Gulbenkian Mental Health Platform

International Forum on Innovation in Mental Health

Lisbon Portugal
3rd October 2013

Integrating the response of health systems to mental disorders and other chronic diseases: Implications for public mental health

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Integrating the response of health systems to mental disorders and other chronic diseases

Acknowledgements:

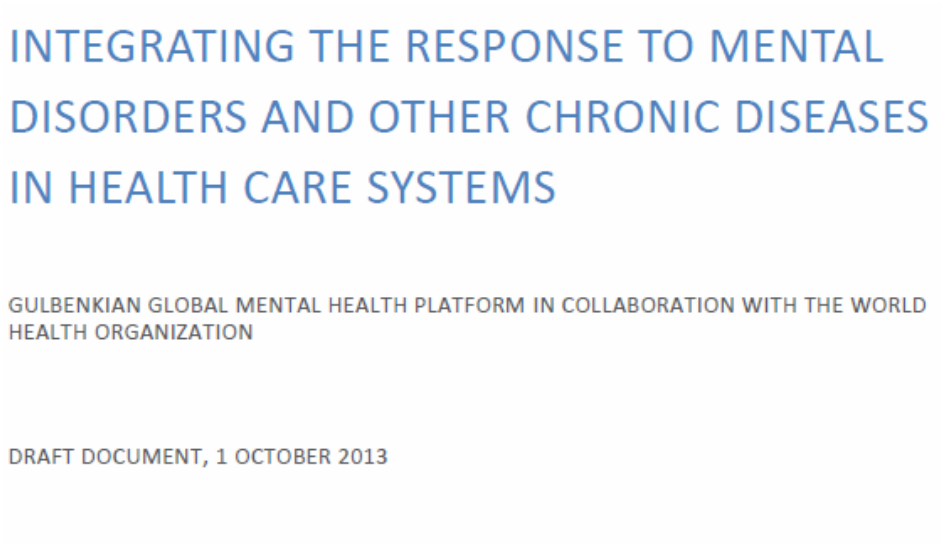
•Thanks to the Gulbenkian Calouste Foundation for inviting me to speak

•Thanks to all the participants who together make this meeting a success

•Professors Jürgen Unützer and Oye Gureje for their presentations and Dr Pamela Collins my fellow discussant

•The contributors to the discussion paper ‘Integrating the response to mental disorders and other chronic diseases in health care systems’

Discussant aims:

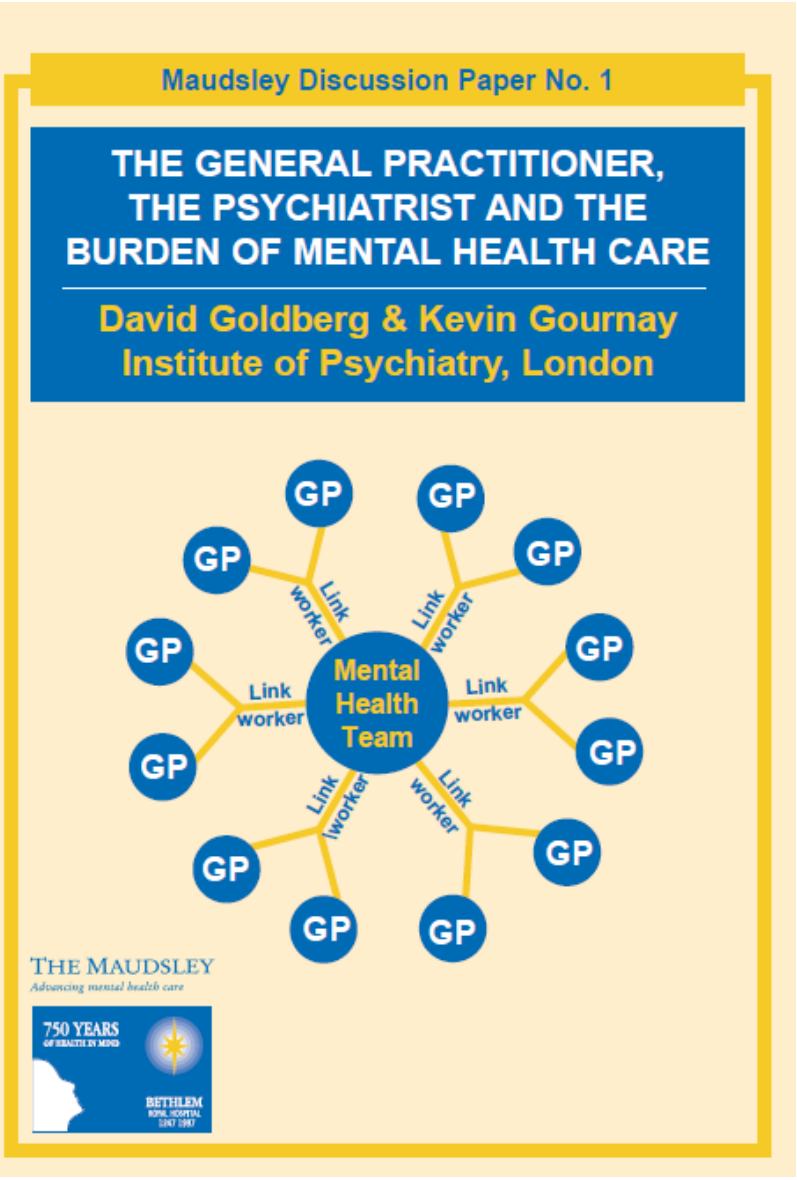

INTEGRATING THE RESPONSE TO MENTAL DISORDERS AND OTHER CHRONIC DISEASES IN HEALTH CARE SYSTEMS

GULBENKIAN GLOBAL MENTAL HEALTH PLATFORM IN COLLABORATION WITH THE WORLD HEALTH ORGANIZATION

DRAFT DOCUMENT, 1 OCTOBER 2013

- To discuss the implications of the evidence presented for public mental health
- To relate this to real life examples
- To consider how systems can be adapted to deliver better mental health outcomes for individuals knowing that doing nothing is no longer an option

The aspiration to reality gap in mental health



'Administrative and medical logic alike ….. suggest that the cardinal requirement for the improvement of mental health services is not a large expansion of psychiatric agencies, but rather a strengthening of the family doctor in his therapeutic role'

Michael Shepherd 1966

The unmet need

1. People with severe mental illnesses have a two to threefold increased risk of death compared to persons of the same age and sex in the general population. They die on average 20 years younger than the general population, cardiovascular disease being the leading cause of excess mortality.
2. People with severe mental illnesses are 2 to 3 times more likely to develop diabetes and other cardiovascular risk factors. Only one-third have normal weight.
3. Poor physical health can entail severe mental illness – the risk of developing depression doubles in people with diabetes. The majority of cancer sufferers will also get depressed, affecting both quality of life and survival.
4. Combined mental and physical health problems engender stigma for individuals and their families. Almost two-thirds of all people with mental disorders do not seek treatment, largely because of stigma.
5. Mental and physical health problems have substantial costs to society: the costs of poor mental health alone in the EU have been estimated at €436 billion each year (more than €2,000/ household). The additional costs of physical health problems in mentally ill may increase this figure by as much as 70%.
6. There are also positive interactions between mental and physical health: mental well-being supports good physical health and vice versa.

The Mental and Physical Health Platform 2009

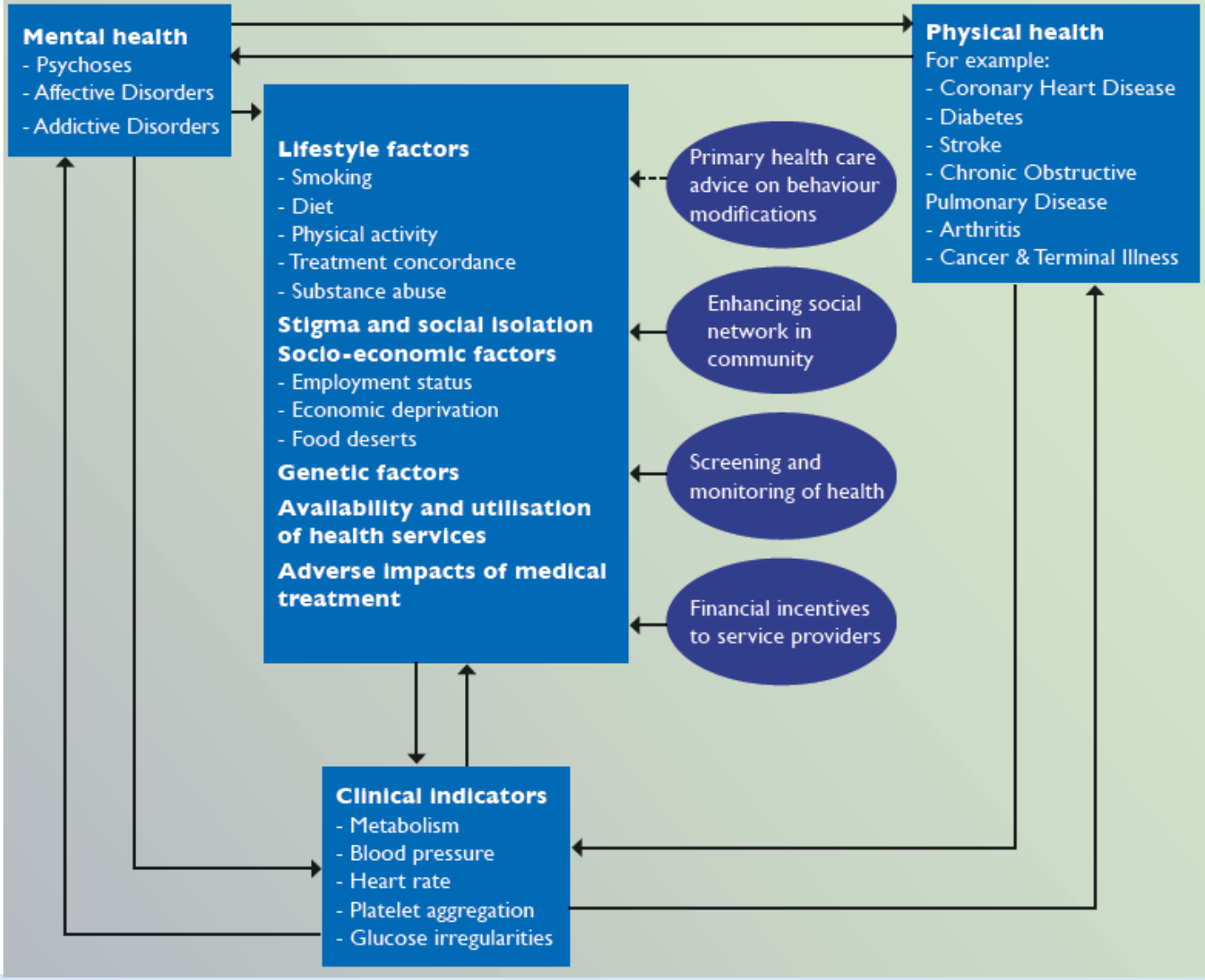
Enabling change through policy

1. The links between mental and physical health must be recognised and addressed in all health-related strategies and programmes at EU and national levels, including disease-specific and other policies such as social, employment, discrimination, research and education, nutrition, tobacco and alcohol. Policy makers should ensure that integrated mental and physical health care is the norm and not the exception.
2. Health systems need to ensure adequate structures and processes, such as training schemes and guidance to health care professionals, carers, families and service users, in order to empower them to tackle combined mental and physical health challenges in their respective environments.
3. Health promotion objectives and measures should better reflect the interplay between mental and physical health, including in health information campaigns and incentives to encourage behaviour change.
4. Decision makers should set up systematic monitoring structures, benchmarks and performance assessments to ensure the implementation of policies supporting integrated care.
5. Targets and actions for improved mental and physical health and well-being must be matched with need-based resource allocation.

The Mental and Physical Health Platform 2009

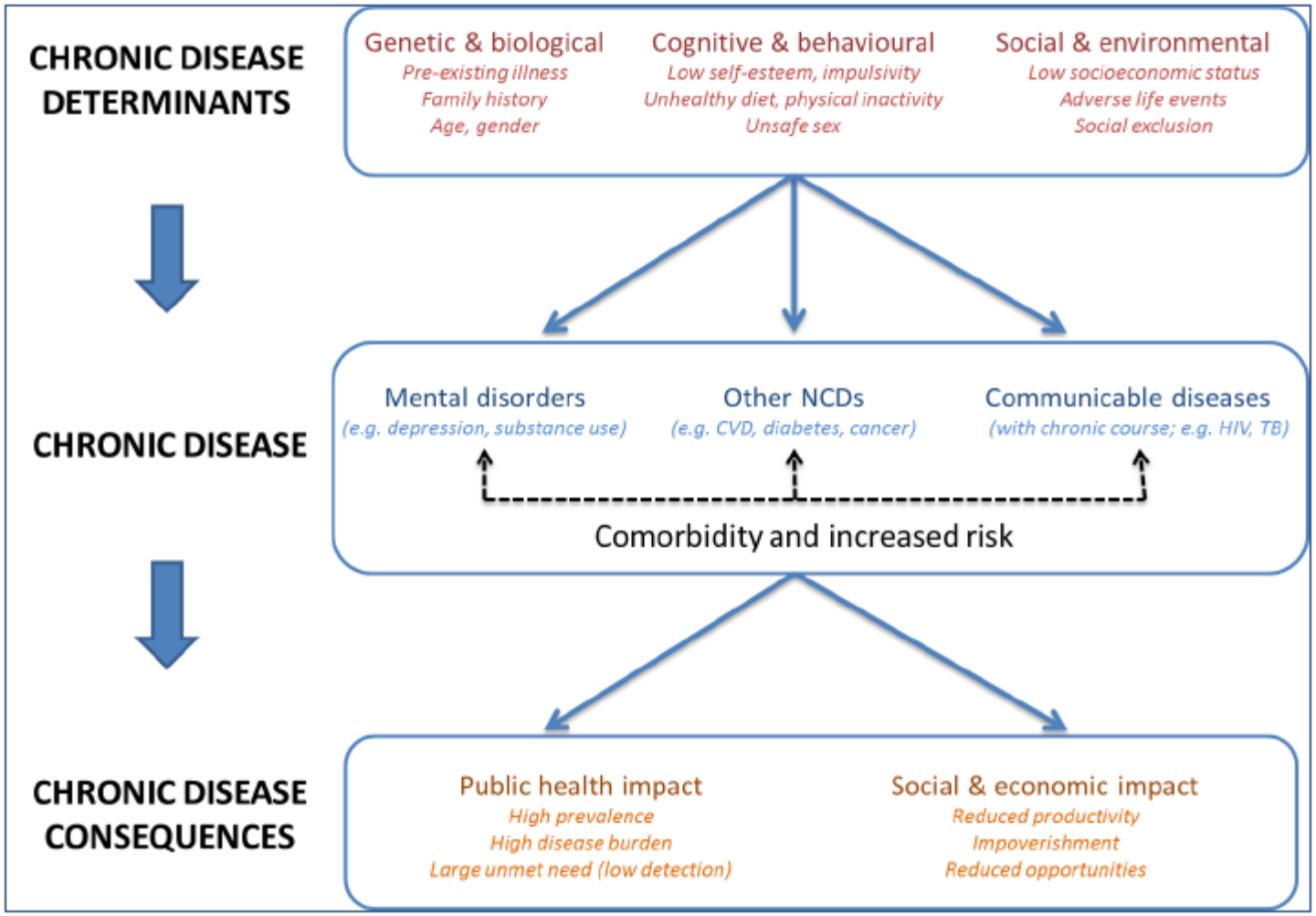
Illustration of some links between mental health and physical health

(Source: David McDaid, October 2008)



