

SUMMARY OF PROFESSIONAL ADVICE

- Education is an important first step in motivating clients to consider quitting. Motivational interviewing helps move them through the stages of readiness.
- Many of these clients need more intensive treatment than a quitline can provide.
- It is important that substance use providers believe that their clients can quit smoking and that it is worth the time and resources to take clients from one step to the next.
- A focus on learning coping skills and developing confidence to quit is needed. These clients may lack experience and self-confidence to undertake cessation.
- Aggressive use of medications is often necessary and may be used over a longer period of time. Medications need to be provided at low or no cost, especially for clients without health care benefits.
- Adoption of smoke-free policy at treatment centers helps support cessation together with participation in smoke-free recovery support groups.
- Clients with experience in recovery settings do well in groups.

PRIMARY CARE PROVIDERS

INTRODUCTION

Primary care providers, because they see many patients and care for them over longer periods of time, are on the “front line” of tobacco dependence treatment. Brief treatment (3 minutes or less), outlined in the PHS Clinical Practice Guideline, is designed especially for primary care providers who have limited time. Because it is relatively easy and can reach many tobacco users, the Guideline recommends that all tobacco users receive at least brief treatment from their primary healthcare professionals.⁸⁶

The introduction of tobacco quitlines in all 50 states has helped streamline the delivery of brief treatment into three steps:

- Ask: screen for tobacco use as part of vital signs at each clinic visit.
- Advise: all tobacco users to quit and prescribe/recommend stop smoking medications for those who are ready to set a quit date.
- Refer: tobacco users to a tobacco quitline for follow-up.

PATIENTS WITH MI/SUD

Compared to other tobacco users, tobacco dependence treatment for patients with MI/SUD is more complex. These patients:

- Need more intensive behavioral therapy. More person-to-person contact yields better outcomes.

Clinical Monitoring Recommendations for Patients with MI/SUD^{1,2}

1. Patients should be seen 1-3 days after initiating smoking cessation.
2. Patients should be monitored weekly for the first four weeks for signs of psychotic relapse, onset of depression or depressive symptoms, and the need to change medication levels.
3. After the first month, patients should be reviewed monthly for six months.
4. The primary care provider and the mental health provider should communicate at the beginning of tobacco dependence treatment and then during the cessation period if any psychiatric complications occur.

1 Strasser, K., Moeller-Saxone, K., Hocking, B., Stanton, J., & Kee, P (2002). Smoking cessation in schizophrenia. General practice guidelines. Australian Family Physician, 31, 21-24.

2 Provincial Health Services.(2006). Tobacco reduction in the context of mental illness and addictions: A review of the evidence. Centre for Addiction Research of British Columbia.

- May require more assistance with motivation and encouragement to try.
- Need to have psychosocial issues addressed that can undermine cessation.
- Have unique medication and pharmacokinetic issues. Cessation may produce rapid, significant increases in medication blood levels (see page 12).
- Need individualized treatment plans based on diagnoses and assessment of stability and functionality (see page 10). If non-compliance is related to instability, it may not be the right time to quit.
- May need a longer preparation time before quitting. These patients may not have tried to quit before and may need more time to practice not smoking in a variety of circumstances to learn coping skills and how to adjust their personal and social environment. They may also need to start cessation medications before they quit completely and wean off smoking more gradually.

Patients who have been assessed, are currently stable, ready to quit, and are not functionally impaired will be able to participate in tobacco treatment programs offered to the general public. Patients who are ready to quit but have more functional impairment will need more individualized management and follow-up. Patients who not stable may need to wait to quit until their MI/SUD is stabilized.

CESSATION PHARMACOTHERAPY

Use of pharmacotherapy is strongly recommended for these patients. Dose level and duration of drug treatment need to be individually tailored. More dependent smokers, including those with psychiatric and substance abuse co-morbidities, may need higher doses of NRT, combination medications (e.g. nicotine patch + fast acting NRT such as nicotine gum or inhaler, NRT + bupropion) and for longer duration of treatment.³⁷ (While increasing dose and combining medications are often clinically indicated, this has not been FDA approved.)

