Tobacco Cessation and Behavioral Health

Today's Objectives

- Why this? Why now?
- Morbidity and mortality
- Prevalence rates
- Unique challenges
- The evidence-base
- Resources and tools

Why Now?

- Partnership
  - San Diego County Behavioral Health, American Lung Association, Communities Against Substance Abuse, Tobacco Control Coalition and Mental Health America

Why Now? (cont.)

- 100% of California state psychiatric facilities are smoke-free
  - Napa – 7/08
  - Coalinga – 8/08
  - Atascadero – 11/08
  - Patton – 4/09
  - Metro – 4/09

"There have been no significant issues in any of the hospitals"

California Department of Mental Health

Why Now? (cont.)

- Promotion of health
- Changing philosophy around addictions & co-occurring treatment
- Putting the “T” back in ATOD
- Increased treatment effectiveness
- A key component of the recovery process
- You are in the best position to offer these services

A Wellness Philosophy

I didn't survive depression
and suicide attempts
so I could die from lung cancer.

I had to stop smoking.

—ARIANA

CIGARETTES ARE MY GREATEST ENEMY

TOBACCO CAUSES MORE DEATHS THAN AIDS, DRUGS, BREAST CANCER AND GAY BASHING COMBINED

To assist people to lead meaningful lives in their communities, we need to promote behaviors that lead to health

Alarming Statistics

Tobacco's Deadly Toll

- 435,000 deaths in the US/year
- 4.8 million deaths worldwide/year
- 10 million annual deaths estimated by year 2030
- 50,000 annual deaths in the US due to second-hand smoke exposure

Tobacco's Deadly Toll (cont.)

- 200,000 of the 435,000 annual deaths are people with mental illness and substance use disorders
- For patients in treatment for alcohol and drug dependence, more than half die from tobacco-caused illnesses[1]
- Among treated narcotic addicts, smokers' death rates are 4 times that of nonsmokers[2]

[1]Hurt et al., 1996
[2]Hser et al., 1994; Lynch & Bonnie, 1994

Morbidity and Mortality

Thirteenth in a Series of Technical Reports

Morbidity and Mortality in People with Serious Mental Illness

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Morbidity and Mortality

- Persons with mental illnesses die up to **25 years** earlier and suffer increased medical comorbidity
  - Often from tobacco related diseases
  - More likely to die from these diseases than from their alcohol use
- Smokers with mental illnesses have more psychiatric symptoms, increased hospitalizations, and require higher dosages of medications

(Brown et al., 2000; Colton & Manderscheid, 2006; Dixon et al., 1999; Joukamaa et al., 2001; Osby et al., 2000; Dalack & Glassman, 1992; Desai, Seabolt, & Jann, 2001; Goff, Henderson, & Amico, 1992; Williams & Ziedonis, 2004; Ziedonis, Kosten, Glazer, & Frances, 1994).

Smoking is arguably the most modifiable risk factor for decreasing excess mortality & morbidity

(National Association of State Mental Health Program Directors, 2006; U.S. Department of Health and Human Services, 2004)

Prevalence Rates

Who Smokes?

- California adult smoking prevalence is **13.3%*** ~ 4 million smokers
  - American Indian – 28.2%**
  - African American – 18.7%**
  - White – 16.2%**
  - Hispanic – 12.8%**
  - Asian/Pacific Islander – 12.0%**

* California Department of Health Services, 2007

** California Health Interview Survey, 2005

San Diego Prevalence Rates

- North Coastal – 12.7%
- North Central – 11.8%
- Central – 12.4%
- South – 11.9%
- East – 15.4%
- North Inland – 13.0%

Smoking and Behavioral Health

- Rates of smoking are 2-4 times higher than among the general population.[1]
- About 41% of people with mental illness & substance use disorders smoke.[2]
- 60% of current smokers report having had a mental health or substance use diagnosis sometime in their lifetime.[1]
- This population consumes 45% of cigarettes smoked.[3]

1. Kalman, 2005 2. Lasser, 2000, 3. Breslau, 2003

Smoking by Diagnosis

Diagnosis	% Smoking
None	22.5
Maj. Dep.	44.7
S-phrenia	45.3
Alcohol	56.1
Anxiety	54.6
Drug	67.9
Bipolar	60.6

Lasser et al., 2000

Smoking by Diagnosis (variety of surveys & settings)

Schizophrenia	45-88%
Bipolar disorder	51-70%
Major depression	36-80%
Anxiety disorder	32-60%
Post-traumatic stress disorder	45-60%
Attention deficit/hyperactivity disorder	38-42%
Alcohol abuse	34-80%
Other drug abuse	49-98%

Beckham et al., 1995; De Leon et al., 1995; Farnam 1999; Grant et al., 2004; Hughes et al., 1996; Lasser et al., 2000; Morris et al., 2006; Pomerleaue et al., 1995; Stark & Campbell, 1993; Ziedonis et al., 1994

Why is This Population Vulnerable?

