Blanca Reneses[1, 2]
Juan J. López-Ibor[1, 2]
Isabel Argudo[1]
Antonio Carrillo[1]
María J. Regatero[1]
Jorge Moreno[3]
Raquel Ruiz[1]

Steps for the development of a management process of Anxiety and Depression from Primary Care up to the Psychiatry Departments

[1]Instituto de Psiquiatría y Salud Mental
Hospital Clínico San Carlos
Instituto de Investigación Sanitaria del Hospital Clínico San Carlos (IdISSC)
Madrid, Spain

[2]Department of Psychiatry and Medical Psychology
School of Medicine
Universidad Complutense de Madrid
Centro de Investigación en Red CIBERSAM
Spain

[3]Primary Care
Dirección Asistencial Centro
Madrid. Spain

INTRODUCTION

Collaboration between Primary Care teams and the Psychiatry Departments to approach most of the psychiatric disorders has become an element that is present in the planning of the health care services in most of the developed countries[1] and it continues to be a strategy recommended by the international organizations.[2] The reasons that support it have not lost relevance since the time when epidemiological research acquired importance in the 1980s in Primary Care.

The elevated numbers of psychiatric morbidity on the care level of Family Medicine continue to be elevated, ranging from 20 to 35% in the developed countries,[3-7] this being 31%[8] in the adult population and 46.1% in the geriatric population in Spain in the most recent data.[9] An important part of these disorders, that is about 50%, are not correctly identified by the Primary Care physicians. This has been repeatedly stated in different studies.[10, 11]

On the other hand, the need to rationalize the always limited resources makes it necessary to establish clear guidelines to define the levels of care. The variability in the quality of care generally leads to a decrease of overall efficacy of the interventions, which makes it necessary to establish clinical protocols and other tools that facilitate standardization of the care on the basis of scientific evidence, especially in the public health systems.

Given that a good part of the most prevalent mental disorders are seen on the Primary Care level and a high volume of individuals receive their treatment exclusively on this care level,[12] it is essential for the clinical protocols and care procedures in these cases to include general physicians, psychiatrists, and other professionals of the Mental Health services.

The collaboration problems with Primary Care and Psychiatric Departments have been labeled in different ways over the last two decades. Terms such as "*Collaborative care programs*" are commonly used in the United States and the United Kingdom, these being incorporated into the so-called managed Medicine or simply, for us, Clinical Management. Other terms with which this type of collaboration is defined are: "*Disease Integrated care*" and on a less specific plane "*Interprofessional collaboration.*"

The greatest accumulation of experience and research in shared management with Primary Care is in the setting of the Depressive Disorders.[13-15] The reason for this is probably that the depressive and depressive-anxious condition is the most prevalent in the Primary Care services together with Anxiety Disorders,[8] this supposing a significant proportion of the social burden of the diseases and incapacity.[16, 17] Furthermore, the spectrum of severity of the depressive disorders is very wide, which supposes that an extensive range of resources are necessary for their attention, that include from Primary Care to the Psychiatric hospitalization and hospital emergencies in the extreme of greater complexity, and passing through the outpatient psychiatric services that support the greatest weight of the specialized care in this condition.

In the United States, the development of these collaboration programs has been greater and an elevated number of experiences adapted to the different systems of supplying of services has been documented.[18, 19] In the United Kingdom, on the other hand, there are already positive results of evaluation of some programs and others are fully underway.[20-23] The scientific publications on the experiences of collaboration programs with Primary Care for Depressive Disorders in other European Countries are more limited.[13, 24]

The common elements identified in the reviews of the Collaboration Programs with Primary Care for Depression are the following:[15, 19] Psychoeducation and self-help for the monitoring of symptoms and treatment adherence, treatment algorithms, follow-up and monitoring after a treated episode, planning of cares for the prevention of relapses, Referrals with Psychiatrists, Training for the care providers, Case Registries, Case Managers, Specialized supervision of the care managers and Additional Resources or readjustments in the existing staff.

When a program of this type within a specific organization is being developed, interest is focused, above

all, on knowing the contribution of each element to the efficacy of the program as a whole. In other words, to know the components that add a substantial value. This is an important question given the cost in resources and personal effort supposed by carrying out more ambitious or extensive programs than that which would be necessary to achieve similar results.

