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Families, Mental Health and Well Being: Pursuing Sustainable Development Goal 3

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Families and Promoting Mental Health and Well Being: Pursuing Sustainable Development Goal 3

1.Introduction

Transforming Our World: 2030 Agenda for Sustainable Development was agreed by the 193 Member States of the United Nations and includes 17 Sustainable Goals (SDGs) and 169 targets. The SDGs build on the Millennium Development Goals (MDGs), eight goals adopted in 2000 and planned to be achieved by 2015. Significant progress has been made towards these, but there are still issues to be addressed.

Sustainable Development Goal 3 is titled *Ensure Healthy Lives and Promote Well-Being for All at All Ages*, and one of its targets (3.4) specifically mentions mental health: *3.4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing*. Other targets are also related to mental health, including 3.5 (strengthen the prevention and treatment of substance abuse, and harmful use of alcohol), 3.8 (achieve universal health coverage), 3.9b (strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks). It is extremely important that the promotion of mental health and well-being, and the prevention and treatment of substance abuse, were recognized as health priorities within the global development agenda.

Other SDGs are also related to health, including Goal 1. End poverty in all its forms; Goal 2. End hunger, achieve food security and improve nutrition and promote sustainable agriculture; Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; Goal 5. Achieve gender equality and empower all women and girls; Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all; and Goal 10. Reduce inequality within and among countries.

The purpose of this paper is to provide an overview of the role that families play in promoting individual health, with a focus on mental health and wellbeing, contributing thus to pursuing Goal 3.

2. Mental Health Complexities

Health is defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being" (WHO 2001, p.1) and health promotion is defined as "actions that support people to adopt and maintain healthy lifestyles and which create supportive living conditions or environments for health" (WHO, 2004, p.5). The reciprocal relationship between physical and mental health has been widely recognized (e.g., Sturgeon, 2007).

Organization for Cooperation and Economic Development (OECD) data suggest that one in two people will experience mental health problems at some point in their life, reducing their employment productivity and wages (2014). In 2013 the Sixty-six World Health Assembly

adopted the Mental Health Action Plan 2013-2020 of the WHO which includes recommendations to tackle mental health at the global level.

WHO *Mental Health Atlas* (2015) report highlights significant inequality in mental health care around the world. Almost half of the world lives in countries where there is one psychiatrist (or less) for 100,000 people, while in the developed countries, there is one psychiatrist for 2,000 people. Limited numbers of available mental health specialists and facilities, and difficulties in accessing them, such as transportation, poverty, military conflict and others, make it very hard for people in less developed countries to benefit from mental health services.

Table 1 includes WHO (2014a) data on the numbers of psychiatrists, nurses, social workers and psychologists working in mental health care in several countries. While the more developed countries (mostly in Europe and North America) have a higher number of mental health professionals per 100,000 people including psychiatrists (e.g., Canada -13; Italy - 10, Norway - 29), nurses (e.g., Australia -70; UK -67), others in Africa and Asia have a very limited number of psychiatrists (e.g., Peru – 0.76; Philippines – 0.46) or psychologists (e.g., Zambia -.03; Bangladesh - .03).

WHO (2015) indicates that, globally, one in ten people experiences mental illness, but only 1% of the health workforce is treating this, suggesting that there is a great need to invest in mental health. Providing mental health care services in countries where there are economic or political/military hardships, is even more important given that people experience increased amount of stress in these regions, and stress is a trigger for many mental illnesses.

Mental health across life span

Mental health is important across life span, impacting children and adults of all ages. Although significant data indicate that antecedents of adult mental disorders can be detected in children and adolescents, the development of policies and programs for child and adolescent mental health have lagged those for adult mental disorders (WHO, 2005). Worldwide, 10-20% of children and adolescents experience mental disorders, most commonly depression or anxiety, with half of mental illness beginning by the age of 14 and three – quarters by mid-20s. If untreated these conditions severely impact children's development, school performance and potential. WHO's 2012 report on adolescent mental health indicated that adolescent mental health is inadequately addressed and actions at country level appear to be fragmented while opportunities to mainstream adolescent mental health in education, health and child protection programs have been available but not used.