Barriers & Vulnerabilities

- Biological predispositions
- Barriers to tobacco interventions
  - Systems Factors
  - Clinician Factors
  - Client/Consumer Factors
- Tobacco industry targeting

Biological Predisposition

- Persons with behavioral health diagnoses have neurobiological & genetic features that may:
  - increase their tendency to use nicotine,
  - make it more difficult to quit, and
  - complicate the withdrawal phase.
- Nicotine enhances
  - concentration
  - information processing
  - learning
  - mood
- May reduce medication side effects

Barriers to Tobacco Interventions: Systems Factors

- Competing demands
- Tobacco as socialization activity, behavioral reward
- Staff acceptance and promotion
- Not part of current treatment milieu
- Lack of reimbursement for services

Barriers to Tobacco Interventions: Clinician Factors

- Expectation of failure
- Competing demands
- Fear of symptom exacerbation & relapse
- Lack of training
- Minimization

Smoking Prevalence Among Mental Health Providers

- 30% - 35% of mental health providers smoke as compared to-
  - Primary Care Physicians 1.7%
  - Emergency Physicians 5.7%
  - Psychiatrists 3.2%
  - Registered Nurses 13.1%
  - Dentists 5.8%
  - Dental Hygienists 5.4%
  - Pharmacists 4.5%

Strouse, Hall, Kovac, 2004

Barriers to Tobacco Interventions: Client/Consumer Factors

- Expectation of failure
- Lack of knowledge
- Fear of withdrawal symptoms
- Fear of weight gain
- Concern about recovery
- Concern about stress management (tension, anxiety)
- Doubt about dealing with boredom
- Part of daily routines
- Integral to social activity

"I've been schizophrenic since I was 14. I was told more or less when I went to the hospitals that cigarettes help control certain areas in my brain and the way we function out in society. I became more of a smoker because I was told it would help me with my illness. I was taught more about it helping my illness than I was about cancer and stuff like that."

- **Consumer focus group participant**

Morris et al, 2009

Tobacco Industry Targeting

- Monitored or directly funded research supporting the idea that individuals with schizophrenia were:
  - less susceptible to the harms of tobacco and
  - that they needed tobacco as self-medication
- Promoted smoking in psychiatric settings by:
  - providing cigarettes and
  - supporting efforts to block hospital smoking bans

Prochaska JJ, Hall SM, Bero LA., 2007

Myths and Myth-breaking Evidence

Myth #1

- **Myth**: Persons with mental illness and substance use disorders enjoy smoking and don't want to quit.
- **Fact: Persons with mental illness and substance use disorders want to quit smoking and want information on cessation services and resources.**

Interest in Quitting Results:
Behavioral Health

- Study of 300 depressed smokers: 79% were interested in quitting. (Prochaska et.al., 2004)
- Study of 224 hospitalized psychiatric patients who smoke: 79% of eligible smokers recruited into the study (Prochaska et al,, 2009)
- Review of clinical trials: 50% - 77% in substance use facilities were interested in quitting. (Joseph et.al., 2004)

Myth #2

- **Myth**: Persons with mental illness and substance use disorders are more addicted to nicotine and therefore are unable to quit smoking.
- **Fact: Persons with mental illness and substance use disorders can successfully quit using tobacco.**

Smoking Cessation Results:
Mental Illnesses

Most combine meds & psycho-education +/or CBT

- Schizophrenia: 8 studies (n= 9-70)

Quit rates 35-56% post-treatment, 12% at 6-months

- Depression: 8 studies (n= 29-615)

Quit rates 31-72% post-treatment, 12-46% at 12 months

(el-Guebaly et al., 2002)

Does Abstinence from Tobacco Cause Recurrence of Psychiatric Disorders?

- For depressed smokers who quit :
  - No increase in suicidality, hospitalization, use of marijuana, stimulants, or opiates
  - Less alcohol use among those who quit (Prochaska et al., 2008)
- For smokers with schizophrenia who quit:
  - No worsening of attention, verbal learning/ memory, working memory, or executive function/inhibition, or clinical symptoms of schizophrenia (Evins et al., 2005)

Myth #3

- **Myth**: Smoking cessation will threaten recovery for persons with substance use disorders.
- **Fact:** Smoking cessation can enhance long-term recovery for persons with substance use disorders.

