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Original article

The use of mental health services by adolescent smokers: A nationwide Israeli study

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ABSTRACT

In this study, we aimed to evaluate the utilization of mental health services by adolescent smokers, the presence of untreated mental disorders in this young population and the associated emotional and behavioral difficulties. We performed a nationwide survey study of an Israeli representative sample of 906 adolescents and their mothers. Mental disorders were assessed using the Development and Well-Being Assessment (DAWBA) Inventory. Emotional and behavioral difficulties were evaluated using the Strengths and Difficulties Questionnaire (SDQ). Mental health services use and smoking habits were evaluated by relevant questionnaires. Adolescent smokers were using significantly more mental health services than non-smokers (79% vs. 63%, respectively, $P < 0.001$), independently of their mental health status or ethnic group. Adolescent smokers also reported more emotional and behavioral difficulties in most areas ($P < 0.001$), which are consistent with their mothers' reports, except in the area of peer relationships. The treatment gap for the smoking adolescents was 53% compared to 69% in the non-smokers ($P < 0.001$). This is the first study characterizing the use of mental health services and the related emotional and behavioral difficulties in a nationally-representative sample of adolescents. The findings of a wide treatment gap and the rates of the associated emotional and behavioral difficulties are highly relevant to the psychiatric assessment and national treatment plans of adolescent smokers.

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1. Introduction

Cigarette smoking is associated with five million deaths annually worldwide and is a leading cause of premature death [20]. However, the production and consumption of cigarettes has been on the rise for the past decades [15]. Smoking initiation typically occurs during adolescence, and it is estimated that 3,000 American adolescents initiate smoking every day. Furthermore, there are currently approximately four million smoking adolescents in the USA [38]. A previous epidemiological study demonstrated smoking prevalence of 35% among Israeli youth [25]. Thus, cigarette smoking should be considered as a “pediatric disease”.

Psychiatric comorbidity is common among adolescent smokers. There have been numerous reports of higher rates of disruptive

behavior disorders [31], major depressive disorder [7], anxiety disorders [6] and substance-related disorders [3] in this population. In addition, smoking is associated with other risky behaviors, such as violence, dropping out of school and unplanned pregnancy [12]. Consumption of cigarettes during adolescence appears to be a strong marker for future psychopathology [38], and prior smoking was shown to predict subsequent suicidal behavior in a German cohort of 3,021 subjects aged 14–24 years [2].

Despite these consistent findings, mental health services for adolescents usually do not include treatment for tobacco dependence, and most general health practitioners are not fully aware of the need to screen this at-risk smoking adolescent population for psychopathology. In a recent report, we addressed the issue of the unmet need for mental health services for adolescents and reported a treatment gap (defined as the presence of a mental disorder without corresponding treatment) ranging from 60% to 66% of a nationally-representative sample of 957 adolescents [21].

While adolescent smokers are at high risk for both mental and physical disorders, there is a lack of knowledge regarding their

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utilization of community mental health services and the emotional and behavioral difficulties experienced by this population and their parents. We have utilized the body of data collected in the Israeli Survey of Mental Health among Adolescents (ISMEHA) Study to investigate the particular characteristics of the smoking adolescents in this community-based representative sample and their associated emotional and behavioral difficulties. Our goal was to characterize the relationship between these particular difficulties and the utilization of mental health services by adolescent smokers and to determine the treatment gap for this population considering their untreated mental health disorders.

2. Subjects and methods

This study is part of the ISMEHA Study. For further details on the sample and sampling method, see Mansbach-Klienfeld et al. [22].

2.1. Sample and procedures

Briefly, the representative sample included 957 adolescents (age range 14–17 years) and their mothers. The sampling frame used was the Israeli National Population Register (INPR), including the names of all legal residents of Israel-born between July 2, 1987 and June 30, 1990 regardless of whether they were in school ($n = 317,604$).

Mothers and adolescents were interviewed separately at home by two trained lay interviewers in the native language of the participants. Fifty-one adolescents refused to participate, although their mothers agreed. Twenty-two mothers disagreed to be interviewed but consented to their child's participation.

The response rate was 80% in the located sample ($n = 1,195$) and 68% ($n = 957/1,402$) in the total sample. No significant differences related to gender or immigration status were noted. The results were weighted back to the total population to compensate for clustering effects and non-responses.