The Mental Health Surveillance among Children report indicated that, in the United States about 13-20% of children experience a mental disorder in a given year and that the costs to address the impact on the child, family and community reach $247 billion (Perou, et.al., 2013). Moreover, suicide was the second leading cause of death among children aged 12-17 in 2010. The report indicated that the most frequently parent-reported diagnosis for children 3-17 years old were: attention –deficit/hyperactivity disorder (ADHD) (6.8%), behavioral or conduct problems (3.5%), anxiety (3%), depression (2.1%), and autism spectrum disorders (1.1%).

School-Based Health Centers (SBCHs) are effective service integration mechanisms in the area of health and social policy and data show that adolescents who were enrolled in a school with a health center were more likely to access mental health services. There are about 2,000 school-based health centers located in elementary, middle and high schools across United States which provide various services including primary medical care, mental and behavioral health care, reproductive health services, dental/oral care, and health education and promotion (e.g., nutrition, physical education) (Keeton, 2012). About 78% of school-based health centers provide mental health care, including crisis intervention (78%), individual psychosocial assessment and treatment (73%), case management (69%), classroom behavioral support (62%), substance abuse counseling (53%) (Lofink, et al., 2013).

Findings from a U.S. national community survey on mental health service use among suicidal adolescents indicate that adolescents from ethnic minority groups were less likely to receive inpatient or outpatient care than whites (Wu et. al., 2010). Moreover, poor self-perceived health and living in a single-parent family were associated with use of inpatient services, while gender (being female), higher family income and participation in extracurricular activities were associated with use of outpatient services. Larger ethnic disparities were found in use of inpatient and outpatient mental health services than in use of school-based services, indicating that mental health services offered within school settings can reach children who need services but may lack resources in affording them (Wu et. al., 2010). While the school-based health centers are effective mechanisms in providing children with mental health services, efforts need to be made in order to ensure that mental health services are accessible to everybody.

Mental health is significant for all ages, including older populations, especially since. at the global levels, between 2015 and 2050, the population over 60 years old is expected to increase from 12% to 22% (900 million to 2 billion people) (WHO, 2015b). About 15% of adults 60 years old and over suffer from a mental disorder. The most common mental health disorders in this age group are dementia and depression; others are anxiety or substance abuse, which many times is overlooked. Among the risk factors for mental health problems in older adults are losing the ability to live independently (because of limited mobility, chronic pain, frailty, etc), bereavement, and drop in socio-economic status due to retirement.

A meta-analysis of mental disorders in older people in Western countries indicated that the most prevalent estimates were dimensional depression (19.47%), lifetime depression (16.52%) and lifetime alcohol use disorders (11.71%) (Volkert, et.al., 2013). It also showed that most of the research is focused on major depression, social phobia and panic disorder (and less on other disorders such as bipolar disorders or PTSD) and thus the authors also recommended developing larger databases on the epidemiology of mental disorders in elderly with comparable data.

TABLE 1. Psychiatrists, Nurses, Social Workers, Psychologists in Mental Health (per 100,000 people) (WHO, 2014a)

	Psychiatrists	Nurses	Social workers	Psychologists
	2014	2014	2014	2014
Australia	9.16	70.91	8.56	16.68
Bangladesh	0.13	0.27	0	0.03
Belarus	7.66	24.13	0.65	3.3
Botswana	0.29	12.17	0.39	0.39
Brazil	3.49	3.05	1.72	3.22
Canada	13.42	53.31	117.79	47.42
Chile	4.66	1.59	2.18	5.19
Denmark	9.57	60.02	5.66	12.78
Ecuador	1.09	0.96	0.54	2.53
Egypt	0.69	3.1	0.29	0.12
Guatemala	0.29	1.31	0.07	0.53
India	0.3	0.12	0.07	0.07
Indonesia	0.29	2.57	0.05	0.18
Iran	1.76	8.84	0.72	5.07
Italy	10.85	27.57	2.43	3.52
Lebanon	0.87	0.77	2.32	1.65
Mexico	0.67	2.81	0.52	2.11
Namibia	0.34	5.32	0.17	1.79
Norway	29.69	123.08	26.45	54.28
Pakistan	0.31	15.43	2.32	1.09
Peru	0.76	6.09	0.22	5.06
Philippines	0.46	0.49	0.07	0.07
Poland	5.07	18.66	0.73	5.34
Romania	5.98	16.87	0.54	1.41
Russian Federation	11.06	33.24	1.76	2.61
Spain	8.08	9.69	2.6	5.71
Thailand	0.87	4.46	0.34	0.72
United Kingdom	14.63	67.35	1.99	12.83
United States of America	12.4	4.25	59.83	29.62
Zambia	0.05	1.07	0.01	0.03