(Prochaska et al., 2004; Saxon, 2003; Signal Behavioral Health, 2008; Lemon et al. 2003; Gulliver et al 2006; Ziedonis et al, 2006; Baca & Yahne, 2009)

Smoking Cessation Results:
During Addictions Treatment or Recovery

- Systematic review of 17 studies
- Smokers with current and past alcohol problems:
  - More nicotine dependent
  - Less likely to quit in their lifetime
  - As able to quit smoking as individuals with no alcohol problems

Hughes & Kalman, 2006, Drug Alc Dep

Does Abstinence from Tobacco Cause Relapse to Alcohol and Illicit Drugs?

- At > 6 months follow-up, tobacco treatment with individuals in addictions treatment was associated with a **25% increased abstinence** from alcohol and illicit drugs
- Caveat – one well done study looking at concurrent vs. delayed tobacco cessation treatment (n=499; Joseph, et al, 2004)
  - Comparable smoking quit rates at 18 months, but lower prolonged alcohol abstinence rates for concurrent treatment group at 6 months

Prochaska et al., 2004

What is Your Role?

Behavioral Health Professionals

- Often the clinician for whom contact is the most frequent and who knows the client/consumer best
- Able to coordinate pharmacotherapy and behavioral/counseling treatment
- Trained in mental health and/or substance abuse treatment
- Able to identify and address any changes in psychiatric symptoms during the quit attempt.

Adapted from Prochaska, 2009

Clinical Practice Guidelines

- Comprehensive, evidence-based approach for smoking cessation
- Released in June 2000 by the U.S. Public Health Service-updated version in 2008
- Systematic approach to tobacco cessation for all healthcare facilities

Clinical Practice Guidelines (cont.)

- All patients/clients should be screened for tobacco use, advised to quit and be offered intervention
- Those trying to quit should be offered pharmacotherapy, unless contraindicated
- There is a dose response relationship with the amount of contact provided

Evidence-Based Model: The 5 A's

Ask: Systematically identify all tobacco users at every visit

Advise: Advise tobacco users to quit

Assess: Assess each tobacco user's willingness to quit

Assist: Assist tobacco users with a quit plan

Arrange: Arrange follow-up contact

The 5 A's and A, A, R

Ask: Systematically identify all tobacco users at every visit

Advise: Advise smokers to quit

Assess: Assess each smoker's willingness to quit →

Refer to the California Smokers' Helpline and/or Peer-to-peer counselor

Assist: Assist smokers with a quit plan →

The Helpline provides behavior modification counseling (quit plan and quit date)

Arrange: Arrange follow-up contact →

The Helpline provides 5 follow-up calls – timing is based on the probability of relapse.

San Diego County Resources

- http://www.californiasmokershelpline.org/CountyListings.aspx
- To add resources to the list contact Kathy Sullivan at KSullivan@alac.org

California Smokers' Helpline 1-800-NO-BUTTS

- Free statewide tobacco cessation program
- Funded by tobacco taxes
  - Propositions 99 & 10
- Scientifically proven to be effective
- All services available by telephone
- In operation since 1992
- Adults, teens, pregnant women and proxy
- Multiple languages

Multiple Languages

- English
  1-800-NO-BUTTS (1-800-662-8887)
- Cantonese
  1-800-838-8917
- Korean
  1-800-556-5564
- Mandarin
  1-800-838-8917
- Spanish
  1-800-45-NO-FUME (1-800-456-6386)
- Vietnamese
  1-800-778-8440

Available Services

- Self-help materials
- Referral lists of local cessation programs
  - Updated by each county's tobacco control program
- Individual telephone counseling
  - Confidential
  - One pre-quit call, multiple proactive follow-up calls
  - Trained counseling staff

Helpline Counselors

- Bachelor level or higher in psychology, social work, or health related field
- Majority are bilingual/bicultural
- Training & quality control
  - 48-hour, in-house training
  - Clinical supervision
  - Continuing education