The study was approved by the Israeli Ministry of Health Review Board. Written informed consent of the parents and their adolescent children for participation in the study were obtained after the nature of the study was fully explained.

2.2. Instruments

2.2.1. Diagnostic assessment

Mental disorders were assessed using the Development and Well-Being Assessment (DAWBA) Inventory [14]. The DAWBA, a multi-informant interview, combines a structured interview with open-ended questions regarding psychiatric symptoms and their impact on the adolescent's life and his or her family. The responses to the structured questions generated a computerized diagnosis according to the Diagnostic Statistical Manual IV-Text Revised (DSM-IV-TR) [1] criteria. Senior child psychiatrists (I.F., A.A. and R.K.) relied on the recorded comments to establish the diagnoses [9].

The specific disorders were categorized into internalizing or externalizing disorders. Internalizing disorders included separation anxiety, specific phobias, social phobias, panic disorder, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD) and major depressive disorder (MDD). Externalizing disorders included attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) and conduct disorder (CD).

Emotional and behavioral difficulties, both self- and mother-rated, were evaluated using the Hebrew, Arabic and Russian versions of the Strengths and Difficulties Questionnaire (SDQ) [23]. The SDQ is also a multi-informant questionnaire designed to screen for mental health problems in children and adolescents

[13]. This tool assesses peer relationships, hyperactivity and inattention, conduct disorders and emotional symptoms. This measure is increasingly being used in both community and clinical settings due to its relative brevity and availability in the public domain (www.sdqinfo.org). The psychometric properties of the Hebrew version of the SDQ (SDQ-H) were shown to be acceptable compared to other translated versions [23].

Assessment of services utilization: Mothers were asked whether during the past 12 months they had consulted a professional or informal service provider about the emotional and/or behavioral problems of their adolescent offspring and provided a list that included a family practitioner or a pediatrician, another medical specialist, an adolescent health clinic, a psychiatrist, psychologist, social worker or psychiatric nurse, a school counselor, any teacher, other school staff, a school nurse, hotline staff, a self-help group, a spiritual leader, an alternative medicine agent, a probation officer or other relevant individuals.

The adolescents were asked whether during the past school year they had consulted someone in school regarding problems not connected to the academic material, such as problems with their peers, problems at home and problems with concentration, and, if yes, whom they had consulted. The list of choices included a school counselor, a teacher, a psychologist, a friend, a school nurse or other. In the option for adding other sources, the adolescents indicated that they had notified a school principal and a youth movement guide.

Mothers were asked whether their adolescent had visited a primary-care practitioner (PCP) during the past year. In Israel, the concept of a PCP includes general practitioners, pediatricians and internists [37].

2.2.2. Smoking habits

Adolescents were asked whether they had ever smoked and whether they still smoke. For the purpose of this study, we included all past and present smokers in the smoking group (lifetime smoking) because of the evidence that smoking patterns in adolescence are largely inconsistent [16,17]; therefore, referring to current smoking vs. previous smoking may not accurately reflect the smoking behavior over the period of adolescence.

2.3. Statistical analysis

Statistical analyses were conducted using an SPSS-17 complex sample analysis module (IBM-SPSS Inc, Chicago, IL). Raw numbers and weighted proportions are presented for the characteristics of the study population. Significance is based on the adjusted F and its degrees of freedom; the adjusted F is a variant of the second-order Rao-Scott adjusted χ^2 statistic. The mean self- and mother-rated SDQ scale scores and standard deviations according to the adolescents' report of having ever smoked were calculated, and the t values are presented.

3. Results

The sample included 957 subjects, but complete data were available for 906 adolescents (age range 14–17 years) and their mothers who were included in the final analysis (50.3% males). A total of 228 adolescents (27.8%) reported having smoked. Of those, 69 (8.8%) still smoked at the time of the study. Thirty-four participants from the smoking group (34/228) were diagnosed as having a mental disorder according to the DAWBA. However, more than half of them ($n = 18$; 53.3%) did not use mental health services. This treatment gap was significantly smaller than for the non-smoking group (49/68; 68.7%) ($\chi^2=11.46$, $df = 1$, $P < 0.001$).

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