Mental health conditions and consequences

There is a wide variety of mental health conditions. The more common ones, such as depression and anxiety are highly treatable; however, many people with mental illness do not receive necessary treatment. Global estimates suggest that treatment gap ranges from 32% for schizophrenia, to 50.2% for bipolar disorders, 56.3% for depression, 57.3% for obsessive compulsive disorders, and to 57.5% for anxiety disorders (OECD, 2014). Under treatment exacerbates the social and economic costs of mental illness and prevents people from living fulfilling and productive lives. The following sections explore more in-depth two mental health conditions as case studies: depression, as one of the most prevalent mental health illnesses and suicide as one of the most dramatic consequences.

Depression

About 7% of the world population (around 350 million people of all ages) suffers from depression at some point in their lives, and in terms of gender, women are more likely to suffer from depression than men (WHO, 2015a). This has a significant impact not only on their own functioning but also on their families and children's mental health. Risk factors for depression include poverty, parental mental health, social isolation, bereavement, and environment (e.g., natural disasters, political and military conflicts). Depression could also lead to even more stress, anxiety, deterioration of physical health (e.g., cardiovascular disease) loss of employment, and deterioration of family relations, among others.

There are effective preventive strategies that could help avert depression before it take roots and, economic analysis also shows that treating depression in primary care is feasible and cost-effective (Annan, 2014). Although there are known effective treatments for depression, fewer than half of those affected in the world (in some countries, fewer than 10%) receive these treatments (WHO, 2015a). Examples of effective preventive methods include school based approaches (for children and adolescents), community programs (e.g., for parents who might experience stress; support groups for elderly to reduce isolation), psychological treatments (e.g., cognitive behavioral therapy/CBT), or antidepressant medication for severe depression.

The increasing burden of depression has been documented, including functional impairment and disability, cardiovascular death and stroke, decreased workplace productivity and absenteeism, resulting in lower income or unemployment (Lepine, & Briley, 2011). Depression also results in family hardship, because it creates family disruptions, sometimes leading to separation and divorce. The barriers to treatments include lack of resources, of trained health care providers, and social stigma associated with mental illness. If untreated, and at its worst, depression can lead to suicide (WHO, 2015a).

Depression is very costly not only at the individual and family level, but at the society level as well. In many societies people with mental health problems, including depression, are discriminated and stigmatized. Depression was estimated to have a global cost of US$ 800 billion, a sum that is expected to double in the next twenty years (Annan, 2014). The importance of addressing depression as major public health policy agenda has been emphasized on the global arena. Former UN Secretary General Kofi Annan's speech at the 2014 The Global Crisis of

Depression Conference indicated that while there is an increased medical knowledge and understanding of depression and how it can be treated, there is a lack of political commitment to tackle it, to develop policies and assign resources to overcome it. He also underlined the urgency to "bring together countries, governments, academic institutions, the private sector, charitable foundations and civil society" (Annan, 2014).

Suicide

The data indicate that an annual global estimate of about 1 million people commit suicide each year (1 every 40 seconds), meaning 11.4 suicides per 100,000 people - 15 for male and 8 for female (WHO, 2014). Suicide is also under-reported, and thus the real numbers are expected to be higher and to increase in the future. Given that this is a phenomenon that impacts the whole family system, many more people are affected and experience suicide bereavement every year.

Suicide is very stigmatized in society, illegal and punishable in some countries (e.g. section 309 of the Indian Penal Code - attempted suicide is punishable with up to 1 year in prison). Decriminalization of suicide and revisions of legislations, together with a more focus on mental health have been proposed and are being considered (Marwaha, 2016). The most common methods for suicide are the ingestion of pesticides, the use of firearms and hanging, but others are used as well (WHO, 2014).