© California Smokers' Helpline

A Randomized, Controlled Trial

Follow-Up Evaluation

Motivate smokers to call

Multiple Counseling

Single Counseling

Self-Help

3 6 12

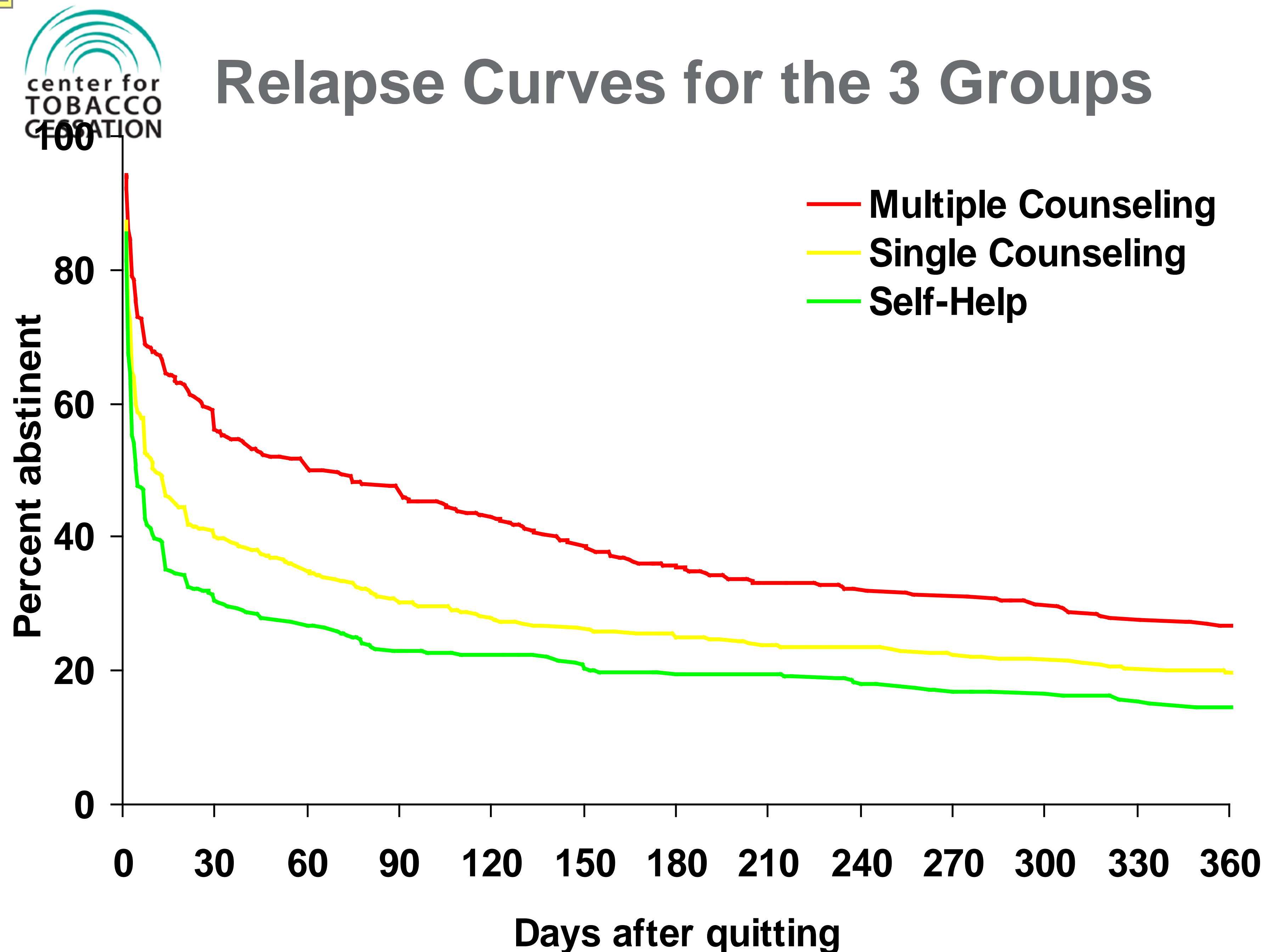
Months

Source: California Smokers' Helpline

Quit Attempts by the 3 Groups

Treatment Group	Made a Serious Quit Attempt %
Self-Help	58.8
Single Counseling	66.7
Multiple Counseling	66.6

Source: Zhu et al. (1996), *JCCP, 64*, 202-211


center for
TOBACCO
CESSATION
Relapse Curves for the 3 Groups
Multiple Counseling
Single Counseling
Self-Help
Percent abstinent
100
80
60
40
20
0
0
30
60
90
120
150
180
210
240
270
300
330
360
Days after quitting
Source: Zhu et al. (1996), JCCP, 64, 202-211

What Happens in Each Call?