Review of link between mental disorder and chronic disease

Figure 1. Links between mental disorders and other chronic diseases



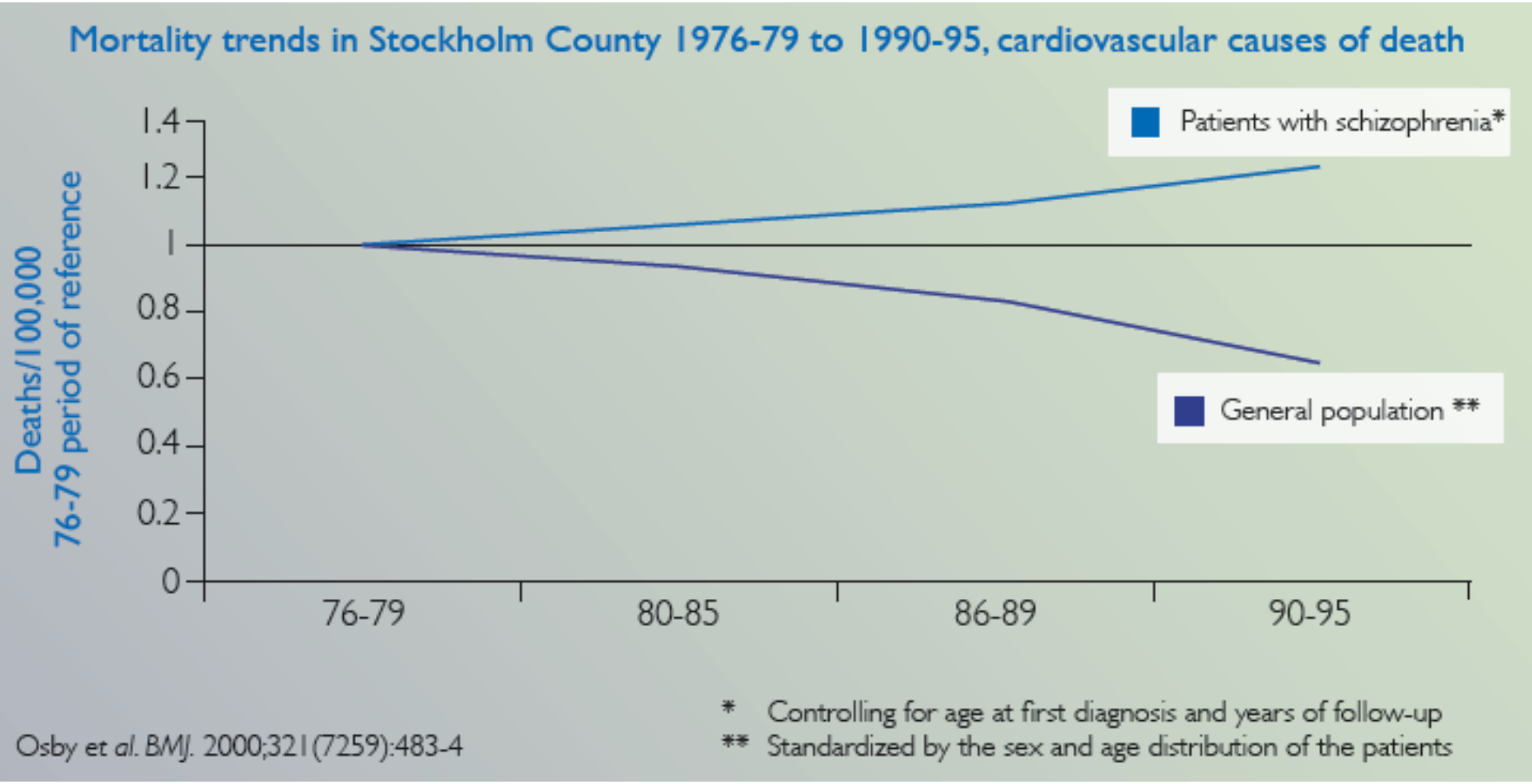
Doing nothing is not an option

Changes in rankings for 15 leading causes of DALYs, 2002 and 2030 (baseline scenario)

Category	*Disease or Injury*	*2002 Rank*	*2030 Rank*	*Change in Rank*
Within top 15	Perinatal conditions	1	5	-4
	Lower respiratory infections	2	8	-6
	HIV/AIDS	3	1	+2
	Unipolar depressive disorder	4	2	+2
	Diarrhoeal diseases	5	12	-7
	Ischaemic heart disease	6	3	+3
	Cerebrovascular diseases	7	6	+1
	Road traffic accidents	8	4	+4
	Malaria	9	15	-6
	Tuberculosis	10	25	-15
	COPD	11	7	+4
	Congenital anomalies	12	20	+4
	Hearing loss, adult onset	13	9	+4
	Cataracts	14	10	+4
	Violence	15	13	+2
Outside top 15	Self-inflicted injuries	17	14	+3
	Diabetes mellitus	20	11	+9

Source: Mathers and Loncar, 2006.

Continued divergence in cardiovascular mortality



Has anything changed?

Alvarez et al. BMC Research Notes 2013, 6:61
http://www.biomedcentral.com/1756-0500/6/61

BMC Research Notes

RESEARCH ARTICLE Open Access

Endocrine and inflammatory profiles in type 2 diabetic patients with and without major depressive disorder

Adriana Alvarez[1,5*], Jose Faccioli[1], Mónica Guinzbourg[1], María M Castex[1], Claudia Bayón[1], Walter Masson[2], Ignacio Bluro[2], Andrea Kozak[1], Patricia Sorroche[1], Lina Capurro[1], Luis Grosembacher[1], Adrián Proietti[1], Carlos Finkelsztein[1], Lucas Costa[3], Patricia Fainstein Day[1], Arturo Cagide[2], León E Litwak[1] and Sherita H Golden[4]

Diabetic patients with depression are more likely to experience cardiovascular events

Contents lists available at SciVerse ScienceDirect

General Hospital Psychiatry

journal homepage: http://www.ghpjournal.com

Depression and risk of mortality in individuals with diabetes: a meta-analysis and systematic review

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Depression significantly increases the risk of mortality in individuals with diabetes. Early detection & treatment of co-morbid depression may improve outcomes in this population

Integrating the response of health systems to mental disorders and other chronic diseases - key messages

KEY MESSAGES OF THIS PAPER

- **Mental disorders share common features with other chronic diseases, including heart disease, stroke, diabetes, and HIV/AIDS:**
  - **They share many underlying causes and overarching consequences;**
  - **They are best managed using comparable ways of organizing and providing care.**

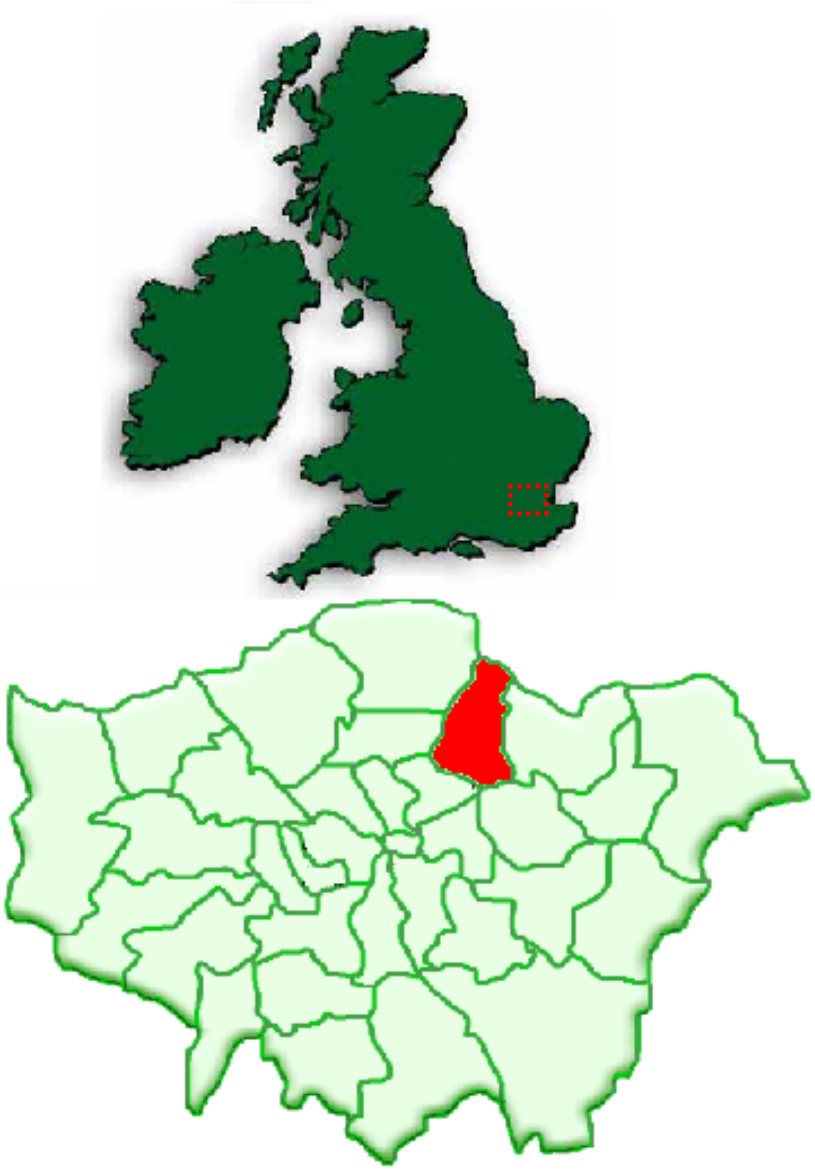
- **The principles and practices for the successful scale-up and integration of mental disorders and other noncommunicable diseases are essentially the same as those already being used for HIV/AIDS in many low- and middle-income countries.**

- **The main challenge in the future is not so much to further demonstrate the utility of chronic disease management models, but rather to bring them to scale.**

Principles and actions for an integrated response to mental disorders and other chronic diseases

Overarching approach	Key principles or functions	Practical steps that can be taken
Public health approach	Life course approach	(Re)design policies and plans to address the health and social needs of people at all stages of life, including infancy, childhood, adolescence, adulthood, and old age.
	Healthy living/behaviours	Promote mental and physical health and well-being through public awareness campaigns and targeted programmes.
	Person-centred, holistic care	Involve service users in the planning of their care; promote and adopt a recovery approach to care and rehabilitation.
	Coordinated care	Provide training in chronic disease management and prevention; strengthen clinical and health management information systems.
	Continuity of care/ follow-up	Develop or enhance case management mechanisms.
Systems approach	Governance and leadership	Ensure health policies, plans, and laws are updated to be consistent with international human rights standards and conventions.
	Financing	Identify and plan for future resource needs; extend financial protection to the poor, the sick, and the vulnerable.
	Human resources	Train and retain non-specialist health workers to provide essential health care and support for mental disorders and other chronic diseases.
	Essential medicines	Ensure the availability of essential medicines at all levels of the health system (and allow trained, non-specialist providers to prescribe them).
	Information	Establish and embed health indicators for mental disorders and other chronic diseases within national health information and surveillance systems.
Whole-of-government approach	Stakeholder engagement	Support and involve organizations of people with mental disorders and/or other chronic conditions.
	Multisectoral collaboration	Establish a multisectoral working group to identify synergies and opportunities for integrated care and support.

Waltham Forest a real life example: demographics

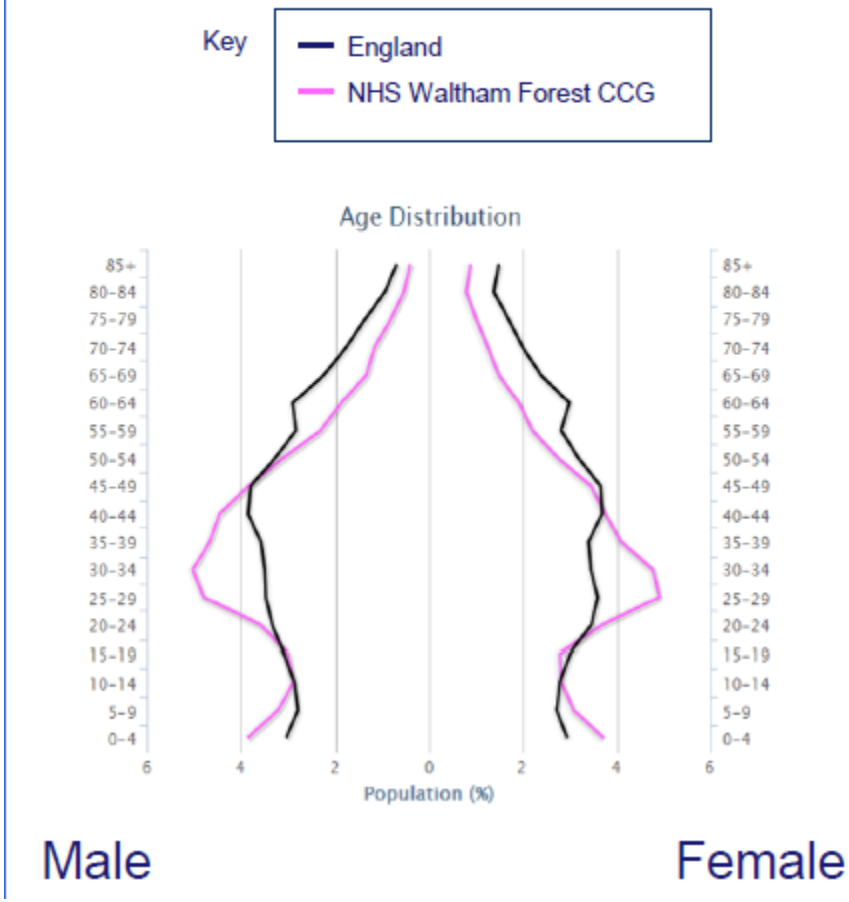


- Population 258,249
- Diverse population - 42 % Black Asian minority ethnicities
- 51% female
- Elderly population in north of borough and younger population in south. Projected older population growing
- 15th most deprived borough in England. Deprivation ranking becoming worst over time
- 1/3 households defined as income deprived and 1/5 households have no member in employment