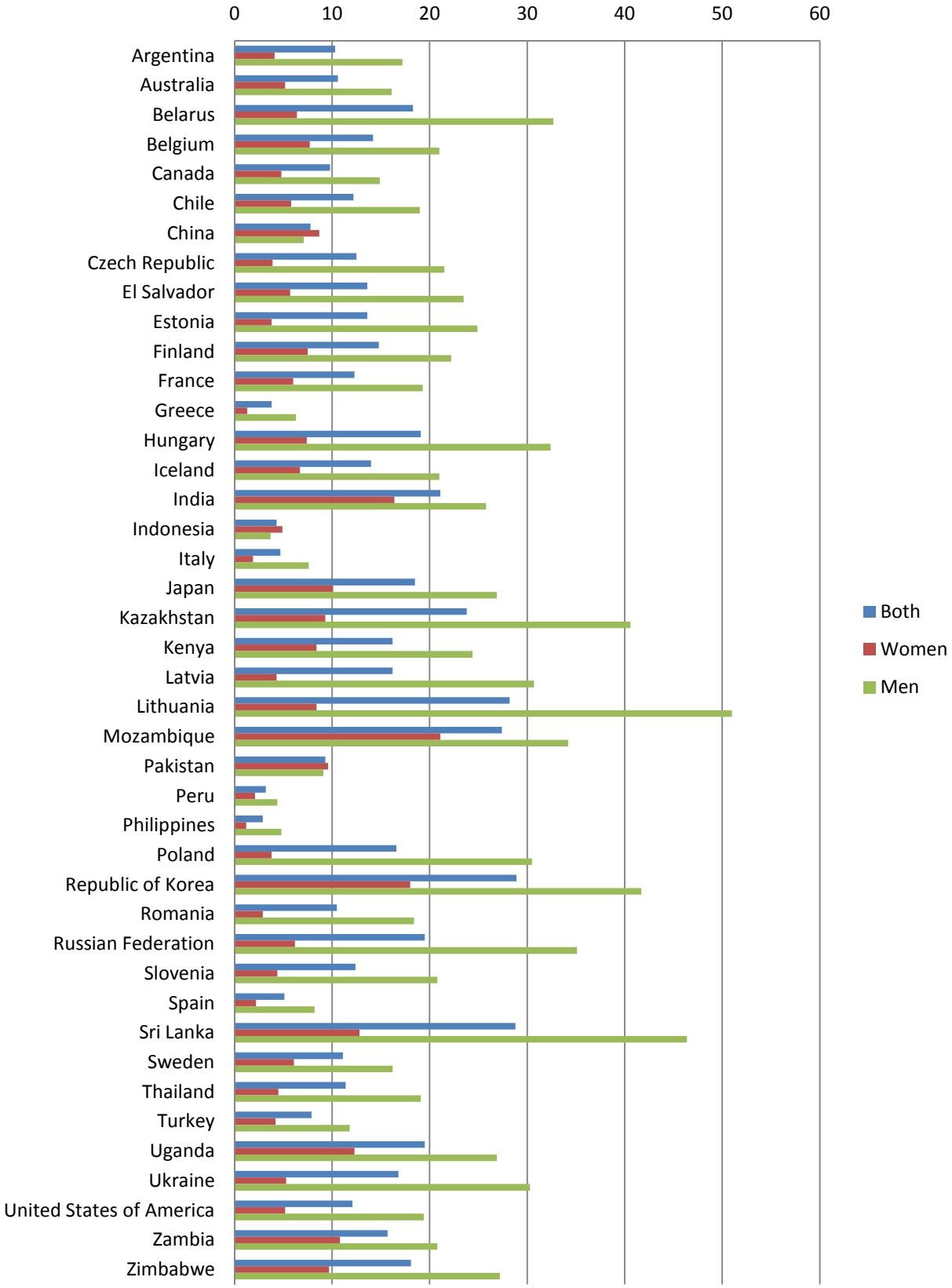
In terms of gender differences, in richer countries three times as many men die of suicide than women do, but in low- and middle- income countries the male-to-female ratio is much lower at 1.5 men to each woman; globally, suicide count for 50% of all violent deaths in men and 71% in women (WHO, 2014). In terms of age, suicide occurs throughout the lifespan, but the rates are among the highest in people 70 years old and older; suicide is also the second cause of death for 15-29 years olds.