- Initial session
  - Comprehensive, 30-40 min. call
  - Preparation to quit
  - Setting a quit date
- Follow-up sessions
  - Up to five 10-15 min. calls
  - Relapse prevention
  - Pharmacotherapy review

First Session

- Treatment overview & rationale
- Motivation
- Health considerations
- Smoking & quitting history
- Quitting methods
- Environmental considerations
- Self-efficacy
- Self-image
- Planning
- Call summary
- Setting a quit date
- Addressing follow-up calls

Source: Zhu S-H, Tedeschi GJ, Anderson CM, Pierce JP. *J Couns Devel* 1996;75;93-102.

center for TOBACCO CESSATION

Relapse-Sensitive Scheduling

Source: Zhu & Pierce (1995), *Prof. Psych. Res.& Practice, 26*, 624-625

Proactive Follow-up Sessions

- Quit status
- Withdrawal review
- Pharmacotherapy review
- Challenges & smoking events
- Motivation & self-efficacy
- Support
- Planning for future
- Self-image

Source: Zhu S-H, Tedeschi GJ, Anderson CM, Pierce JP. *J Couns Devel* 1996;75;93-102.

Helpline Intervention Summary

- – Identify a strong reason **(Motivation)**
- – Bolster belief in ability **(Confidence)**
- – Develop a solid plan **(Skills)**
- – Adopt a new view of self **(Self-image)**
- – Keep trying **(Perseverance)**

Helpline Callers with Behavioral Health Issues

Self-Reported Behavioral Health Issues Among Helpline Callers

- Do you have any current mental health issues such as:
  - An anxiety disorder?
  - Depression?
  - Bipolar disorder?
  - Schizophrenia?
  - Drug or alcohol problem?
    - If yes, have you been actively using/drinking in the last month?

Self-Reported Behavioral Health Issues Among Helpline Callers

Issue	% Smoking
Depression	36.9
Anxiety	27.8
Bipolar	16.1
Schizophrenia	7.1
Drug/Alcohol	5.2
Any	48.9

(Zhu,et al, 2009. Unpublished data)

Received Counseling

No Mental Illness	74.0%
Mental Illness	84.0%

(Zhu,et al, 2009. Unpublished data)

NRT Use

No Mental Illness	33.3%
Mental Illness	41.7%

(Zhu,et al, 2009. Unpublished data)

Quit Attempts

	Quit in 2 Months (%)
No Mental Illness	53.1*
Mental Illness	56.4*

(Zhu,et al, 2009. Unpublished data)

* Descriptive data, not based on results of a randomized controlled trial

Quitting Success

	30-Day Point Prevalence (%) at 2 Months
No Mental Illness	20.8*
Mental Illness	19.0*

(Zhu,et al, 2009. Unpublished data)

* Descriptive data, not based on results of a randomized controlled trial

Conclusions from the Helpline

- Smokers with mental illnesses call in high numbers
  - Across all demographics
- They appear to be more motivated
  - More likely to get counseling & use NRT
- The motivation and use of treatment seem to compensate for the vulnerability associated with their mental health condition.
- As a result, they are equally likely to try to quit & succeed
- Randomized controlled trials are needed to determine efficacy of telephone counseling for smokers with mental illnesses

Treatment Considerations

Treatment: MI/SUD Fundamentals

- Demonstrated interest in quitting across populations
- Smoking cessation rarely jeopardizes stability of primary disorder or recovery
- Similar treatment/relapse prevention techniques

Assessment Considerations

- Past/current history of MI treatment and SUD recovery
- Current health history including medications
- Current life situation
- Social support
- Tobacco use history
  - Determine current interest in quitting
  - If interested; determine readiness to quit

Determining Readiness to Proceed

- Motivation
  – “Interested” is sufficient
  – Not ruling out some type of intervention, even if motivation to quit now is low
- Stability
  – Need to be psychiatrically stable-do not need to be in full remission

Unique Tobacco Treatment Needs

- Determine need for involvement from primary care/other health care providers
- Determine need for more intensive behavioral therapy
- Address psychotropic medication issues
- Tailor treatment plan based on
  - Current stability of symptoms/recovery
  - Functional status
  - Current psychotropic medications
  - Previous quit history

Helpline Counseling Considerations

- Psychiatric stability
  - How are the client's symptoms?
  - Is the client in treatment?
  - How consistent is the client with treatment & how is it working?
- No major life changes
- No major medication changes
- No active intoxication/withdrawal from other substances

Counseling Considerations (cont.)