The following shows a summary of the data found in the literature on the elements that could contribute more value in the best evaluated collaboration programs with Primary Care for Depressive Disorders:

- Structured referral sheets from Primary Care to the Psychiatric Departments accompanied by active education on the subject improve the referrals.[25]
- Joint action with Primary Care strengthened by clinical practice guidelines or treatment algorithms suppose a greater benefit than separate actions.[26]
- Algorithms of help to the diagnosis and treatment within the framework of reengineering processes in Primary Care.[27]
- Systems to improve antidepressant treatment adherence.[28]
- Use of case managers,[28] especially with experience in mental health.[29]
- Regular and planned supervision by psychiatrists.[30, 29]
- Systematic follow-up and monitoring after an episode under treatment.[15, 19]

To justify the development of these experiences, it is important to also know the evaluation data from the cost-effective ratio. Along this line, the most extensive information also refers to the collaboration programs in Depressive Disorders. Although all the studies state that the collaboration programs always entail an increase in costs, the characteristics per se of each system and each region must also be taken into account to analyze the results. Simon[31] analyzed the cost-effectiveness of a program on persistent depression, finding clear benefits in efficacy with a moderate cost increase that was comparable to other commonly accepted medical interventions. This and other short-term studies have shown an increase in the costs of the intervention.[32-34] On the contrary, studies with a more extended evaluation period show lower cost increases and even similar costs to conventional treatment.[35, 36]

Another element to consider when analyzing these experiences is the impact produced on the organizations derived from the creation and implementation of the process itself.

On the level of the implementation of the programs, Richards[20] manifests that the effect of a collaboration program with primary care is probably influenced by the organizational aspects of the intervention. On the other hand, Craven[26] warns that successful collaboration requires time and preparation and must be supported by relations established previously, alerting on the supported experiences in research protocols that are only maintained in time if there is maintained financial support.

In view of the data provided by the existing literature on this subject, it is clear that the collaboration initiatives between the psychiatric departments and Primary Care, at least for depressive and anxiety disorders, are justified and extending them is desirable. In turn, it should be taken into account that any program of new development should be based on scientific evidence data, on its utility, and also be evaluated prospectively to adjust it to the real needs of a specific population.

Based on these premises, the Institute of Psychiatry of the Hospital Clínico San Carlos of Madrid has developed a Clinical Management Process with Primary Care (PC) for Depressive and Anxiety Disorders. The Objective of this work is to show the steps to develop a process in collaboration with Primary Care following this practical example.

MANAGEMENT BY PROCESSES AND COLLABORATION PROGRAMS WITH PRIMARY CARE

Management by processes is a tool of clinical management that permits ordered integration of all of the diagnostic and therapeutic interventions to cover the needs of a specific group of diseases or patients with a determined profile. A clinical management process includes all the agents that participate in the diagnosis or treatment involved in the defined condition.

One of their most relevant characteristics is that it makes it possible to identify the essential components of the clinical care, so that these can be evaluated and measured independently and jointly. The clinical result is therefore easier to evaluate.

Management by processes can be applied to most of the resulting psychiatric disorders, and is also especially adequate given their characteristics of chronicity and need for multiple services. Most of the psychiatric diseases require different levels of attention (Primary Care, outpatient psychiatric care, psychological care, hospitalization, etc.) which should be provided by different professionals according to the cases and moments of evolution of the disease.

The development of a clinical process requires an approach to the care based on the prediction of needs and clinical outcomes according to a defined clinical situation. Going from an explanatory paradigm to a predictive one is both a challenge and a need within the framework of managed medicine.[37] A clinical process requires the effort to define the precise care needs adjusted to the specific clinical

situations, all of this on the basis of scientific evidence and within the framework of the organization providing these services. This supposes taking the available human, material, and economical resources into consideration at all times. For this reason, the design of a clinical process goes beyond that of a maneuver of improvement of management. It requires a solid scientific basis and disposition to continuous updating.[38]

Based on the accumulated scientific evidence on the effectiveness and cost of the collaboration programs with primary care, especially in depression, and on the other hand, on the strategy of our organization oriented towards Management by processes, we adopted the objective of developing a Clinical Management Process of Depression and Anxiety in the year 2010. In this process, all of the Primary Care Services of the area of influence of the Hospital Clínico San Carlos (HCSC) and the outpatient Care Units, and its Hospitalization and Emergencies Units of the Institute of Psychiatry and Mental Health were included.

Key elements for the development of a Clinical Management Process of Depressive and Anxiety Disorders in Psychiatry and Primary Care

The conditions necessary for the beginning of a clinical management process are the following:

- The process should be coherent with the strategy of organization so that the support of the latter is necessary.
- The designation *a priori* of a leader or coordinator to direct its design, development and implementation is advisable.
- The design and internal development should be made by professionals from the different member services.
- The clinical recommendations that are formulated should have a solid support on scientific evidence.
- An evaluation system that includes the measurement of the clinical results should be incorporated.
- Each Clinical Management Process requires an *ad hoc* design depending on the specific characteristics of the health system where it is going to be introduced.
- There should be an Information System that supports the clinical management process.