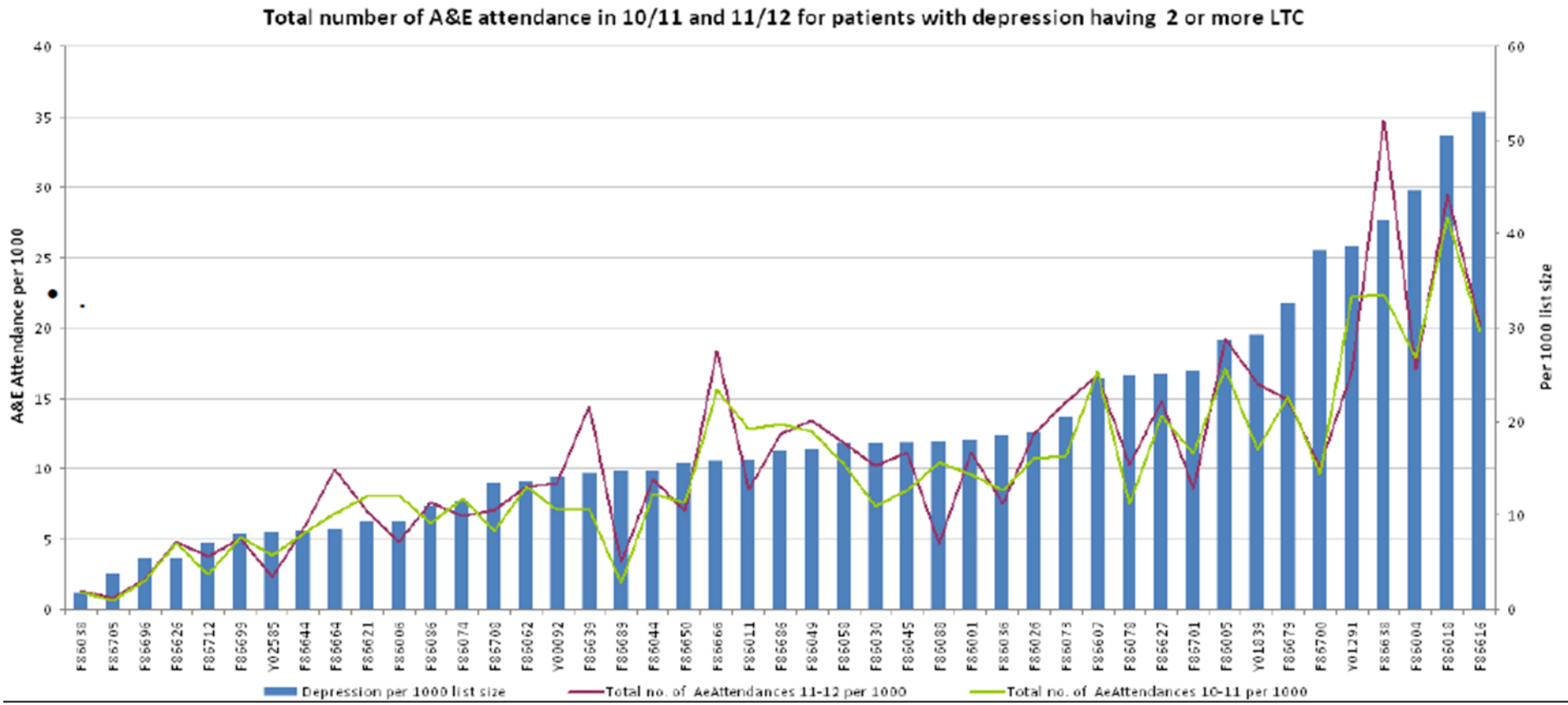
Waltham Forest: Some key challenges

- A relatively young population compared to England
- Above national average in 0-10 & 20-44 age groups
- 42% BME
- 6th most deprived London Borough with >1/3 population income deprived
- High birth rate
- High prevalence of low birth weight

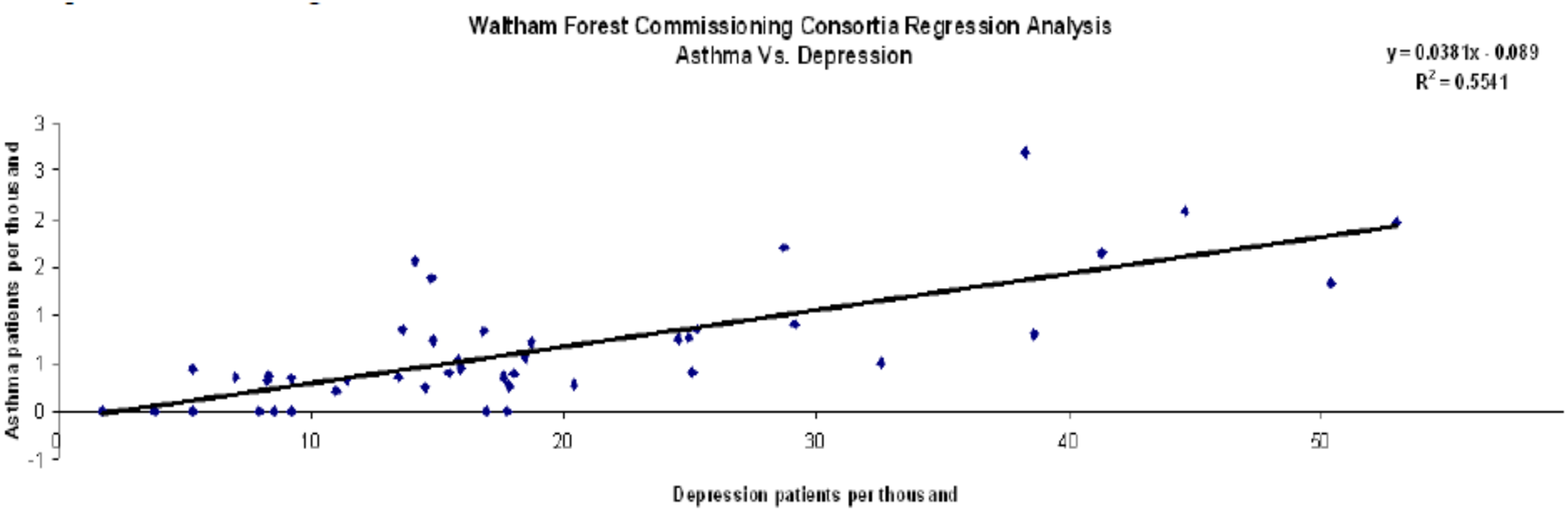
2011 ONS population census	258,200
Number registered with Waltham Forest GPs	283,343



A&E attendance per practice for patients with depression & long term conditions in Waltham Forest



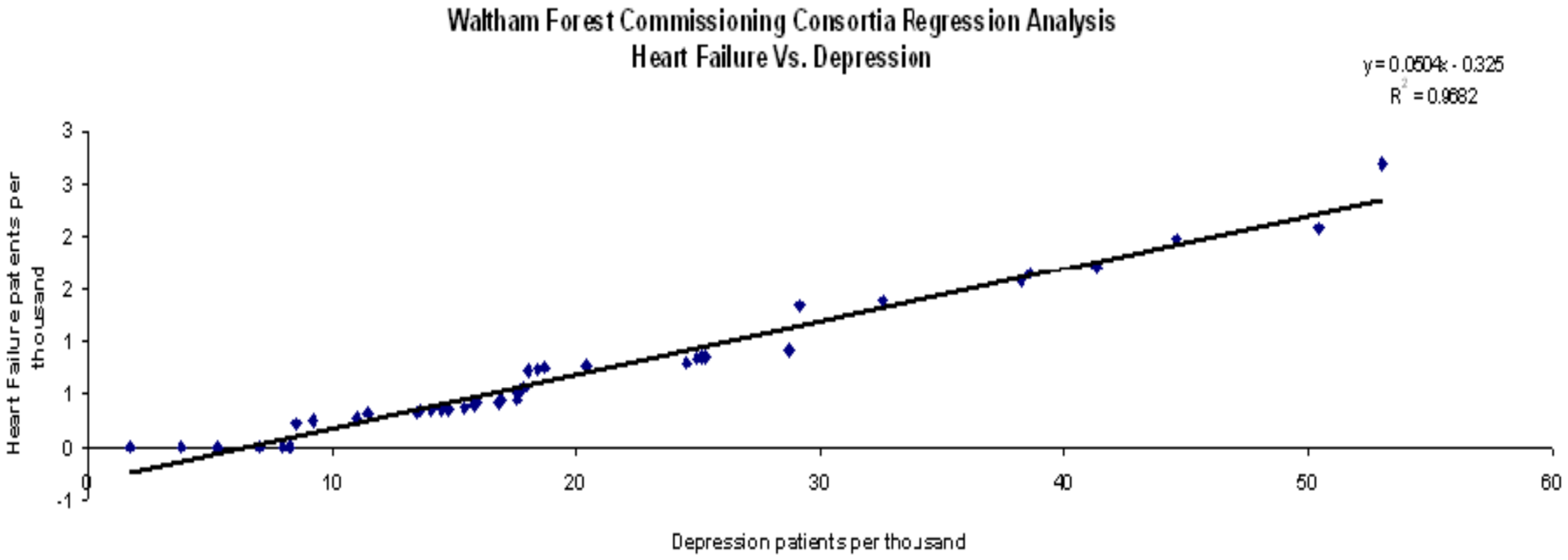
Asthma & depression in Waltham Forest: regression analysis



CORRELATION 0.74439735

There is a direct correlation between asthma & depression and higher use of services in the Waltham Forest GP practice population

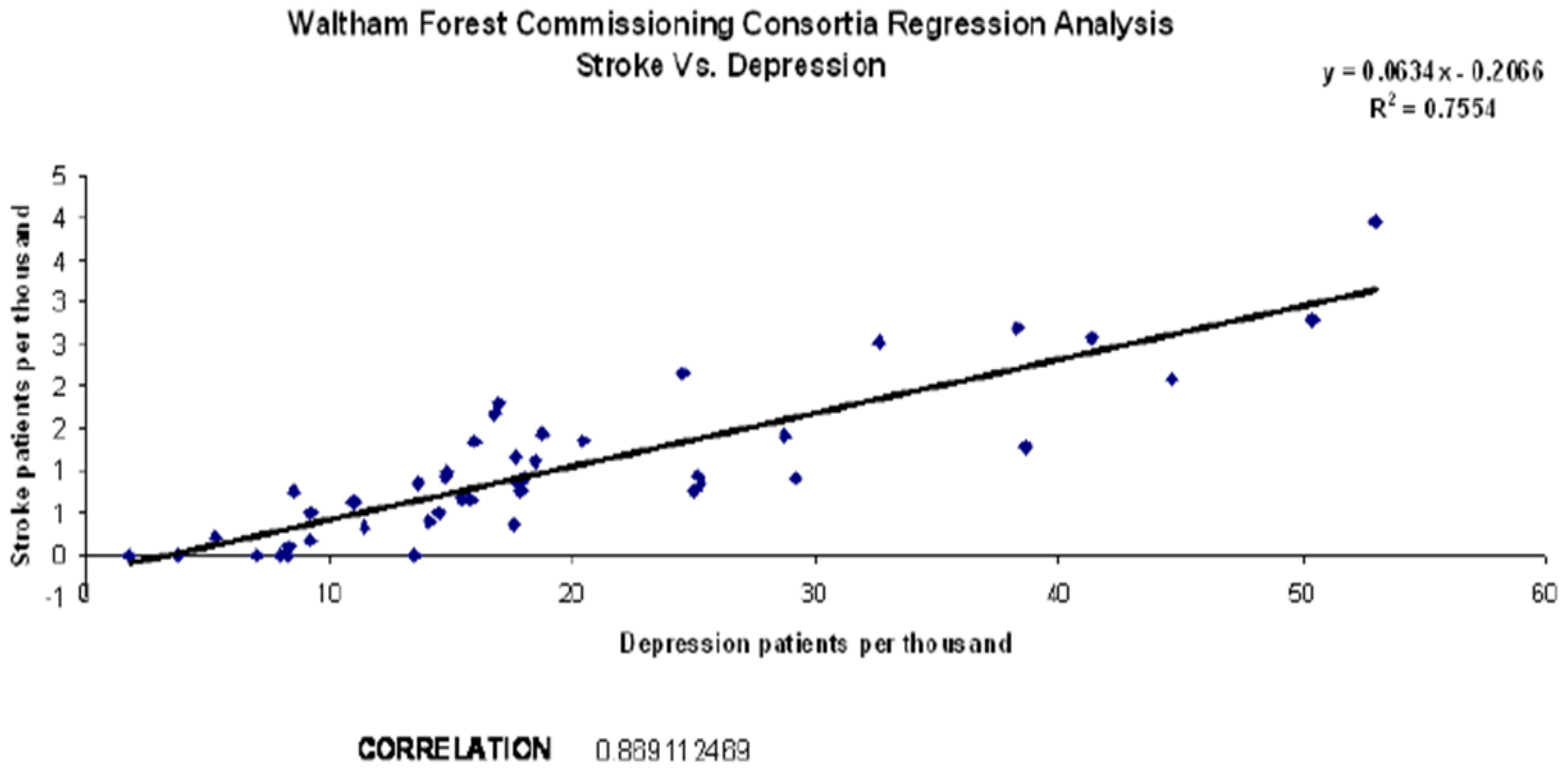
Heart failure & depression: regression analysis



CORRELATION	0.98398617

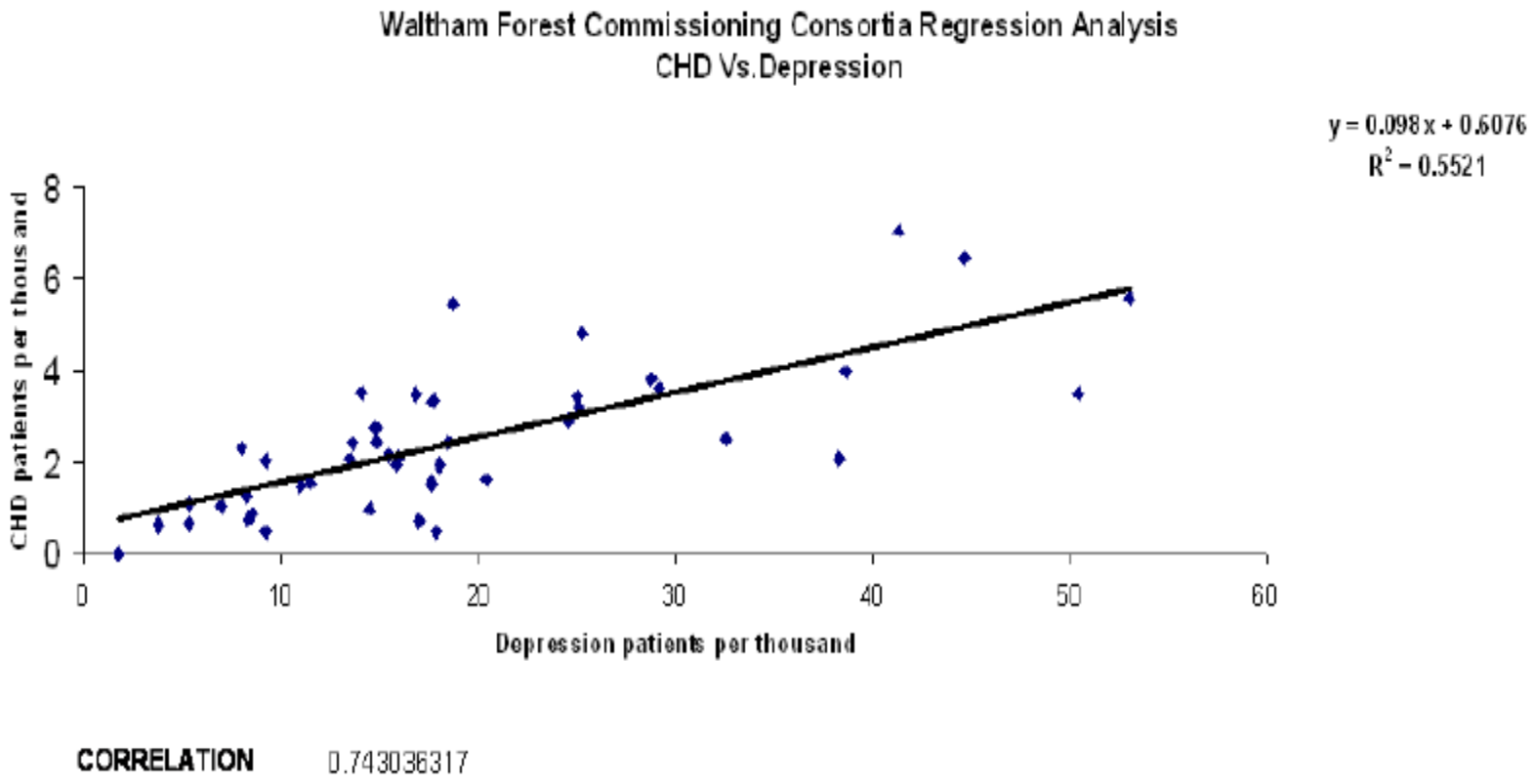
There is a direct correlation between heart failure & depression and higher use of services in the Waltham Forest GP practice population