- Quitting history & symptoms
  - Past quit attempts are helpful indicators of what to expect.
  - What changes in symptoms were noticed?
- Biochemical factors
  - Nicotine acts much like a psychotropic medication on brain chemistry.
  - The blood levels of some the medications can increase dramatically when quitting.
  - Medications may need to be adjusted.

Counseling Considerations (cont.)

- Content, length, & number of calls
  - Based on level of functioning and professional support
- Counselor style
  - How much direction vs. facilitation should a counselor provide?

Counseling Considerations (cont.)

- Client contact with prescribing MD
  - Refer back to the primary physician
- Professional support & referral
  - May need to help clients identify support in their local area

Pharmacotherapy

Role of Nicotine Receptors

- Chronic nicotine use results in permanent increase in the number of receptors.
- The brain gets used to a new, "nicotine normal" level.
- Reduced nicotine use (e.g. quitting smoking) disrupts "nicotine normal" receptor activity; causes nicotine withdrawal symptoms.
- Without nicotine, receptor activity normalizes again in 3-6 months, but increase in receptors remains indefinitely.
- Increase in receptors is responsible for:
  - – Difficulty reducing amount smoked.
  - – Quick relapse to former levels of smoking

Withdrawal Symptoms

- Depressed mood
- Sleep disturbance
- Irritability, frustration or anger
- Difficulty concentrating
- Anxiety
- Restlessness
- Decreased heart rate
- Increased appetite or weight gain
- Craving

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed.) Washington, DC.

Pharmacotherapy Options

- Nicotine Replacement Therapy (NRT)
  - Nicotine Patch (OTC)
  - Nicotine Gum (OTC)
  - Nicotine Lozenge (OTC)
  - Nicotine Inhaler
  - Nicotine Spray
- Medication
  - Bupropion SR (Wellbutrin SR, Zyban)
  - Varenicline (Chantix)
  - Other: Nortriptyline, Clonidine

Nicotine Replacement Therapy

- Used to help smokers get off nicotine slowly. Nicotine is released into the bloodstream (via the type of NRT) in order to help reduce physical withdrawal symptoms.
- NRT works by replacing some of the nicotine from smoking at the receptor sites with nicotine from less harmful sources.
- Reduced efficacy for women over time, unless paired with high intensity support (Cepeda-Benito et al., 2004).

Contraindications: pregnancy or nursing, recent heart attack, irregular heart beat, severe or worsening heart pain, stomach ulcers, overactive thyroid, high blood pressure, diabetes requiring insulin.

Bupropion (Wellbutrin S-R, Zyban)

- Bupropion (Zyban) is a non-nicotine prescription drug, the sustained-release form of the antidepressant Wellbutrin.
  - The “pill” is thought to stimulate dopamine and norepinephrine, brain chemicals that give smokers the sensation of alertness & energy.
  - Reduces the withdrawal symptoms such as cravings, irritability and depressed mood.
  - Works equally well for men and women.

  Contraindications: seizure disorders, cranial trauma, stroke, withdrawing from alcohol, current or prior diagnosis of bulimia or anorexia nervosa, pregnancy/nursing, other meds like MAO inhibitors

Varenicline (Chantix)

- Varenicline (Chantix) is a non-nicotine prescription drug developed specifically for smoking cessation. Not an antidepressant.
  - The “pill” releases dopamine, but substantially less than with smoking.
  - Varenicline specifically targets the alpha-4 beta-2 (α4β2) nicotinic receptors, blocking the binding of nicotine from smoking.
  - Reduces the urge to smoke and reduces the pleasure derived from smoking.
  - Works equally well for men and women.

Contraindications: < age 18, pregnancy/nursing, caution if psychiatric disorder, renal impairment, other meds like insulin, blood thinners, asthma puffers

Varenicline (Chantix)

- Post-marketing reports of adverse mood and behavior changes.
- Available research data has been reviewed and causal links have not yet been established.
- Warnings are for both patients and providers to closely monitor psychiatric symptoms of anyone taking varenicline to stop smoking.
- Studies are underway to test varenicline in patients with MI.