Steps to successfully made a clinical management process

1. *Choose a leader and work group for the design and development of the process*
   The direction of the process should be defined *a priori*. Choosing a professional to coordinate the development of the process and who leads its introduction is recommendable. The choice of this professional is based on the criteria of management of the knowledge.[39, 40] In other words, it is convenient to choose among the professionals of the organization and those who have a special interest in the material, or who are expert in it and who also have skills to coordinate a work group and initiate the proposals to produce changes. Motivation, scientific rigor, and some professional leadership capacity are essential elements.
   The ideal work group should include both professionals from the Psychiatry Departments as well as from Primary Care, including those who have maximum protagonism in the clinical management process to be introduced. In this scenario of the more developed Western countries, and in the case of a Process of Depressive and Anxiety Disorders, the physicians, both psychiatrists as well as family doctors, are the principal persons involved, since the decision for the pathway of attention for the patient at each time will be their responsibility. Clinical psychologists and nursing staff for the programs of care, psychoeducation and early detection should also be included. Furthermore, there should be some member of the management team of the organizations and, as far as possible, a specialist in clinical management and / or quality management. A member of the team should be responsible for the writing and collection of the documents during all of its development.
   Ideally, the participants in the core work group will then be the intermediate leaders of the process, that is, they will form a part of it after its establishment with more protagonism then the rest of the staff. Furthermore, they should be those responsible for the periodic evaluation and up-dates in the determined periods.
   A work group is a team with a common explicit task and specific time frame to carry it out. There should not be more than eight participants for it to be operational. The possibility should exist for the group to be increased for specific purposes, inviting specific participants according to some specific tasks. For example, one or several psychologists can enter to approach the specific indications of treatments or psychological studies. The same is valid for the nurses and other professionals.
   In the case of Anxiety and Depression Management Process of the HCSC, the work group was made up of four psychiatrists, two family doctors and on economist who coordinated the management. Of all of them, one was the leader of the process and another had the post of Medical subdirector in the Primary Care establishment. There were external participants for specific timely tasks at certain moments of the development of the process. There were psychologists, professions who were experts in psychic trauma, experts in management and evaluation of health care services and experts in external health care computer systems, all being outside of the organization.
   The work method, in the example of HCSC, consisted in work meetings of the principal group with defined tasks for each participant and joint discussion prior to the

final writing of each part, over approximately one year. These meetings included the definition of quality indicators of the evaluation system and the design and content of the computer system.

Total hours of work in the joint meetings of a stable team of six members were approximately 100 on-site hours in joint work meetings. The same approximate number of hours of individual work of each team member should be added to this, without counting the external collaboration.

2. *Consider the institutional frame*

A clinical management process can only be established in an organization that includes this management approach in their strategy. The inclusion of specialized services together with those of Primary Care in the same process would then require the support of both. Another important element to facilitate the processes is the previous existence of professional links between the involved parties.[26] Thus, it would be easier to construct a clinical management process with Primary Care in those organizations in which there is a culture of coordination and communication between both levels.

3. *Clinical recommendations based on scientific evidence data*

A clinical management process includes the different possible care pathways in the organization for a specific condition and the diagnostic procedures and treatment agreed on according to the specific characteristics of the disease in the patient. It is unavoidable to include some clinical protocols and recommendations for the diagnosis and treatment in the process. Basing these recommendations on the available scientific evidence is an essential criterion of quality. An essential part of the work of writing the process and after that of a periodic review is the scientific update of these recommendations. The work group should scientifically document their proposals or decisions.

4. *"Ad hoc" design of the process according to the supporting healthcare system*

The clinical management processes require a design adapted to the characteristics of the organizations in which they are carried out. For this reason, they cannot be totally exported and it is necessary to adapt one specific design or another.

The limitations imposed by the combination of the rules, economic limitations, service portfolio, type of providing of care and evaluation of the population addressed should be taken into account.

Generally, in Spain, the directive structures of Primary Care and specialized care are independent on a certain level, which requires a permanent agreement between both classes. The organization of the psychiatric departments and mental health services may be somewhat more homogeneous although the link between the outpatient and hospital structures is not resolved similarly in the different Regional Communities, not even within the same territory.

Usually, the Psychiatry Departments are structured as a network of facilities which, at best, have a common hierarchy, or at least a system of coordination. The characteristics also occur within the setting of the institutional "culture." We refer to it as the combination of components that shape the work style of each center: organization of the daily care, theoretical references used by the professionals to base their practice, explicit or implicit criteria for the referral of patients to Primary Care, etc.

Probably, one of the most differentiating elements in the last three decades has been the work model based on different "psychiatrist:" communitary, biological, psychodynamics, hospital, etc. as well as the different ways of integrating clinical psychology and nursing into the practice. These different patterns of understanding the care are a challenge for the organization of the services and are also sometimes a problem for the trust of the healthcare administration.