Table 2 provides data on age standardized suicide rates (per 100,000 people) (WHO, 2012a). The countries with the highest suicide rates are from Eastern Europe (e.g., Lithuania, Russia, Kazakhstan, Belarus, Latvia), Asia (e.g., South Korea, Japan, Sri Lanka, India), and Africa (e.g., Mozambique and Uganda). It can be seen that men have higher rates than women. Governments need to develop effective mental health and suicide prevention strategies to lower suicide rates.

The risk factors for suicide are many and include mental disorders, economic hardship, alcohol and substance abuse, family history, chronic pain, sense of isolation and loneliness, abuse, violence; environmental problems (e.g., disasters, wars, discrimination); difficulties with accessing health care. Strategies to address these risk factors include promoting mental health (e.g., increasing access to mental health care), reducing the stigma, reducing alcohol and drug abuse, promoting education and coping strategies, ensuring social inclusion, among others.

The WHO Mental Health Action Plan developed a goal of reducing the suicide by 10% by 2020 (WHO, 2013). Although many deaths are preventable, suicide prevention is a low priority on the policymaking agenda. The WHO *Preventing Suicide: A Global Imperative* (2014) report intended to encourage prioritizing suicide prevention on the global public health policy agenda.

TABLE 2. Age standardized suicide rates (per 100,000 people) (WHO, 2012a)



Achieving the target requires countries to take several actions including reducing risk factors like substance use. Substance use was the cause of 175 000 out of the 800 000 suicides worldwide in 2012 – at least one in five (WHO, 2016).

There is a strong knowledge base about suicide behaviors and prevention methods. This knowledge can be used to design national suicide prevention strategies. Many countries have already developed such strategies, and others are encouraged to include this strategy, tailored to different cultural context, in their public health policy agenda.

Investing in Mental Health

Given the great impact and the wide implications that mental health has on people and their wellbeing and functioning, investment in mental health is of great importance. The WHO 2011 Mental Health Atlas indicates that 2.8% was the median amount of the health budget allocated to mental health in 2011. The data in Table 3 show governments' expenses on mental health as a percent of total expenditure on health. The countries with the largest allocations include countries from Western Europe (France, Germany, Netherlands, Sweden), and New Zeeland. Among the countries with the fewest contributions are Mozambique, Peru, Cameroon, Bangladesh, and Malaysia. The 2013-2020 Mental Health Plan calls for a 20% increase in funding for treatment for mental health, including depression, by 2020 (OECD, 2014).

3. The Role of Families in Promoting Mental Health

The role of families in preventing mental health problems has been underlined on multiple occasions. WHO (2004a) report on *Prevention of mental disorders: Effective interventions and policy options* indicated that "individual and family related risk and protective factors can be biological, emotional, cognitive, behavioral, interpersonal or related to the family context" (p.22). These factors have strong impacts at different moments in the lifespan and could be transmitted from one generation to another (e.g., depression, anxiety, alcohol abuse). Mental health promotion should receive appropriate attention within the general health promotion. It is of great concern that, in practice, mental health promotion is frequently overlooked in health promotion programs (Sturgeon, 2007).

Approximately 25% of children and young people in the developed world have an identifiable mental health problem, of whom 10% fulfill criteria for a mental health disorder (Weare, & Nind, 2011). Given that children spend most of their time with their family and in school, these two factors play a significant role in mental health promotion. During childhood, mental health problems most commonly manifest as externalizing (behavioral) and internalizing (emotional) problems, affecting about one in seven school-aged children and being a strong predictor of mental health problems into early adolescence (Hiscock et al. 2012). Given that the burden of mental health problems persists globally, childhood prevention of mental health problems is extremely important and can be offered to all children (universal) or to children at risk of developing mental health problems (targeted). Thus, childhood and adolescence provide opportunities to develop the foundations for mental health and the school can support this process, given the central role it plays in children's lives (Weare, & Nind, 2011). Developing