Stroke & depression : regression analysis



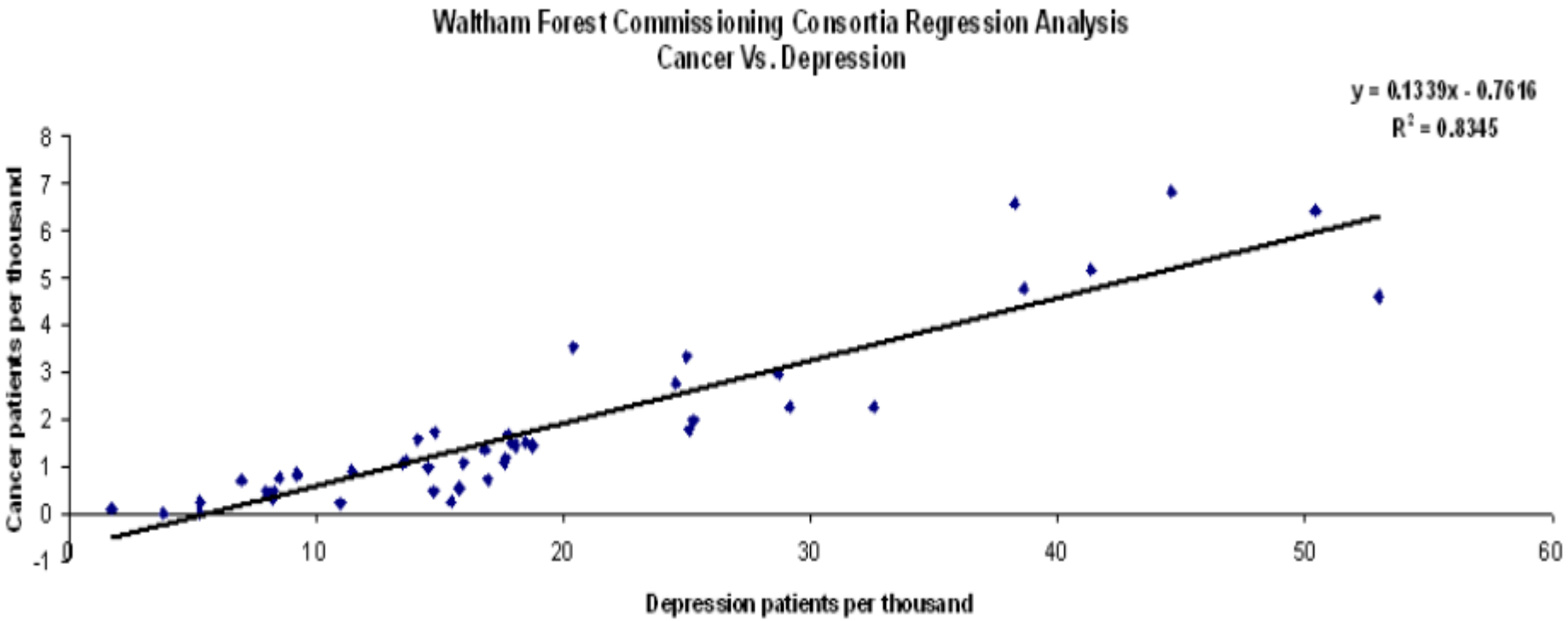
There is a direct correlation between stroke & depression and higher use of services in the Waltham Forest GP practice population

CHD & depression : regression analysis



There is a direct correlation between CHD & depression and higher use of services in the Waltham Forest GP practice population

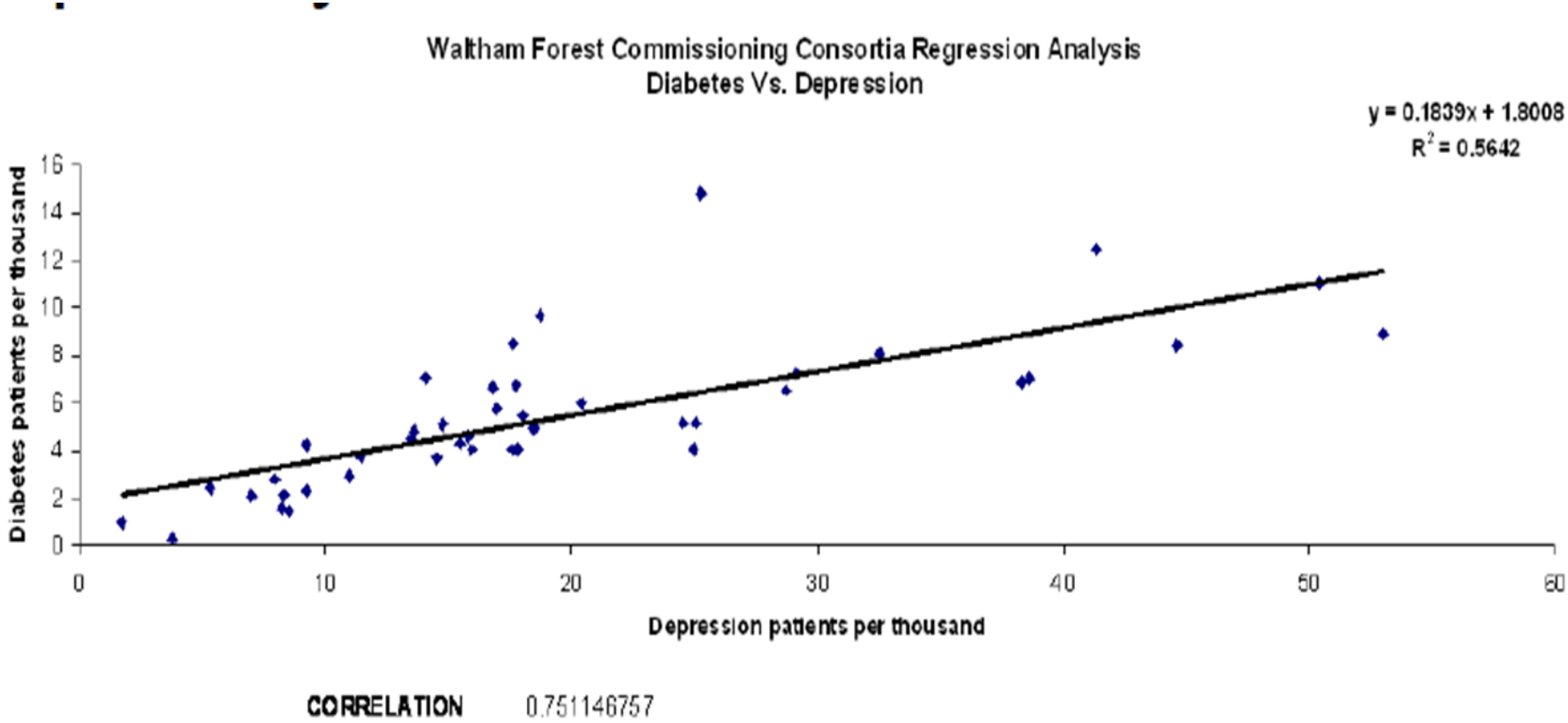
Cancer & depression: regression analysis



CORRELATION 0.913533955

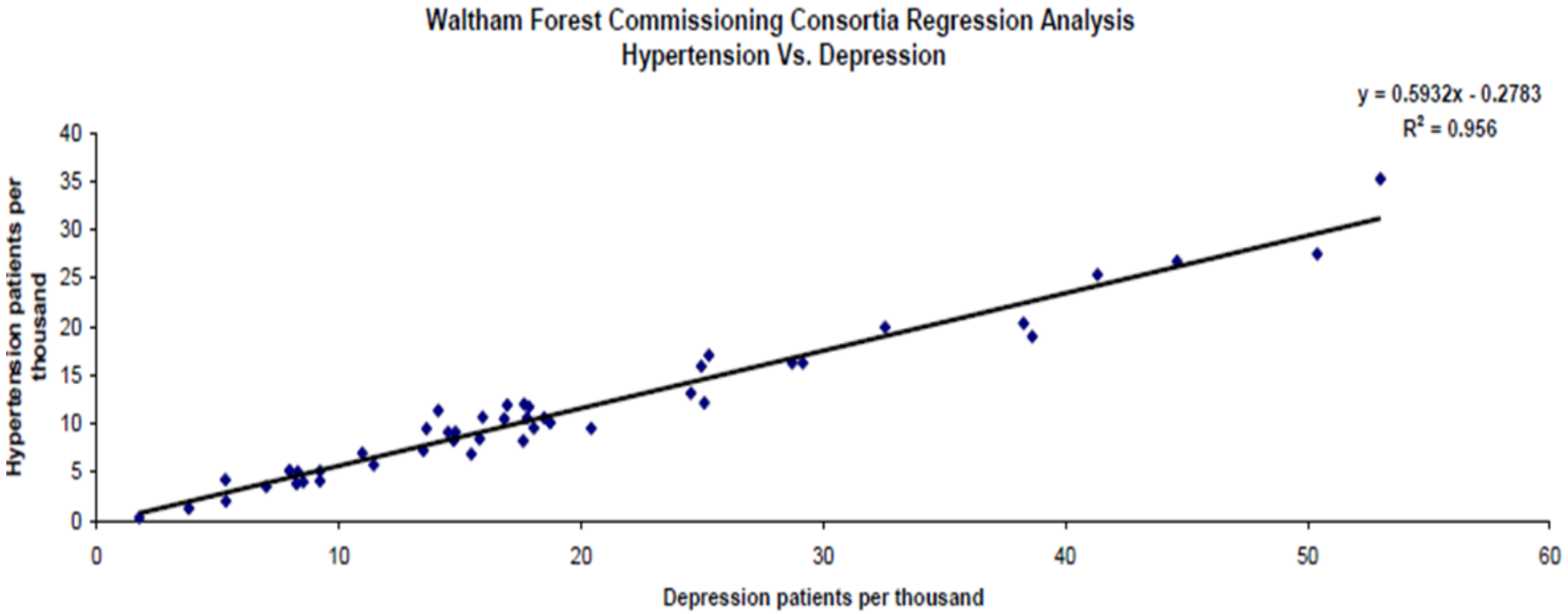
There is a direct correlation between cancer & depression and higher use of services in the Waltham Forest GP practice population

Diabetes & Depression: Regression Analysis



There is a direct correlation between diabetes & depression and higher use of services in the Waltham Forest GP practice population

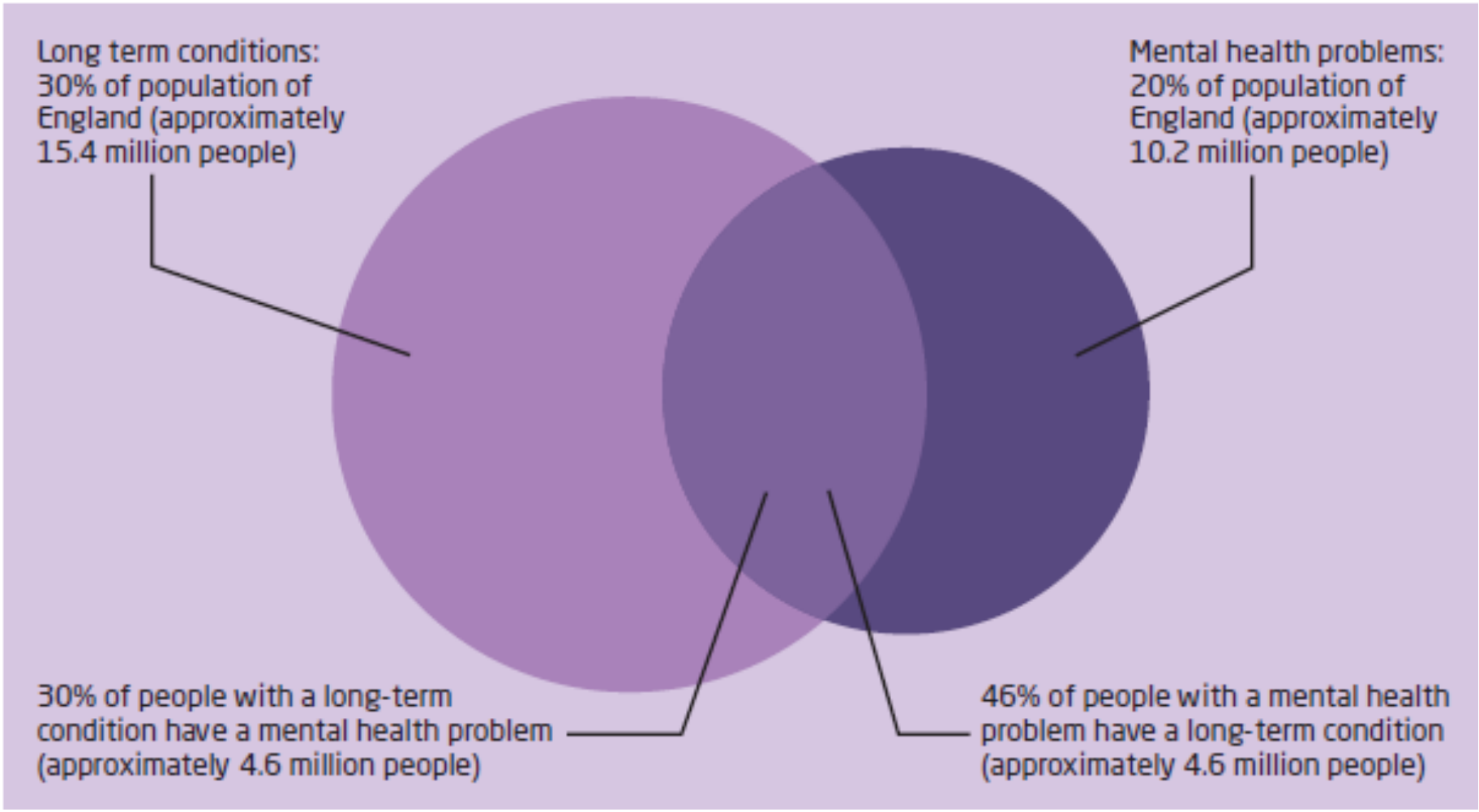
Hypertension & Depression: Regression Analysis



CORRELATION 0.977735547

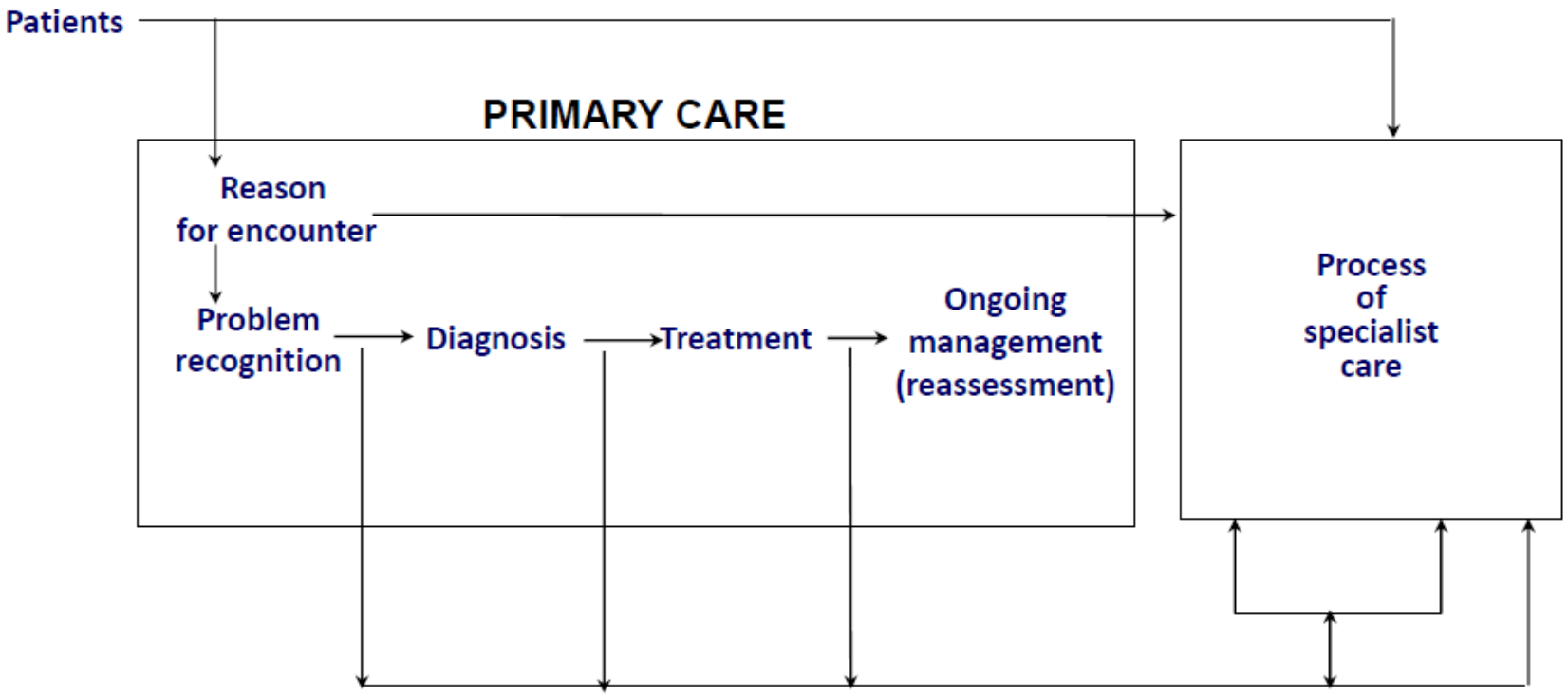
There is a direct correlation between hypertension & depression and higher use of services in the Waltham Forest GP practice population

Mental health and multimorbidity in the UK



Kings Fund UK

Patient Journey



Source: R. Reid Adapted from Starfield. Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998.

