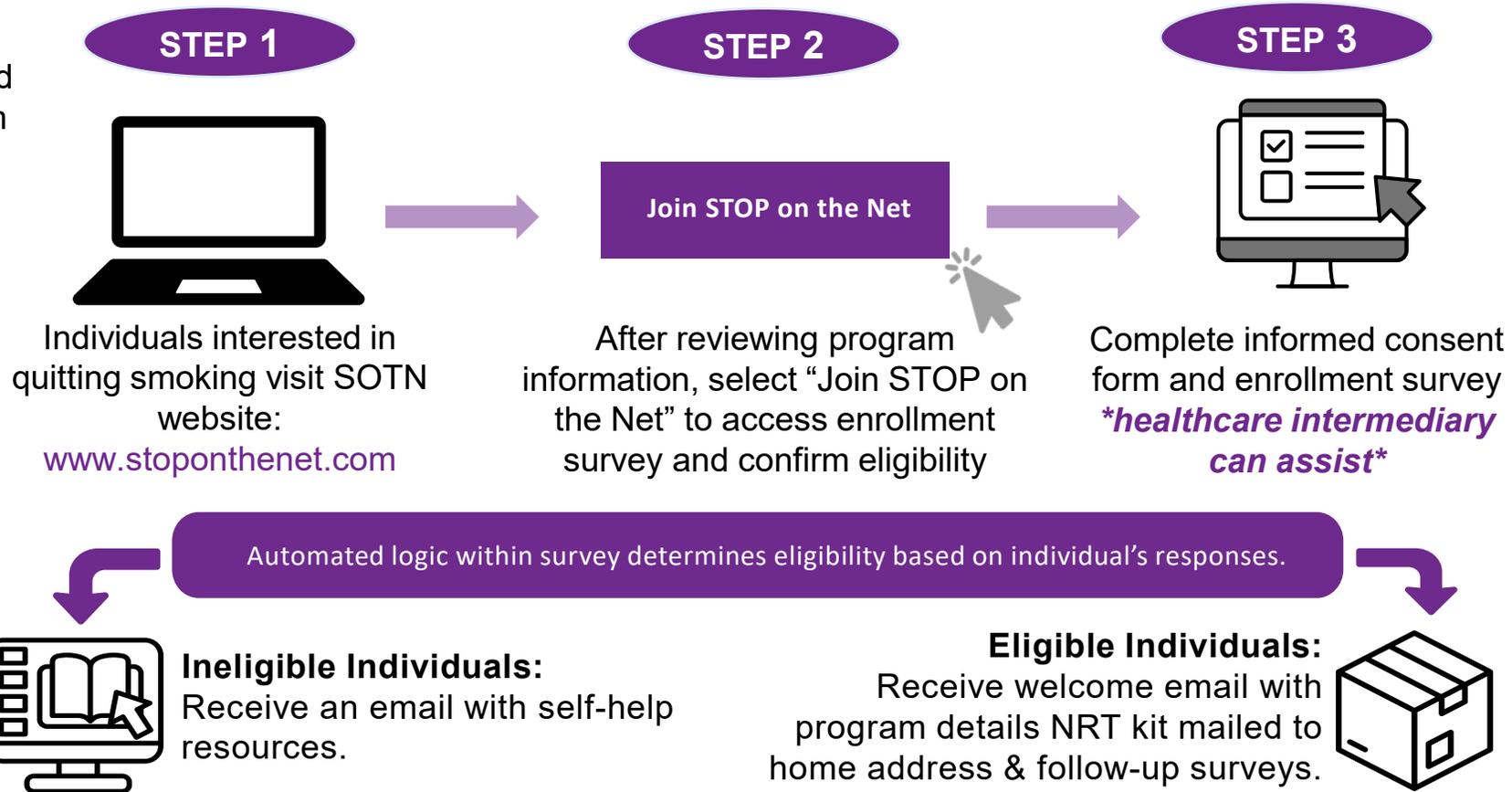


## About

Developed in response to the COVID-19 pandemic, STOP on the Net was launched in **October 2020** as a fully virtual program to ensure continued access to cessation support across Ontario. Eligible participants (18+ years of age, email address & additional criteria) receive a mailed kit containing NRT.



Learn more at  
[stoponthenet.ca](https://www.stoponthenet.ca)



# PROJECT VECTOR

Vaping and Electronic Cigarette Toxicity Overview and Recommendations: Evidence-Informed Guidance on Harms and Benefits



## About

Developed in collaboration with subject matter experts and people with lived experience, Project VECTOR provides healthcare providers and people who use, or are thinking of using e-cigarettes, with evidence-informed insights and resources on e-cigarette use and its impact on health. Scan the QR codes to learn more.

## Health effects of E-cigarette use: Guidance and Recommendations

A comprehensive overview of the key health impacts of e-cigarette use, including considerations for topics with more limited evidence.



## Pathways to a Smoke-Free Life Decision Map

A decision map to guide people who smoke in exploring quit options.



## How Does Vaping Affect Me?

A visual description of the health effects of vaping.



## FAQs About Vaping

Answers to commonly asked questions about e-cigarettes.



## Harm Reduction Tips

Tips to reduce the health impacts of e-cigarette use.