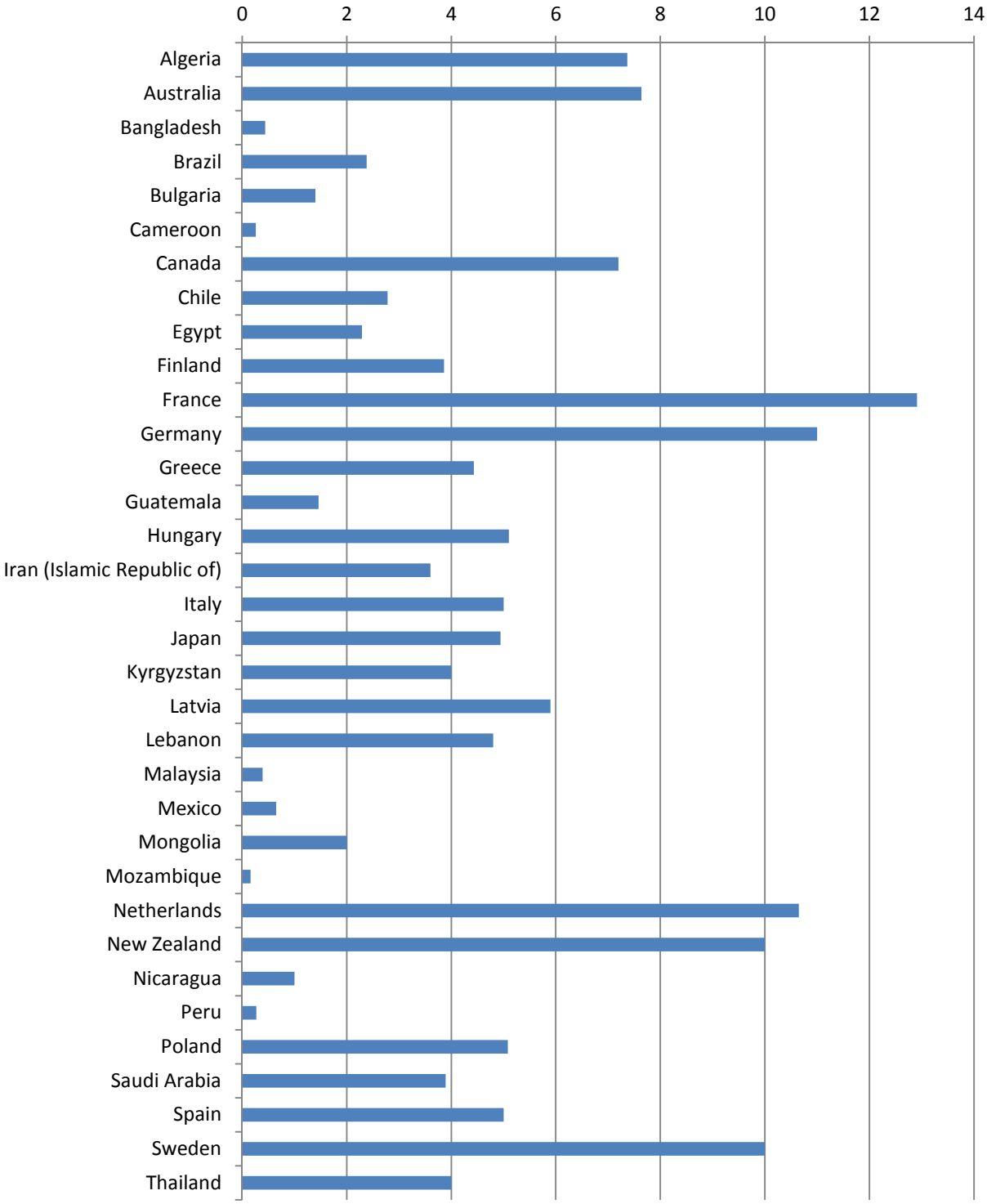
effective partnerships with families and compensating when the family environment is not well functioning, schools are well positioned to identify risk factors and provide effective intervention.