The Waltham Forest Long Term Mental Health Conditions Plan

- Employed project manager
- Developed protocol to support discharge from secondary mental health to primary care
- Reviewed primary care reimbursement (LES)
- Employed 4 generic primary care navigators
- Provided GP practices with standardised computer template for data collection
- Provided mental health training to GP practices

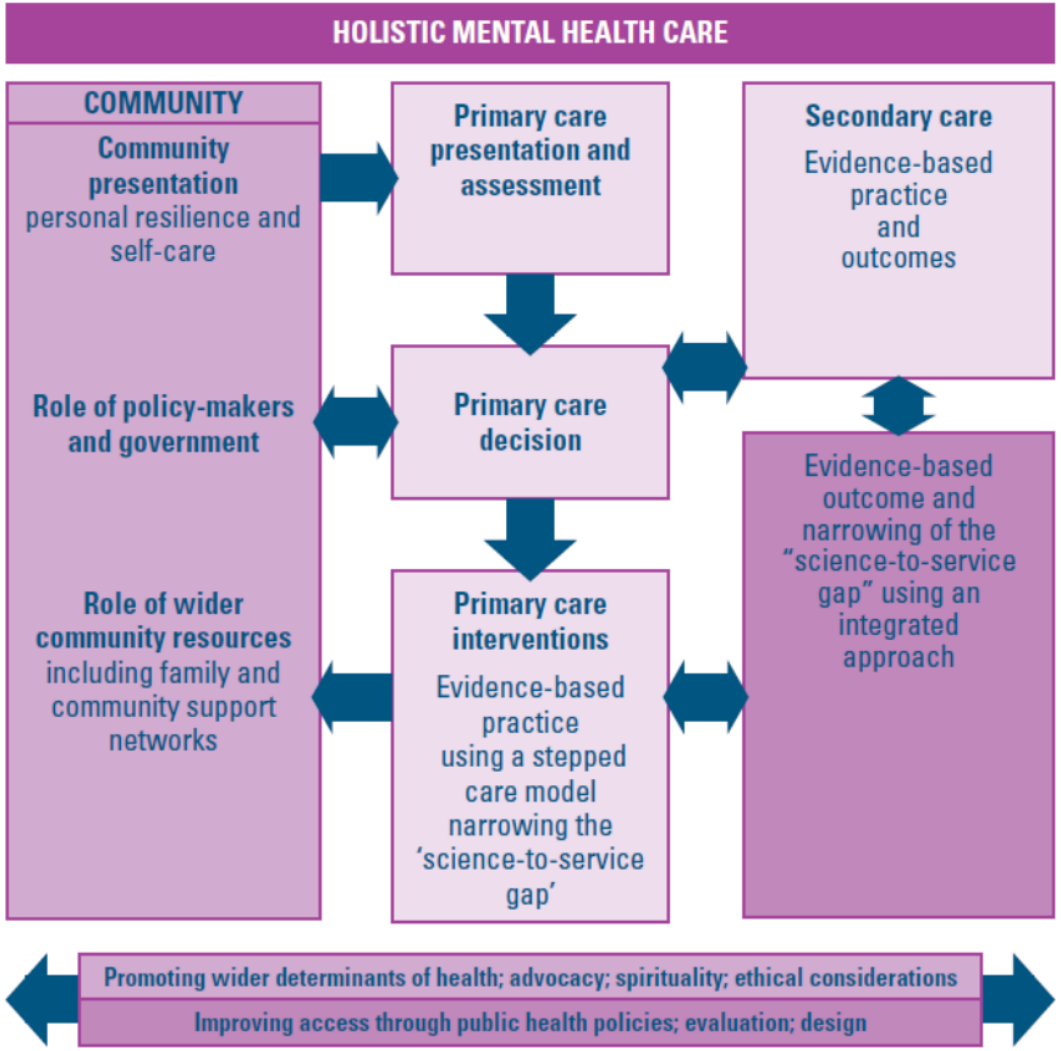


Figure 1.1 The interrelationships between elements of holistic mental health care

Case Study – 4 months of primary care management

Patient Background

- 64 yr old white European male
- Mental health problems since 15 yrs
  – childhood neglect & abuse
  – history of aggression
  – paranoid schizophrenia
- In contact with secondary mental health care services 7/8 yrs
- Active lifestyle – cycling, volunteering x 2 weekly at recycling project, cultural centre x 2 weekly
- Olanzapine and Citolopram
- Lived alone in own house
- No immediate family in UK

Navigator interventions

- Physical health review: pre-diabetic and provided information on lifestyle changes and diet
- GP monitoring
- Regular meetings to discuss social inclusion and mental health monitoring
- On waiting list for basic cookery course & basic IT course
- Had to leave volunteering placement at Charity Shop after 2 months due to misunderstanding and argument with another volunteer because he ran out of medication. Navigator has worked with client to put system of remembering medication in place

Complexity and integration

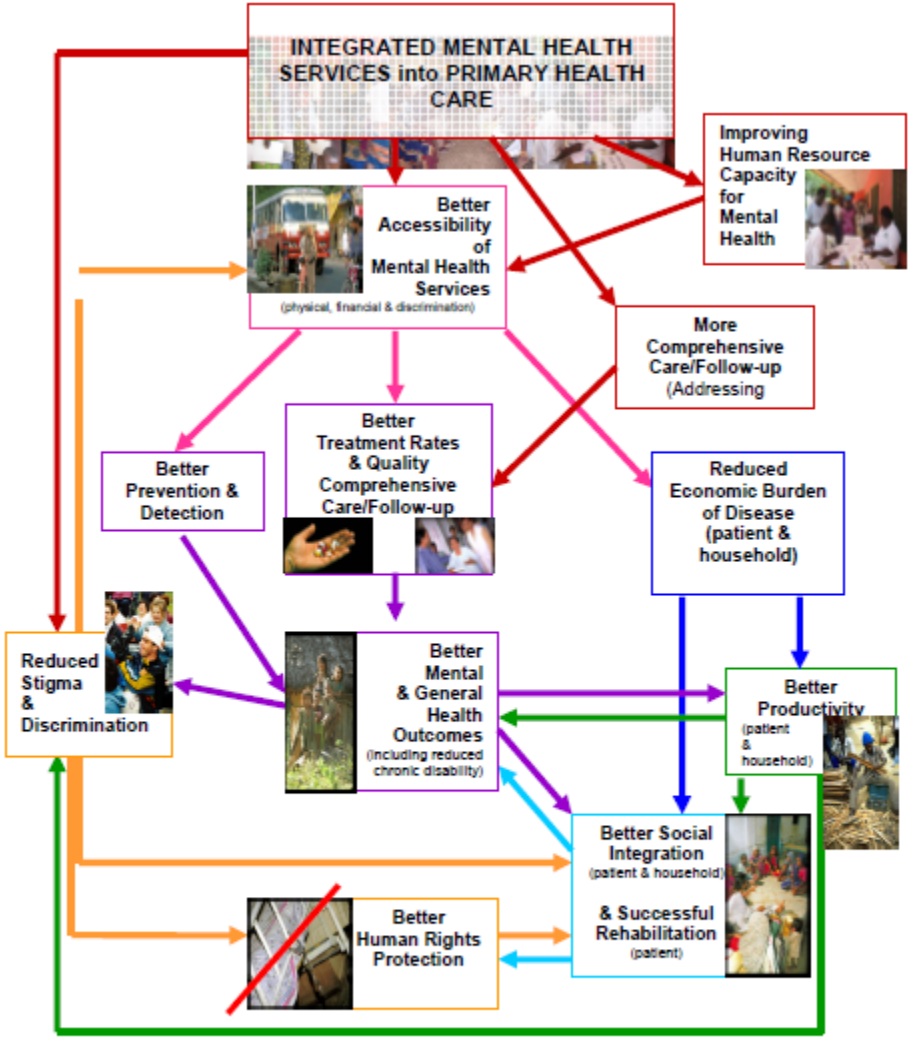


Figure 1: Rationale for Integrating Mental Health Services into Primary Health Care

World Health Organization

The WHO MIND Project: Mental Improvement for Nations Development
Department of Mental Health & Substance Abuse, WHO Geneva
Wonca Working Party on Mental Health

Wonca

The role of primary care

Integração
da saúde mental
nos cuidados
de saúde primários

Uma perspectiva global

Organização Mundial de Saúde

Wonca

Alto Comissariado da Saúde

Coordenação Nacional para a Saúde Mental

Integrating
mental health
into primary care

A global perspective

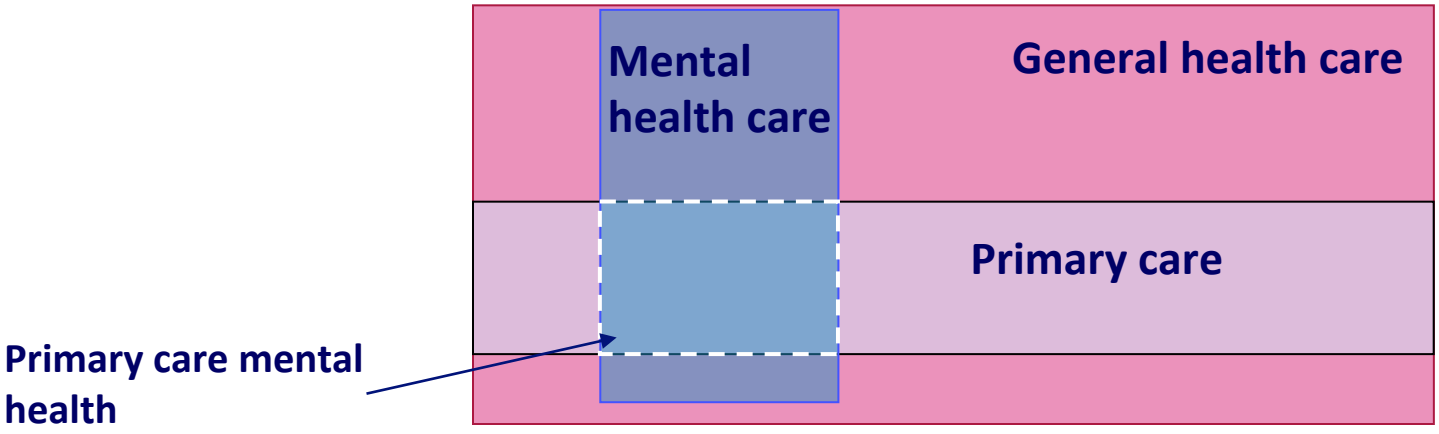
World Health Organization

Wonca

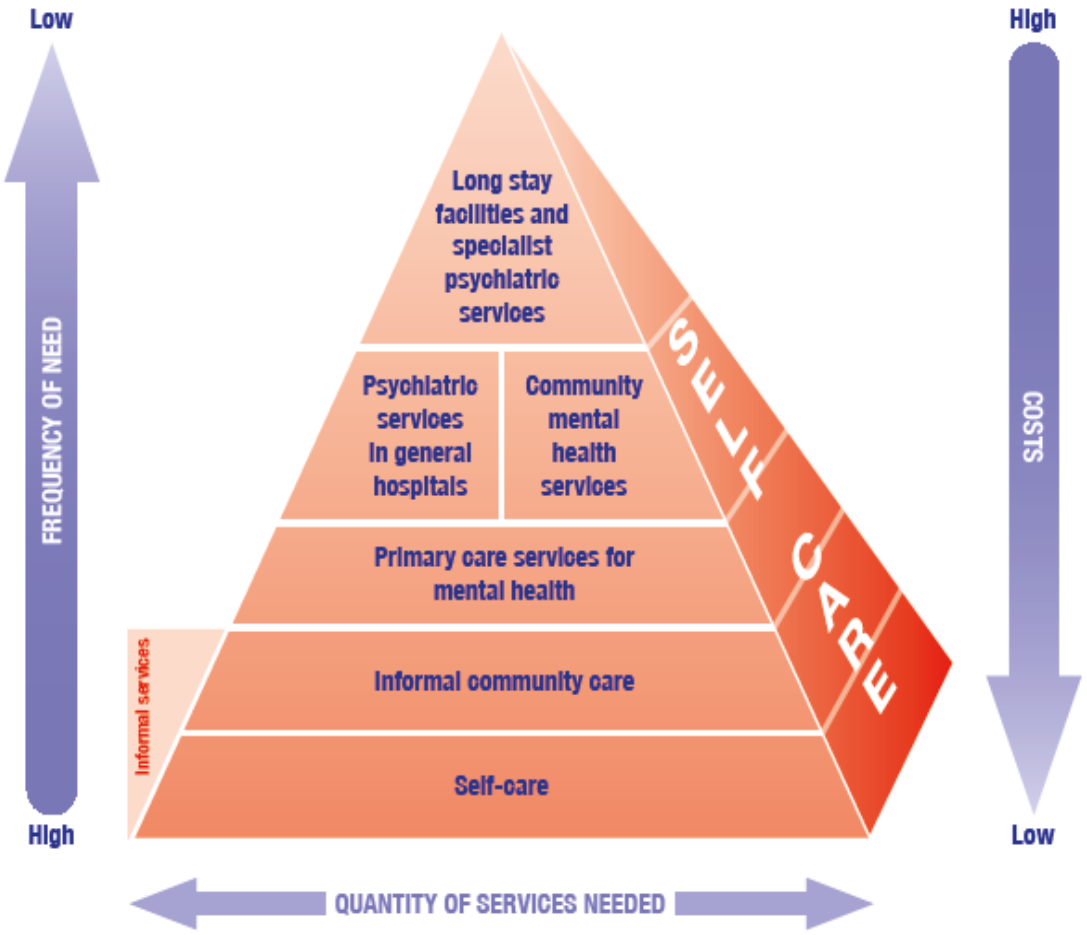
Why is primary care mental health essential?