Boxed Warning for Chantix & Zyban

- July 1, 2009 – FDA announced it is requiring manufactures to use a Boxed Warning
- It will highlight the risk of serious issues including:
  - Changes in behavior
  - Hostility & agitation
  - Depressed mood
  - Suicidal ideation, behavior, & attempts
- The FDA also stated - the risk of serious adverse medication events must be weighed against significant health benefits of quitting smoking

Six Month Point Prevalence Quit Rates for FDA-Approved Cessation Medications

Medication	Percent quit	OR	(95% CI)
Nicotine gum	19.0%	1.5	(1.2, 1.7)
Nicotine patch	23.4%	1.9	(1.7, 2.2)
Nicotine nasal spray	26.7%	2.3	(1.7, 3.0)
Nicotine inhaler	24.8%	2.1	(1.5, 2.9)
Bupropion	24.2%	2.0	(1.8, 2.2)
Varenicline	33.2%	3.1	(2.5, 3.8)

Y-axis: Percent quit (0–35)

Nicotine lozenge: (single study results) 2 mg = OR 2.0 (1.4, 2.8) 4 mg = OR 2.8 (1.9, 4.0)

*PHS Clinical Practice Guideline, May 2008.

On the Horizon: Nicotine Vaccine

- In Phase III trials: Will take a few more years.
- Works by stimulating immune system to produce antibodies to nicotine + protein molecule
- Antibodies then bind to any nicotine in bloodstream; can't pass the blood/brain barrier
- Effects of nicotine can't reach brain

Pharmacotherapy Guidance for Behavioral Health

- Smokers with behavioral health diagnoses who are trying to quit should receive pharmacotherapy (PHS Clinical Practice Guideline, 2008)
- Dose level and duration of drug treatment individualized.
- Many will need
  - Higher doses
  - Combination treatments
  - Longer duration of treatment

Bupropion SR

- Effective in smokers with Major Depression but relapse high when treatment discontinued
- Not appropriate as only medication in Anxiety disorders
- Effective in smokers with PTSD (limited evidence)
- Effective in smokers with Schizophrenia but relapse high when treatment discontinued

Bupropion SR (cont.)

- Contraindicated in seizure and eating disorders
- Not recommended
  - Alcohol abuse/dependence
  - Bipolar disorder
  - Extended sleep deprivation
  - Past head trauma
- Interferes with efficacy of protease inhibitors used for HIV/AIDS treatment

Varenicline

- Anecdotal reports of effectiveness for MI/SUD
  - One study in UK; positive results
  - Gap in the varenicline evidence base
- Post marketing adverse behavior and mood changes
  - Have been reported in all samples
  - Boxed warning for neuropsychiatric issues, BUT still widely used by individuals with these issues
- Providers need to closely monitor mental status of anyone quitting smoking on varenicline

Pharmacotherapy Guidance

- Smoking induces CYP1A2 isoenzyme
- Approximately doubles clearance of
  - **Antipsychotics:** Prolixin (fluphenazine), Haldol (haloperidol), Zyprexa (olanzapine), Clozaril (clozapine), Thorazine (chlorpromazine)
  - **Antidepressants:** Elavil (amitriptyline), Aventyl (nortriptyline), Jaminine (imipramine), Anafranil (clomipramine), Sinequan (doxepin), Fluvox (fluvoxamine)
- Cessation may produce rapid, significant increase in blood levels
- Need to monitor for increased side effects