Research indicates that children of parents who have mental illnesses are at risk of developing psychological problems (e.g., Van Loon, et al. 2013). The difficulties that sometimes parents with mental illness experience in communicating with their children, expressing support, or monitoring them increase family conflict and children's internalizing and externalizing problem behaviors (e.g., Goodman, et al., 2011). Different therapeutic techniques have been developed to help parents manage their illness effectively and decrease its impact on their family life. For example, Keeping Families Strong (KFS) is a systemic intervention that uses the family as a focus and agent of change in working with families where the mother is experiencing depression (Riley, et. al., 2008; Valdez et al. 2011). At the end of the intervention mothers and children reported "strengthened coping skills, increased family activities and connections, and improved maternal mental and physical health" (Valdez, et.al., 2011, p.8) which also resulted in improvements in the children's mental health. A review of intervention programs for children whose parents have a mental illness indicate that a core component of these programs was the provision of psycho-education about the mental illness to the children and families, and suggested that more rigorous research is necessary in order to compare the different methods and the conditions in which they work best (Reupert, et al., 2012).

There is a large body of research indicating that family relations have powerful consequences on individual functioning. Good family relations, with good marital relations and parenting behaviors are conducive of well functioning parents and children, while parental mental health problems, marital conflict, low quality parenting determining dysfunctions for children (e.g., low academic achievement, psychological problems) (e.g., Robila, & Krishnakumar, 2006). Similarly, family relations impact health and health care utilization. For example, evidence showed that marital conflict negatively impacted health and health care utilization in older couples (Sandberg, et.al., 2009) and that family and marital support were associated with better treatment adherence and illness adaptation (e.g., Trief, et.al., 2003). Family support is also significant in mental ill-health treatments, determining better outcomes and fewer remissions.

A recent Human Rights Watch report presented the abuses against people with psychosocial disabilities in Indonesia, indicating the persistence of mental health stigma, the lack of knowledge about mental health illnesses and treatments, and lack of community-based support services (Sharma, 2016). The report shows that, due to lack of information and resources for treatment, thousands of people with psychological disorders are at times locked up in confined spaces by their families, sometimes in chains, with no possibility to move or use a toilet, or they are kept in overcrowded institutions, where they also face restraint, and/or physical or sexual violence. Although the Indonesian government has enacted a law in 1977 banning these practices, the law has not been implemented properly.

Table 3. Government expenditure on mental health as a percent of total government expenditure on health (WHO, 2011)



In the United States, the Systems of Care is a multi-agency approach to the delivery of effective services and programs that help children with mental health problems and their families function well and live productive lives in their communities. Stroul and Friedman's (2011) report on effective strategies for expanding the Systems of Care Approach provided a national evaluation of the comprehensive community mental health services for children and their families. A System of Care has been defined as "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic need, in order to help them to function better at home, in school, in the community, and throughout life" (Stroul & Friedman, 2011, p.2). The Children Mental Health Initiative (CMHI), started in 1992 provides funds to communities, states, tribes and territories to implement systems of care. Some of the guiding principles of the systems of care include: ensuring availability of and access to a broad and effective, evidence-based community services for children and their families; providing individualized services in accordance with the unique potential and needs of each child; delivering services in the least restrictive, most normative environments, ensuring cross-system collaboration, and providing developmentally appropriate mental health services. Evaluations showed that the system of care approach are successful and improve outcomes for children, youth and families (Stroul & Friedman, 2011). Different good practices, such as the systems of care approach, could be adapted and used in other countries to increase the effectiveness of mental health care.

Involving families in the promotion of mental health, and in the prevention and treatment of mental illness is of tremendous importance. Family policies in different countries also provide family life education as a way to promote family and individual well functioning (Robila, 2014). Through family life education programs, community support groups, family therapy and counseling, families need to be considered a strong partners in achieving individual health and wellbeing.

4. Recommendations

- Educate families and societies about the mental health conditions, symptoms and treatment
- Develop partnerships between families and mental health providers to achieve good treatment outcomes and fewer remissions
- Provide family life education classes and family services that promote family wellbeing (high quality marital and parenting behaviors), good mental and physical health
- Develop Mental Health Action Plans and Policies to assure comprehensive and coherent systems of care, and follow through implementation and evaluation
- Develop National Suicide Prevention Strategies tailored based on contextual and cultural beliefs to decrease the number of suicide attempts

- Increase governmental expenditure for mental health services, including increasing the number of professionals in the mental health field

- Promote social inclusion and access to health care, specifically mental health care services, for all ages

- Promote formal employment with benefits and health insurance to increase the probability of using health care services

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