Primary care mental health forms an essential part of both:

- comprehensive mental health care
- general primary care



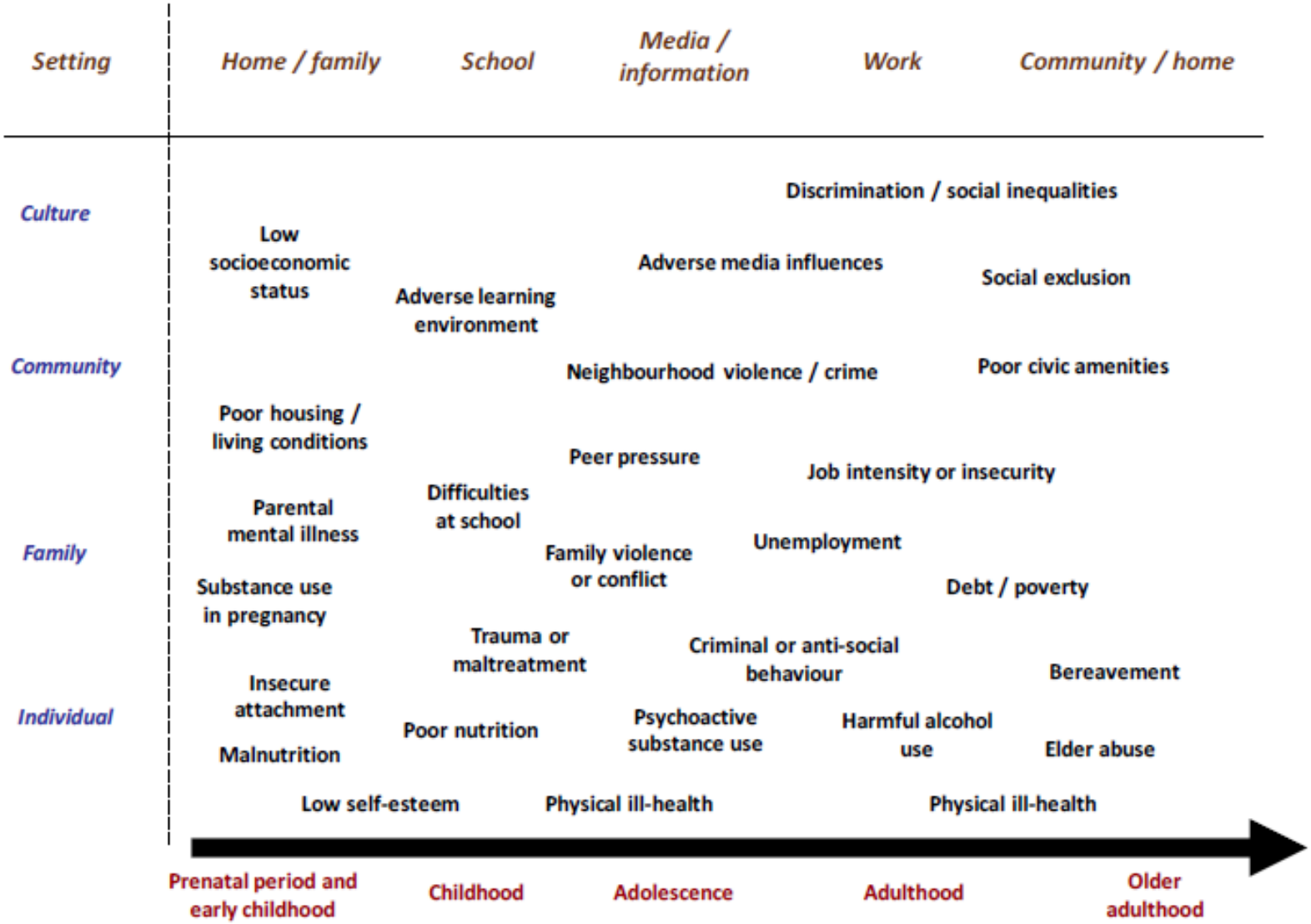
Meeting the need



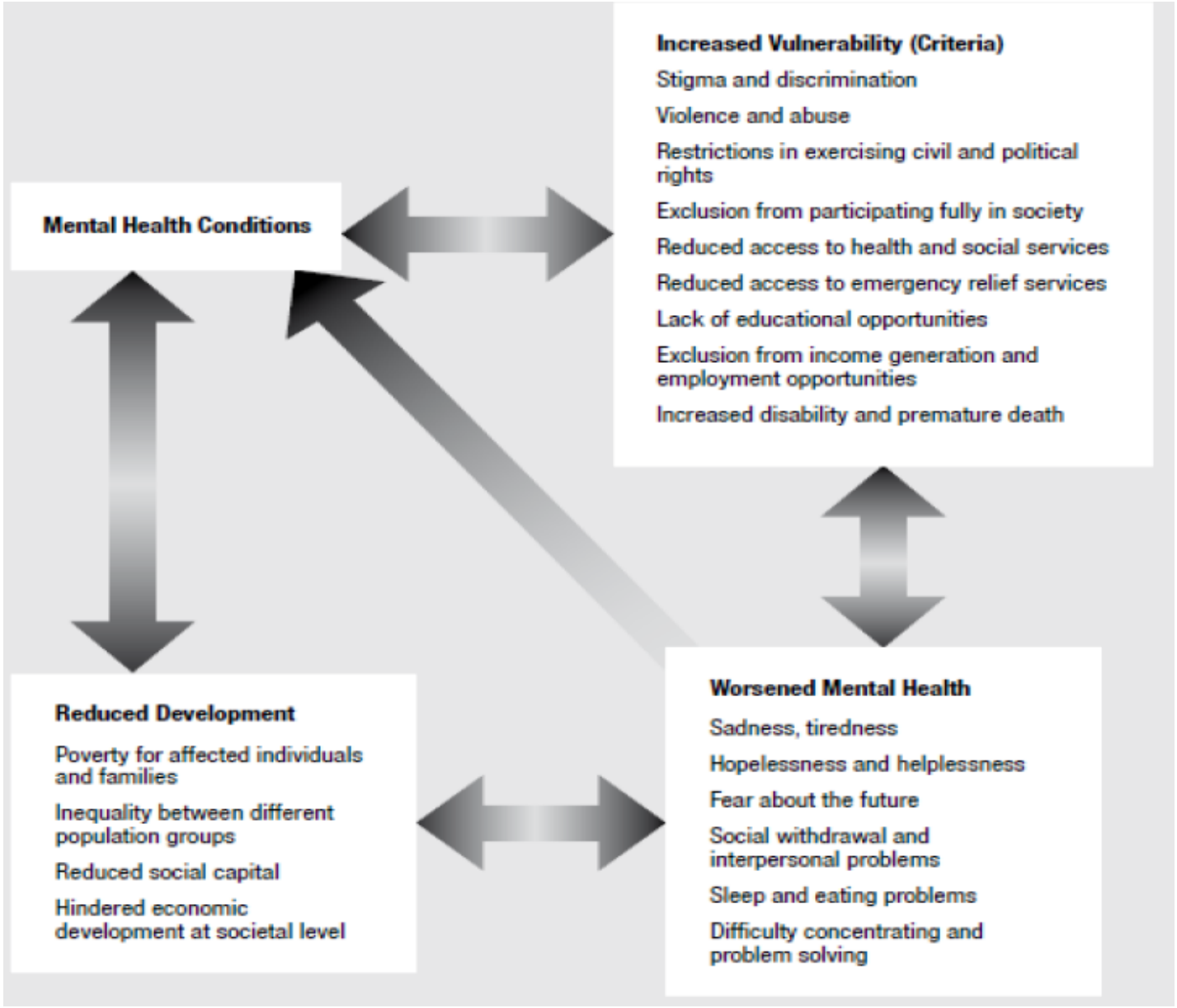
Primary care mental health must be supported by other levels of care including :

- community-based and hospital services
- informal services
- and self-care

Figure 2 **Schematic overview of risks to mental health over the life course**
(Adapted from: Foresight project, 2008; Kieling et al, 2011; Fisher et al, 2011)[4 5 6]



Mental health: potential points for intervention



10 principles for integrating mental health into primary care

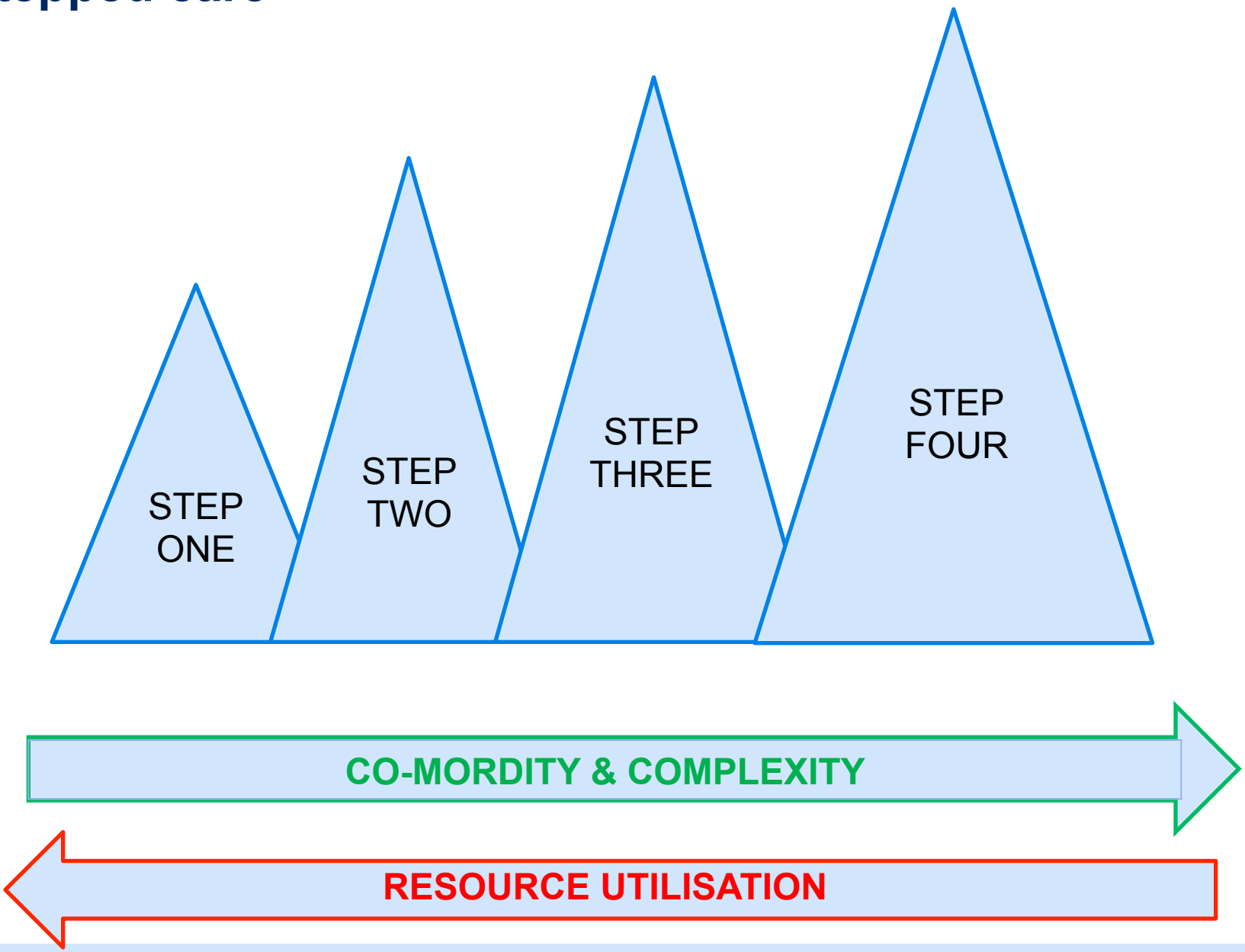
1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
10. Financial and human resources are needed.

Collaboration and integration: mental health & primary care

MINIMAL	BASIC at a distance	BASIC on-site	CLOSE partly integrated	CLOSE Fully integrated
← COLLABORATION CONTINUUM →				
Separate sites	Separate sites	Same facility	Same facility	Same facility
Separate systems	Separate systems	Separate systems	Some common systems	A common system
Sporadic contact	Communicate periodically about shared patients by phone or letter	↑ communication due to proximity	↑ face to face communication due to proximity	Same team
Separate cultures	Separate cultures	Separate cultures	Some shared culture	Patient experiences mental health treatment as part of regular primary care

Milbank Memorial Fund 2010

Stepped care



Stepped care model for managing multimorbidity in primary care mental health

(Edwards, Svab, Ivbijaro, Scherger, Clarke, Kallenberg -Companion to Primary Care Mental Health 2012)

STEPS:	FOCUS OF INTERVENTION	NATURE OF INTERVENTION:
Step One: Low risk	• All uncomplicated patients with two or more conditions • Low or no disability • To be screened for co-morbid mental & physical health conditions • No thoughts or plans regarding harm to self or others	• Assessment & screening • Treatment of identified conditions • Support • Information about illness including coping and self management strategies through readily available community resources using skill mix available within community & primary care workforce • Problem solving techniques • Monitoring • Promotion of self-care activities
Step Two: Low-moderate risk	• All patients with two or more conditions • At least one identified mental health problem • Mild disability • No thoughts or plans regarding harm to self or others	• Treatment of identified conditions • Psychological therapy e.g. Cognitive Behaviour Therapy (CBT) • Expert patient programme to improve self care techniques • Use of skill mix available in primary care setting

Stepped care model for managing multimorbidity (cont)

(Companion to Primary Care Mental Health 2012)

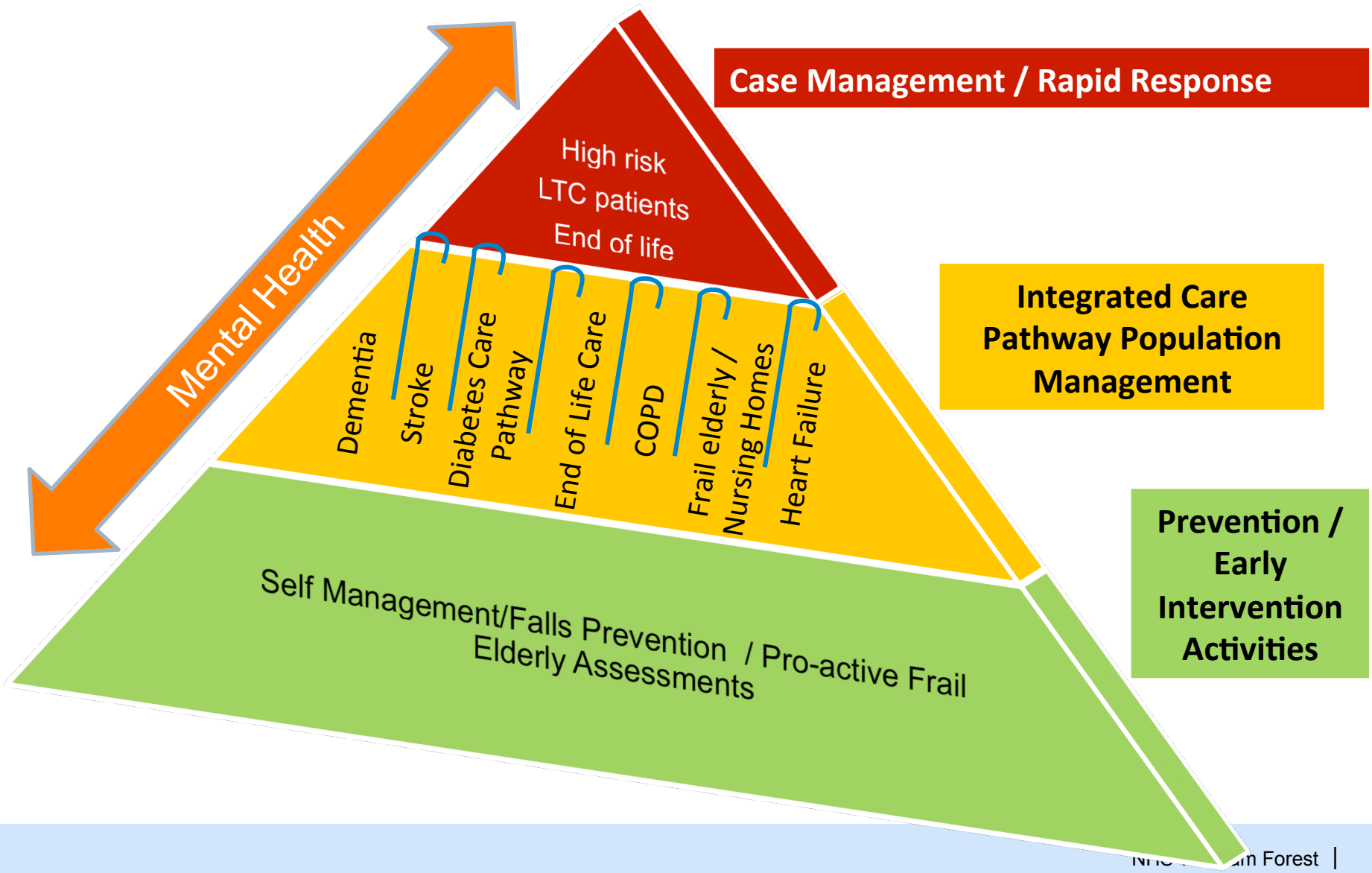
STEPS:	FOCUS OF INTERVENTION	NATURE OF INTERVENTION:
Step Three: Moderate risk	• All patients with two or more conditions • At least one identified mental health problem • Moderate disability • Has non-specific thoughts or ideas regarding harm to self or others – eg: regrets that self-harm failed to lead to death, but no intention to undertake further self-harm	• Treatment of identified conditions • Psychological therapy e.g. Cognitive Behaviour Therapy (CBT) • Expert patient programme to improve self care techniques • Use of skill mix available in primary care setting • Family interventions • Shared care/collaborative care with other community providers e.g. charitable organizations, NGO's etc • Appointment of health advocate from primary care skill mix