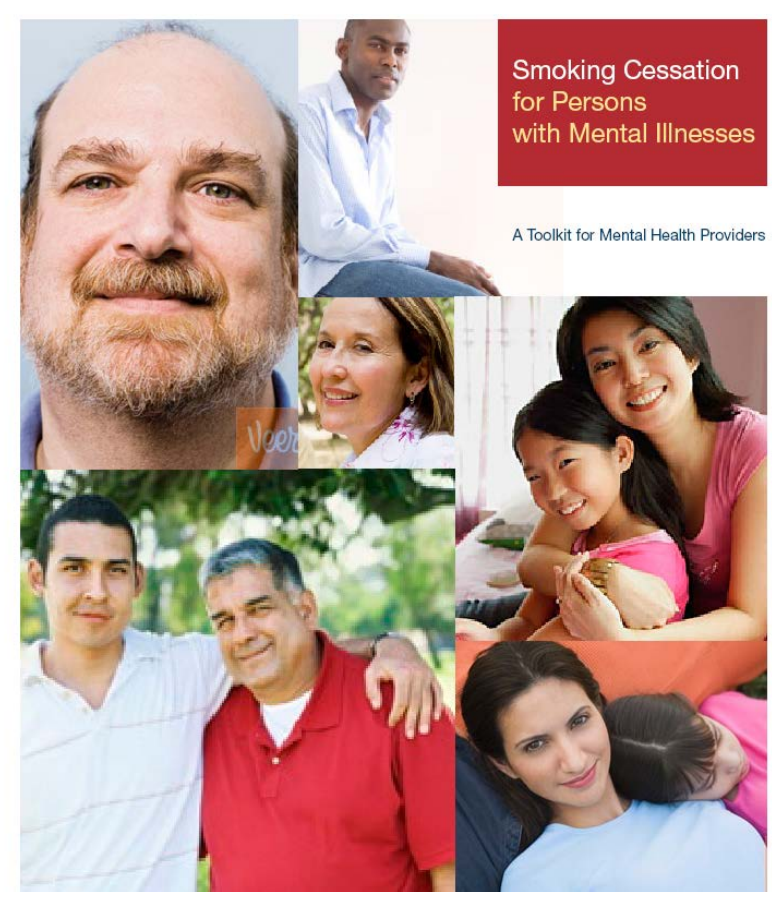
Clinical Monitoring Recommendations

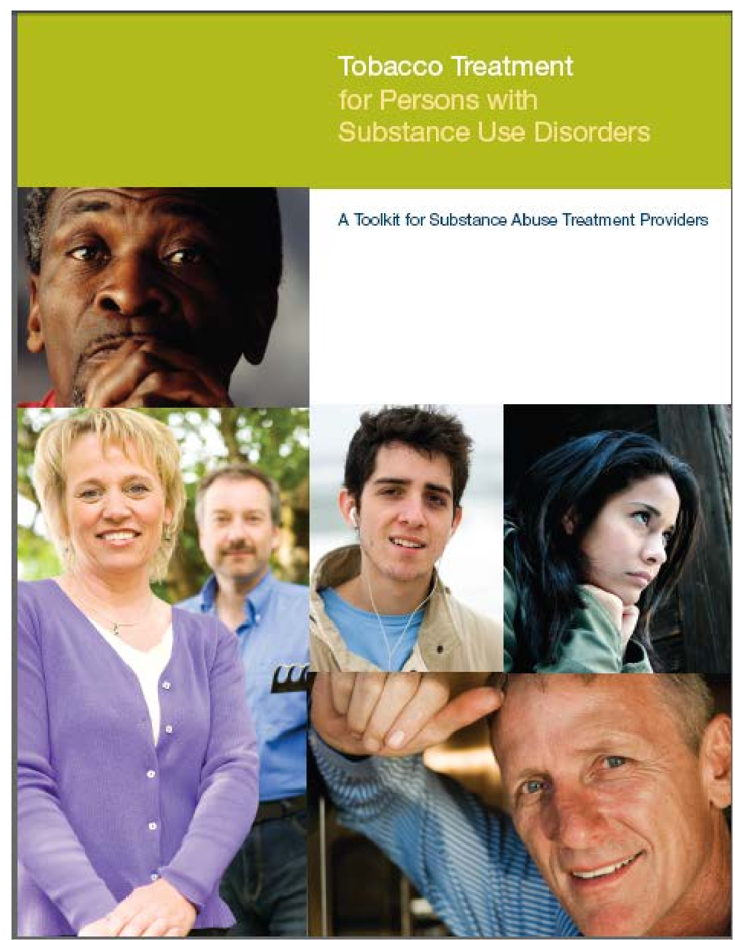
- Patients should be seen 1-3 days after initiating smoking cessation
- Monitor weekly for the 1st 4 weeks for MI/SUD relapse and the need to adjust medication levels
- After 1st month, monthly review for 6 months
- Communication between the primary care provider and MI/SUD provider(s) should occur
  - During the initiation of the cessation attempt
  - During the cessation period if any psychiatric complications occur

Coverage for Tobacco Dependence Treatments

- Health insurance coverage & requirements vary by plan
- Medi-Cal provides FREE pharmacotherapy with:
  - Certificate of enrollment in behavior-modification, e.g. 1-800-NO-BUTTS
  - Prescription
- Medicare
  - Prescription drug benefits – Part D
  - Reimburses for cessation counseling
    CPT Codes:
      - 99406 (3-10 minute intervention)
      - 99407 (>10 minute intervention)

Resources





For free copies go to:
www.centerforcessation.org

American Lung Association in CA
www.californialung.org

Center for Tobacco Cessation
www.centerforcessation.org

Communities Against Substance Abuse
http://www.drugfreesandiego.org/

County of San Diego Behavioral Health
http://www.sdcounty.ca.gov/hhsa/programs/bhs/

Mental Health America of San Diego County
http://www.mhasd.org/

Smoke-Free San Diego
http://www.smokefreesandiego.org/

Smoking Cessation Leadership Center
www.smokingcessationleadership.ucsf.edu

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