MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION: PUBLIC HEALTH STRATEGIES FOR INTEGRATION WITH CHRONIC DISEASE PREVENTION

- **SURVEILLANCE** Support collaboration of public health and mental health (MH) agencies and organizations to develop shared operational definitions of MH, mental illness (MI) and determinants associated with each by using clinical, public health, MH and policy perspectives.
- **EPIDEMIOLOGY** Support research into determinants and protective factors for MH, antecedents and risk factors for MI and their relationships to chronic disease.
- **PREVENTION RESEARCH** Determine the importance of MH and MI as factors in broader public health promotion and prevention programs.
- **COMMUNICATION** Develop educational products that include appropriate cultural, linguistic and developmental characteristics.
- **EDUCATIONAL OF HEALTH PROFESSIONALS** Develop educational plans that are appropriate for each professional audience.
- **PROGRAM INTEGRATION** Support the integration of traditional public health, MH promotion and MI health services at the state and local levels.
- **POLICY INTEGRATION** Develop policies at all government levels for all audiences, including the public, public health and health care providers, and policy makers.
- **SYSTEMS TO PROMOTE INTEGRATION** Establish systems integration within CDC's Division of Adult and Community Health to promote program and policy integration across multiple infrastructures.

From: Centers for Disease Control. (2011). Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011-2015. Atlanta, GA.

ASSESSMENT AND INTERVENTION PLANNING

STAGES OF CHANGE

- Pre-contemplation: No change is intended in the foreseeable future. The individual is not considering quitting.
- Contemplation: The individual is not preparedto quit at present, but intends to do so in the next six months.
- Preparation: The individual is actively considering quitting in the immediate future or within the next month.
- Action: The individual is making overt attempts to quit. However, quitting has not been in effect for longer than six months.
- Maintenance: The individual has quit for longer than six months.

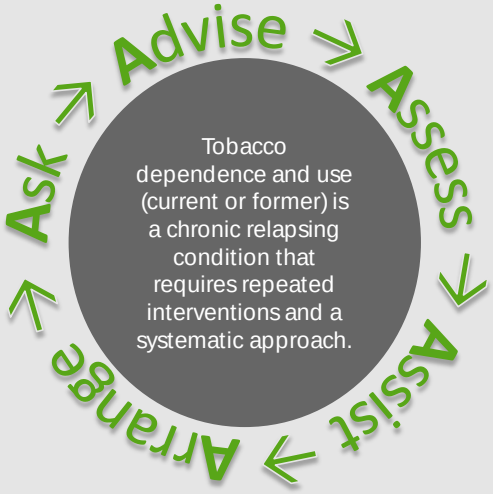
THE 5 A'S:

Ask, Advise, Assess, Assist and Arrange

The U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence provides healthcare clinicians an onsite strategy for smoking cessation treatment that is built around the "5 A's" (Ask, Advise, Assess, Assist and Arrange). Knowing that providers have many competing demands, the 5 A's were created to keep steps simple. Regardless of the patient's stage of readiness for a cessation attempt, the 5 A's should be utilized at every patient visit.

The Guideline recommends that all people entering a healthcare setting should be asked about their tobacco use status and that this status should be documented. Providers should advise all tobacco users to quit and then assess their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be assisted in the effort. Follow up should then be arranged to determine the success of quit attempts.

The full 5 A's model is most appropriate for agencies and organizations that have tobacco cessation medications and/or behavioral services available for persons with mental illnesses. For agencies and organizations that do not have tobacco cessation services readily available, we recommend the use of the first two A's (ask and advise) and then the agency can refer to available community services (this is referred to as the 2 A's + R model).



If you have limited time:
Ask → **A**dvise → **R**efer

From: Morris, C, Waxmonsky, J, May, M, Giese, A, Martin, L. (2009). Smoking Cessation for persons with Mental Illness: A toolkit for mental health providers.