Stepped care model for managing multimorbidity (cont)

(Companion to Primary Care Mental Health 2012)

STEPS:	FOCUS OF INTERVENTION	NATURE OF INTERVENTION:
Step Four: High risk	• All patients with two or more conditions • At least one identified mental health problem • Severe disability • Has a clearly identifiable risk characteristic, such as imminent thoughts or plans relating to self harm (or harm to others) or suicide	• Treatment of identified conditions • Need to collaborate with local specialist services • Combined use of primary, secondary & tertiary care resources through case management • Psychological therapy e.g. Cognitive Behaviour Therapy (CBT) • Expert patient programme to improve self care techniques • Use of skill mix available in primary care setting • Family interventions • Shared care/collaborative care with other community providers e.g. charitable organizations, NGO's etc • Appointment of health advocate from primary care skill mix

Integrated care a whole systems approach: scaling up in Waltham Forest



Experience from successful integrated systems shows that three building blocks are required for Integrated care, that put together can generate significant savings

Success in integrated care

Address specific patient needs in a pathway …

Pathways	Patient segments: Low risk	Medium risk	High risk
Diabetes			
COPD			
Dementia			

… by working in a multi-disciplinary system …

1. Patient registry
2. Risk stratification
3. Clinical protocols & care packages
4. Care plans
5. Care delivery
6. Case conference
7. Performance review

… supported by key enablers


Accountability and joint decision-making


Clinical leadership and culture development


Information sharing

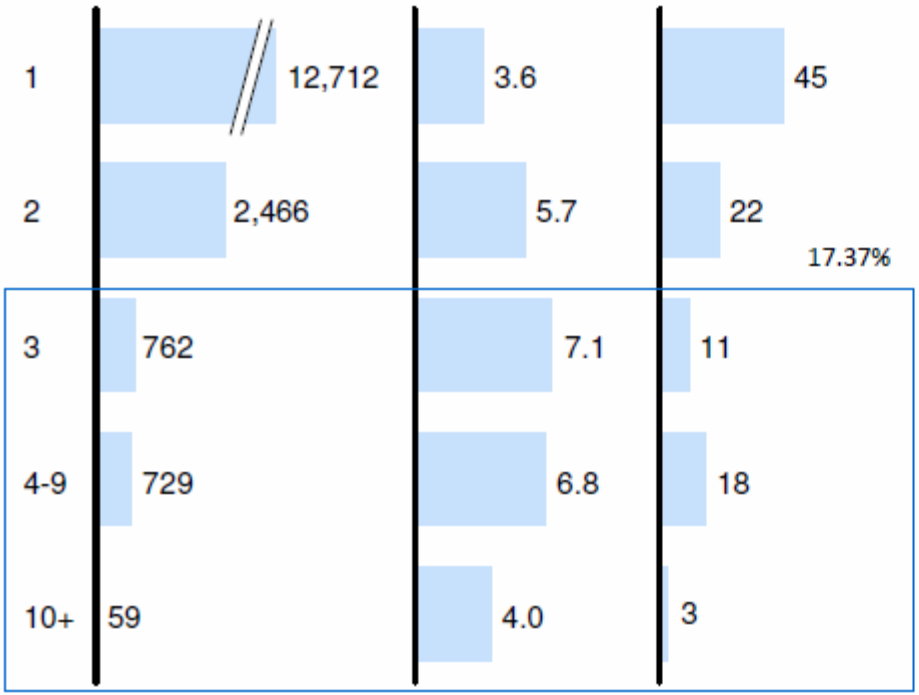

Aligned incentives


Patient engagement

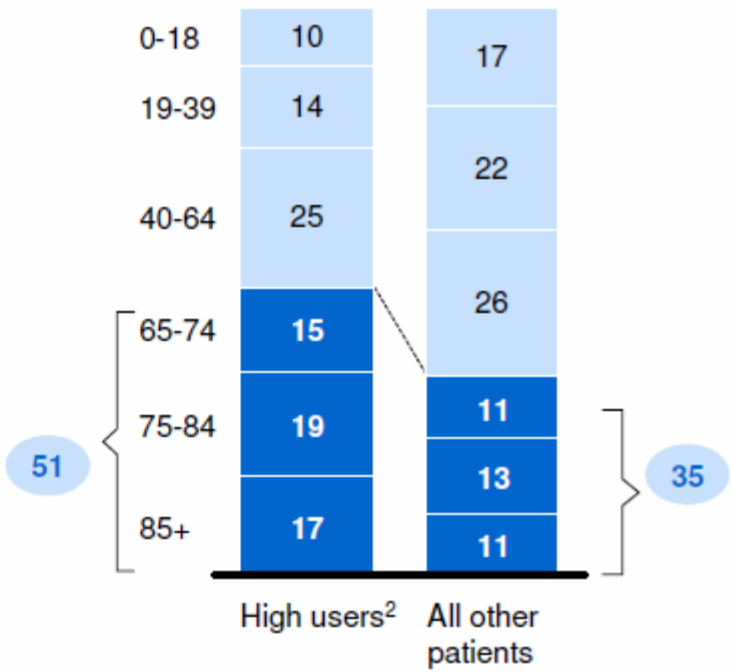
Introducing the case-for-change:
~1,500 people accounting for ~30% of acute spend, with half being over 65

2010/2011

9% patients account for 32% of emergency spend, due to their frequent admissions...



Elderly patients (>65) account for 50% of high users (3+ admissions)



1 Length of stay
2 Defined as having 3 or more emergency admissions in 1 year

Waltham Forest has introduced Integrated case management to care for high risk patients

Overview

Objective	▪ Reduce avoidable hospital admissions and make a net savings for the healthcare economy, by – Proactively identifying high risk patients – Enabling quality services for them – Coordinating out-of-hospital working – Reducing duplication of services
Focus	▪ Top 1% of patients with highest risk of admission referred to ICM by either the PARR tool or GP clinical judgement (target 75% from PARR and 25% from GP)
Case Conferences	▪ Fortnightly or monthly per practice ▪ 1 hour to discuss 4 patients ▪ Attendees: GP, Community matron, Social worker, District nurse, Care coordinator. May include Practice manager, Specialist nurse ▪ Create holistic care plan for new patients and review plans for existing patients

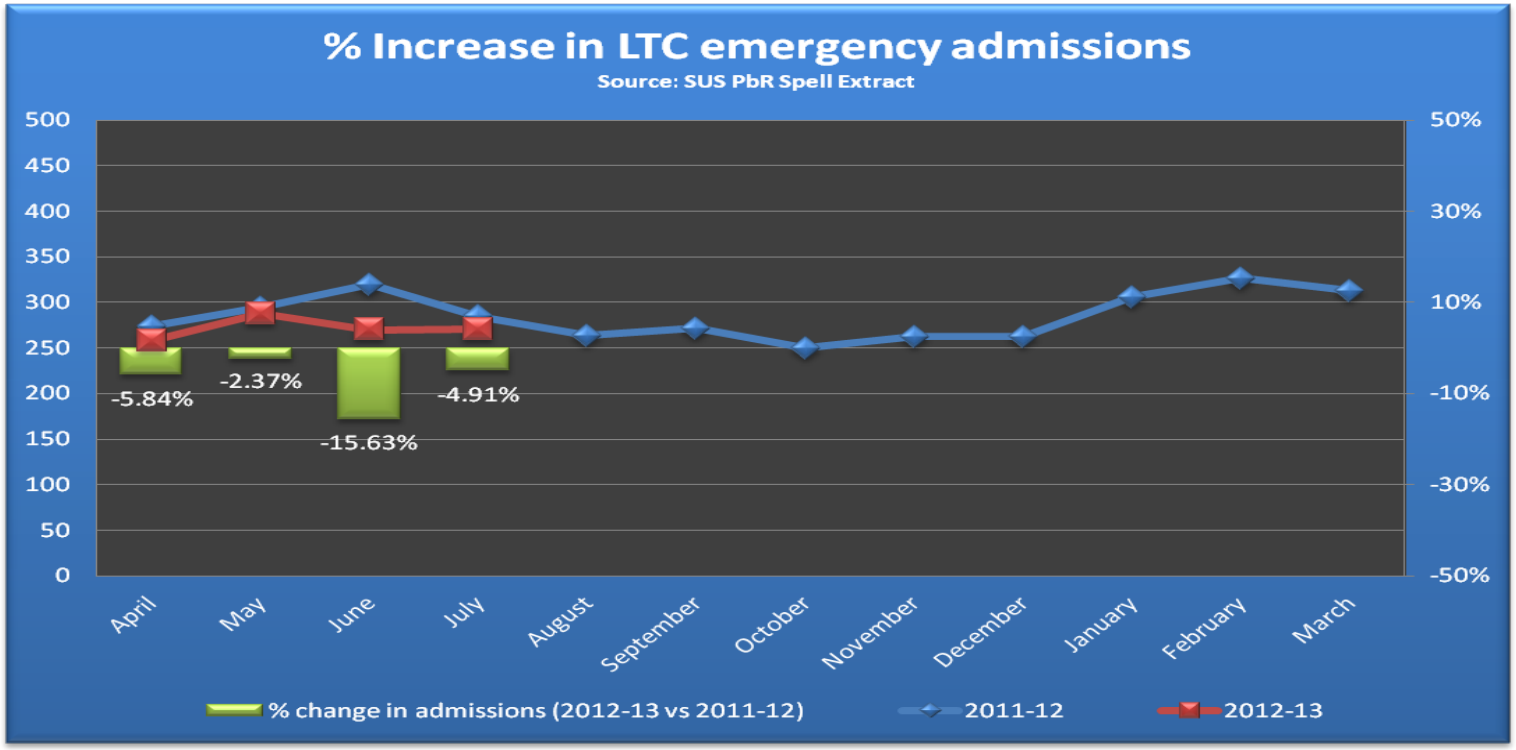
Team Roles

GPs	▪ Identify patients at risk and refer to ICM ▪ Sign up patient for ICM ▪ Host case conference in practice ▪ Refer to other providers as appropriate
Care co-ordinators	▪ 7 Band 4 integrated care coordinators ▪ Each supports 6-7 GP practices ▪ Key tasks – Receive patient referral from GP, arrange case conference, update all relevant attendees with schedule – Email care plans to GP after MDT co-develops with patient – Follow-up key care providers to ensure care delivery
Community matrons	▪ Provide necessary patient care and work closely with coordinators ▪ Respond to A&E or in-hospital admission to facilitate discharge

Waltham Forest has begun putting enablers in place

	Already in place in Waltham Forest	Key developments required
 **Organisation and Accountability**	▪ Project boards, in place for ICM, are accountable to the CCGs, including all stakeholders providing transparent decision making mechanisms	▪ Strengthen long term governance arrangements to bind in acute care and CHS and social care ▪ Ability to commit CHS and LA to packages of care ▪ A performance framework needs to be established to manage all stakeholders
 **Clinical leadership and culture development**	▪ ICM has improved working between primary care and community matrons ▪ ICM clinically led: Dr Mayank Shah as ICM project board chair in Waltham Forest	▪ Develop better working between health and social care, and between acute and primary care ▪ ICM launched in Chingford; 2 out of 3 launched in Walthamstow ▪ Leadership from BLT needs to come on-board
 **Information sharing**	▪ Health analytics system in place allowing risk stratification of patients ▪ Clear metrics identified to be reported monthly to integrated care project boards ▪ Patient consent for information sharing obtained by GP ▪ Plans to give GPs access to social care data and social care to view statistical but not patient level information	▪ Create consolidated patient registry viewable by primary care, acute, CHS and social care ▪ Ensure metrics identified help drive performance and reimbursement and are effectively tracked
 **Aligned incentives**	▪ Implicit incentives based on a underlying “win-win principle”	▪ Direct alignment required between the benefits of savings for the whole system vs potential negative impact on one provider eg. acute ▪ Incentives needed to ensure stakeholder participation in the care delivery model
 **Patient engagement**	▪ Care plans co-developed by integrated care MDT and patient	▪ Stronger engagement required with a bigger role for patients in planning and managing their own health