Different medications have been shown to be effective in patients with different diagnoses. Programs using the nicotine patch have been used with some success in patients with schizophrenia.⁷³ Nicotine replacement therapy has also been successfully used in patients with PTSD.⁷⁴ Bupropion has been shown to be most effective in patients with depression, but relapse is high when treatment is discontinued.^{69,70} Bupropion has also been effective in treating patients with post traumatic stress disorder (PTSD)⁷¹ but has adverse effects in patients with bipolar disorder and eating disorders.⁷² Bupropion is contraindicated with a history of alcohol abuse. Agitation is a potential side effect of bupropion that substance use treatment providers report can remind clients of the effects of their drug of choice. Some patients may want to avoid use of bupropion to eliminate this potential side effect. For similar reasons, nicotine nasal spray is not recommended for people who abuse drugs intranasally. Bupropion interferes with efficacy of protease inhibitors and other medications used by people with HIV/AIDS. Varenicline has been effective for many patients, include patients with MI/SUD but has not yet been tested in patients with mental illness. There have been two recent reports suggesting a psychotic exacerbation in a person with schizophrenia and in a person with bipolar disorder who were taking varenicline.^{57, 58} Additionally, post marketing adverse behavior and mood changes have been reported. Although no casual links have yet been established, patients and providers are warned to closely monitor the psychiatric symptoms of all patients who are quitting smoking.⁵⁹ For a more complete discussion of prescribing cessation medications for patients with mental illness, see *Smoking Cessation for Persons with Mental Illness*⁷⁵ and *“Tobacco-Free Living in Psychiatric Settings”*³⁰.

Advice for Tailoring Services in Primary Care		
CLINIC VISIT STEPS	PATIENTS WITHOUT MI/SUD	PATIENTS WITH MI/SUD
Vital signs	Expand vital signs to screen all patients for tobacco use at every visit.	Expand vital signs to screen all patients for tobacco use at every visit. Update MI/SUD questions in medical history.
Review of systems	In a clear, strong, and personalized manner, urge every tobacco user to quit. Determine willingness/readiness to quit now (e.g. in next 30 days).	In a clear, strong, and personalized manner, urge every tobacco user to quit.
		<p>Determine current interest in quitting.</p> <p>If interested, review:</p> <ul style="list-style-type: none"> • Tobacco use history and any previous experience in quitting (how prepared is the patient?) • Stability of MI/SUD and current psychosocial issues that can impact cessation. • Functional impairment that can impact cessation efforts. • Level of tobacco use and nicotine dependence. <p>If not interested:</p> <ul style="list-style-type: none"> • Discuss reasons for not being interested. • Discuss pros and cons of quitting and identifying reasons to consider quitting. • Encourage trying later and offer to help.
Treatment plan	<p>1) If ready to quit,</p> <ul style="list-style-type: none"> • Set a quit date (ideally within 2 weeks). • Recommend/prescribe stop smoking medications. • Refer to national tobacco quitline or other program for follow-up. • Follow-up at next clinic visit. 	<p>If interested;</p> <p>Determine readiness to quit. If ready:</p> <ul style="list-style-type: none"> • Discuss patient preferences. • Discuss a quit date (be flexible) and begin preparation steps (e.g. cutting down and delaying cigarettes; not smoking in home or car.) • Recommend/prescribe cessation medications (may need higher NRT doses or combination doses). • Address psychosocial needs that might undermine cessation. • Refer to tobacco quitline (if no functional impairment) or other program for more person-to-person contact. • When quit, schedule return visit in 1-3 days, then weekly for the first month to monitor symptoms and medication levels. Monthly thereafter for six months. • Communicate with mental health provider (if appropriate) initially and then during cessation process if complications occur.
	<p>2) If not ready to quit:</p> <ul style="list-style-type: none"> • Discuss reasons for not being ready. • Discuss pros and cons. • Encourage quitting later when ready and offer to help. • Give national quitline information and number. 	

NATIONAL QUITLINE: 1-800-QUIT NOW OR 1-800-784-8669