Financial performance

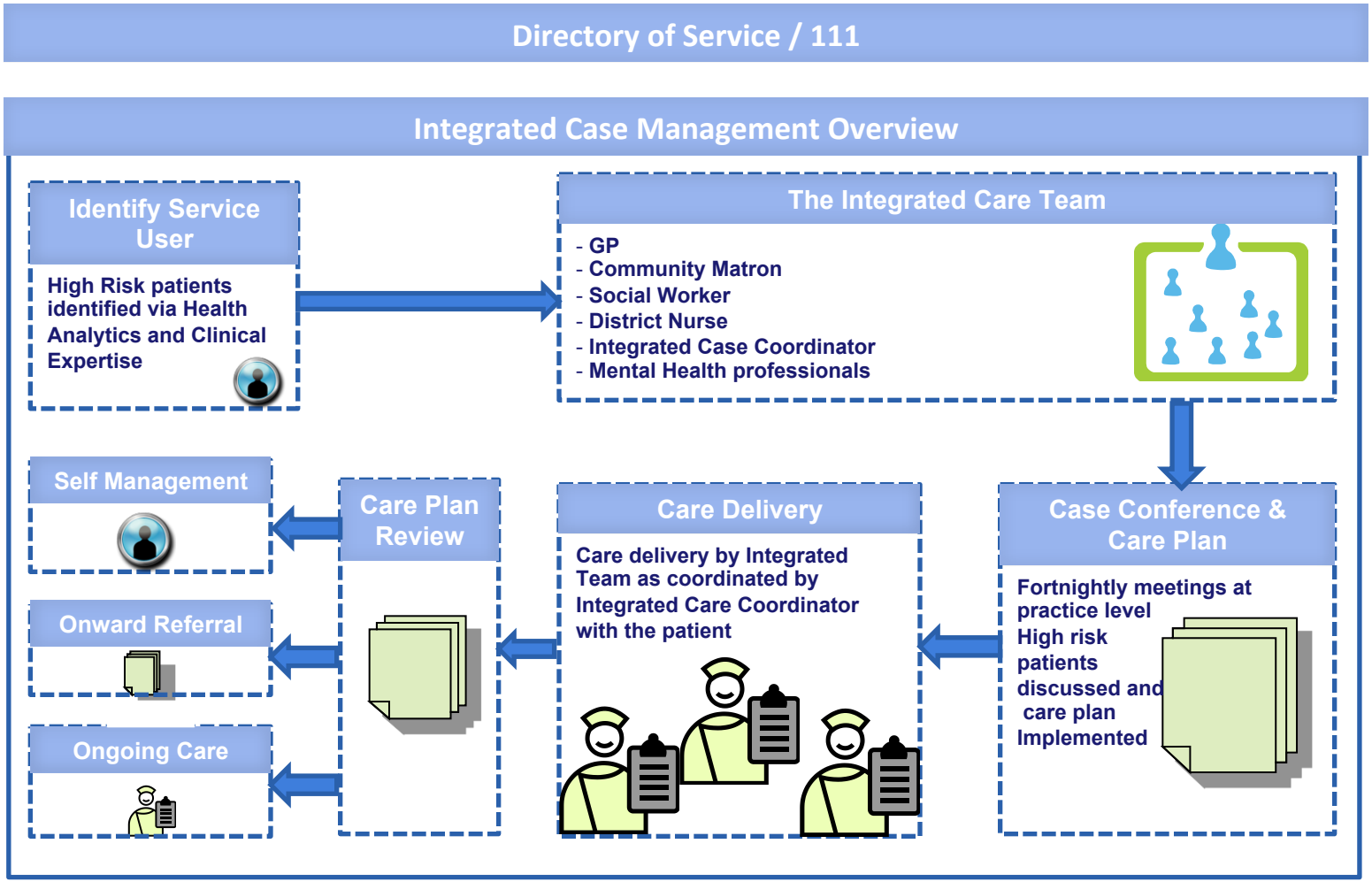


- Demonstrated savings of 337 K over first 5 months 2012/13 through reduction in unplanned admissions and associated attendances in comparison to last year
- 114 less admissions for target population in comparison to last year
- This demonstrates consistent reduction in unplanned hospital admissions for the target LTC group for integrated care in comparison to last year

Integrated care – the model

Access

Community Planned Care (Health and Social Care)



IC is supported by unplanned community services

Rapid Response support to provide 24/7 unplanned care
Out of Hours medical cover working in partnership with Rapid Response

Outcomes since April 2012

Quality

- > 1000 patients with integrated care plans since April 2012
- All 46 GP practices, Local Authority, Acute Hospital Trusts and 1 community provider delivering the model of care
- Improved co-ordinated care by multi-disciplinary teams and reduced duplication
- Every patient has a nominated and dedicated coordinator to coordinate personalised care
- Rapid access to social care as needed through direct referral to social care

Experience

- **Patients say**… " I have a plan of my care on my fridge that the girls gave me. I just call up Joanna (my coordinator) if I am unsure of when the Julia (matron) is next coming to see me. Makes me feel less worried knowing that there is someone who I can contact"
- **GPs tell us** ….. "having the staff attend our practice on a regular basis has helped us establish great relationships. I know now more about my patients than before as I hear the perspectives the social worker and nurses and this helps provide the best care my patients"

Audit results: primary care

- The GP records generally had more information on diagnoses, medications and current mental health status of patients
- 2º care records had patients who had left the practices and in some instances, those that had died
- A good number of patients were seen for one episodes of care some years back and their presentations were already recorded as significant past by their GPs, but are still being left on the 2º care active list
- The GPs have been managing more complex patients in primary care. In one practice for example, there are two patients receiving depot injections for which their GP does not get paid. The patients are stable and the GP prefers managing them himself as that seems to be the only way to avert relapses and representation at A&E
- There were a few patients with SMI diagnoses in 2º care for whom there were no such diagnosis in GP records

Why is delivery & integration of primary care mental health so patchy?

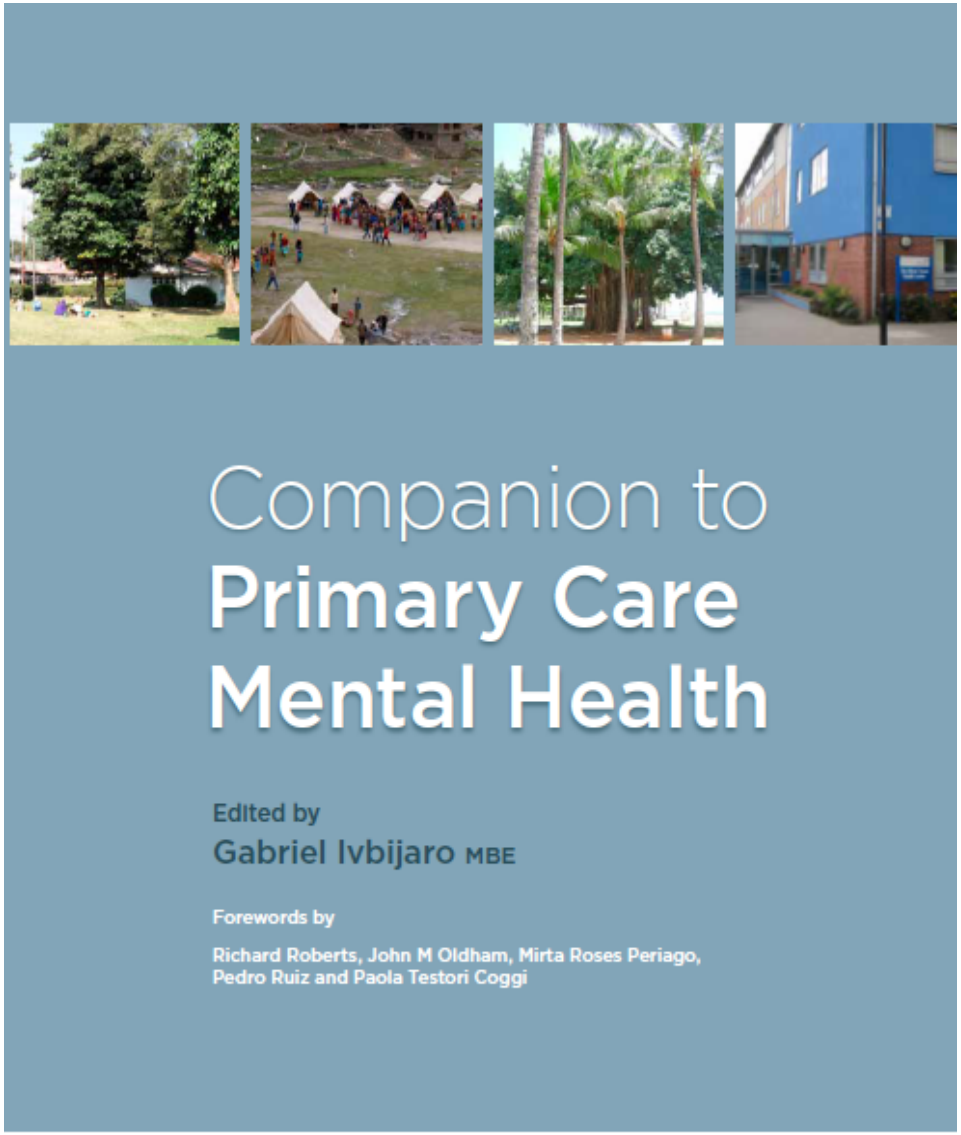
- The Alma-Ata Declaration did not specifically refer to mental health when setting out the seven principles for primary care (Sartorius & Gask 2008)

- Perhaps, mental health had been specifically referred to, governments worldwide would have taken it more seriously and progress would have been different

- Skills shortages in the primary care workforce

- A lack of meaningful engagement with self-care and non-medical workforce (e.g. traditional healers)

Educating the workforce

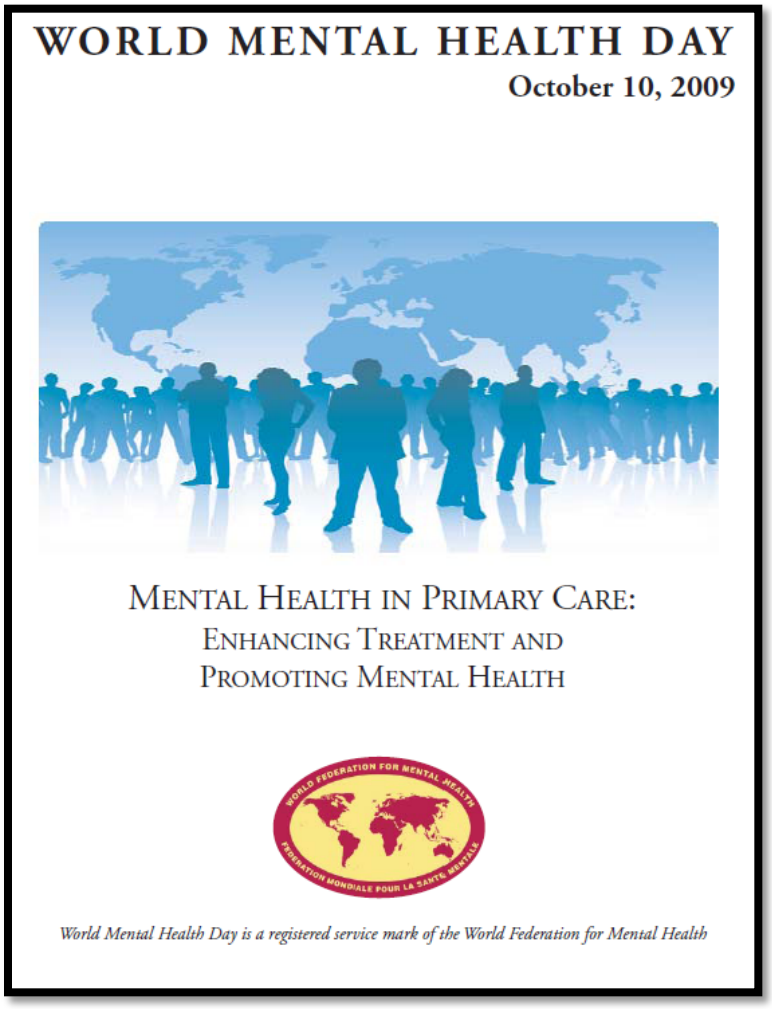


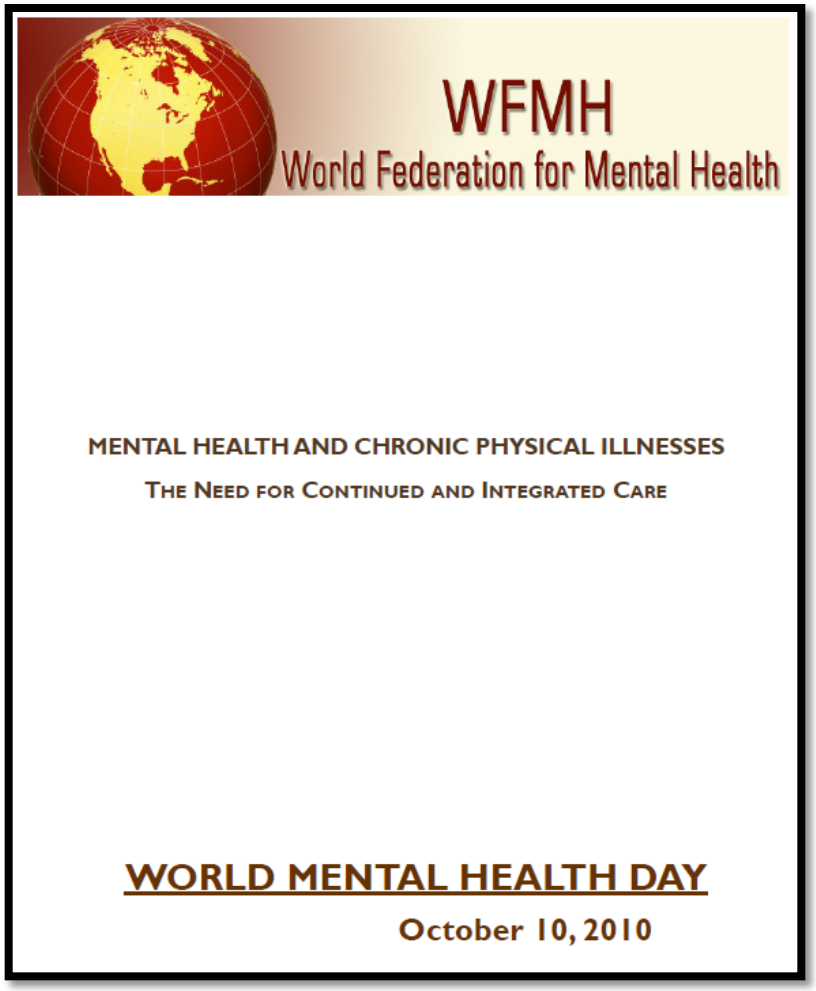
- Primary Care Mental Health International Diploma Course NOVA University, Lisbon
- www.fcm.unl.pt

Getting our message across

Mental health advocacy should learn lessons from the NCD Alliance

Campaigning for mental health: WFMH





WFMH – be a part of the future World Mental Health Day campaigns

2014

Living with schizophrenia

2015

Making the comprehensive mental health action plan a reality

World Federation for Mental Health
Fedération Mondiale pour la Santé Mentale Secretariat
PO BOX 807
OCCOQUAN, VA 22125 USA
Email: info@wfmh.com

Global Mental Health Action Plan

Vision

A world in which mental health is valued, mental disorders are effectively prevented and in which persons affected by these disorders are able to access evidence-based health and social care and exercise the full range of human rights to attain the highest possible level of health and functioning free from stigma and discrimination.

Cross-cutting Principles

Universal access and equity	Human rights	Evidence-based practice	Life course approach	Multisectoral approach	Empowerment of persons with mental disorders
All persons with mental disorders should have equal and equitable access to health care and opportunities to achieve or recover the highest attainable standard of health, regardless of age, gender, or social position.	Mental health strategies, actions, and interventions for treatment, prevention and promotion must be compliant with international human rights conventions and agreements.	Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and good practice.	Mental health policies, plans, and services need to take account of health and social needs at all stages of the life course, including children, adolescents, adults, and older adults.	A comprehensive and coordinated response of multiple sectors such as health, education, employment, housing, social and other relevant sectors should be utilized to achieve objectives for mental health.	Persons with mental disorders should be empowered and involved in mental health policy, planning, legislation, service provision, and evaluation.

Goal

To promote mental well-being, prevent mental disorders, and reduce the mortality and disability for persons with mental disorders

Objectives and Targets

1. To strengthen effective leadership and governance for mental health	2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	3. To implement strategies for mental health promotion and protection including actions to prevent mental disorders and suicides	4. To strengthen information systems, evidence and research for mental health
T 1.1: 80% of countries will have updated their mental health policies and laws (within the last 10 years) by year 2016.	*T 2.1: The number of beds used for long-term stays in mental hospitals will decrease by 20% by year 2020, with a corresponding increase in the availability of places for community-based residential care and supported housing.*	*T 3.1: 80% of countries will have at least two national, multisectoral mental health promotion and protection programmes functioning by year 2016 (one universal, one targeted on vulnerable groups).*	*T 4.1: A global observatory for monitoring the mental health situation in the world will be established by year 2014.*
T 1.2: 80% of countries will be allocating at least 5% of government health expenditure to mental health by year 2020.	*T 2.2: The treatment gap for severe mental disorders will be reduced by 50% by year 2020.*	*T 3.2: Rates of suicide in countries will be reduced by year 2020.*	*T 4.2: 80% of countries will be collecting and reporting at least a core set of mental health indicators annually by year 2020.*

Thank you

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