A clinical management process which, due to its horizontal structure, incorporates all of the elements of the health care chain, to our understanding, resolves the potential differences between the different "psychiatries"[41] that supposes an unnecessary division of psychiatry from the scientific knowledge in the current time.

5. *Evaluation system including clinical outcome indicators*

It is frequent to find evaluation systems of services or programs that only include indicators of the structure and process. Without minimizing their importance, the measure of the clinical outcomes is essential to know if a clinical management process really provides a value to the improvement of the health of a population.[42, 43]

Evaluation of the clinical results requires the routine registry of the target objectives of health, usually by simple evaluation scales. In the Anxiety and Depression Process of the HCSC, some routine scales have been incorporated for the measurement of the severity and incapacity as well as the model for Staging of the Depressive Disorders proposed by Hetrick and Mcgorry[44] as a complement to the diagnosis and evaluation in different milestones of the clinical evolution. This model has been modified by our work group as shown in another article in this supplement (See: Carrillo A et al. "Clinical Management Process for Depressive Disorders in Departments of Psychiatry").

The standardized evaluation and routine registry of the clinical data in any information system not only favors quality of service but also can be potentiators and facilitators of the research,[45] especially promoting the

study of the care needs and their link to outcomes, a necessary base for the calculation of the funding.[2] It also facilitates the convergence of interests between the academic organizations and those of management, providing data bases of homogenous populations for clinical, biological and epidemiological research.

6. *The clinical management process should be supported by an information system*
   Clinical management processes require a computer-based support both for clinical case registry and to have rapid access to the decision algorithms or diagnostic and treatment help systems. The ideal is to have a single computer system for the primary care and specialized care levels so that the pathway used by a patient as well as all of the diagnostic and therapeutic pillars that occur are known by the professionals who participate in the clinical activity of the process. In the same way, it is necessary to register the administrative data (appointments, admissions, tests, etc.) for care and economical management purposes.
   The reality of the different health care systems is extremely varied within the Spanish territory, not only because of the differences in the information systems of the regional communities, and between the of Primary Care and Specialized Care levels, but also, unfortunately, because of the heterogeneity between hospitals and others even within the same region. This situation makes it very difficult to have a common system in which different clinical processes can be integrated. In our case, we decided to define a different level for primary care and specialized care. The subprocesses in primary care have been designed in order to have easy access to the help algorithms for diagnoses and treatment. On the other hand, the subprocesses, both diagnostic and therapeutic, in the psychiatric and mental health services, have been constructed on a specific computer-based support that can be integrated into an electronic clinical history.
   The computer information system in any clinical management process makes it possible to carry out the periodic evaluations since the indicators can and should be based on clinical and administrative data collected routinely and therefore recoverable for their analysis.
   The absence of a computer-based support of the process would make it necessary to manually collect and use the data, which enormously hinders evaluation.

7. *Communication and implementation plan*
   Once the process has been completed, they should be known by all of the members of the organization, both professionals and directors. It is recommendable to have a time period to receive the contributions that should be taken into account.
   The diffusion and implementation plan is expensive and probably it is the most difficult process phase. It has great similarities with the implementation of other management tools such as the clinical paths.[46] It generally means a change in the daily work form and although it may be validated theoretically, its practical application is always unequal in a large group of professionals. Therefore, the implementation period should be prolonged in accordance to the specific characteristics of each organization in regards to size, heterogeneity and structures of the support available.

REFERENCES

1. Smith SM, Allwright S, O'Dowd T. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. Cochrane Database Syst Rev. 2007;(3):CD004910.
2. OMS. Informe sobre la Salud Mental en el mundo. La Financiación de los Sistemas de Salud. Ginebra: Ediciones de la OMS, 2010.
3. Regier DA, Narrow WE. The de facto US mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rate of disorders and services. Archives of General Psychiatry. 1993;50:85-94.
4. Bijl RV, Ravelli A. Psychiatric morbidity, service use, and need for care in the general population: results of The Netherlands Mental Health Survey and Incidence Study. American Journal of Public Health. [NLM - Medline]. 2000;90(4):602.
5. Kessler RC, Berglund P, et al. The epidemiology of major depressive disorder. JAMA. 2003;289(23):3095-105.
6. Marino S, Gallo JJ, et al. Filters on the pathway to mental health care I. Incident mental disorders. Psychol Med. 1995;25:1135-48.
7. Wittchena HU, Jacobib F, et al. Size and burden of mental disorders in Europe- a critical review and appraisal. European Neuropsychopharmacology. 2005;15:357-76.
8. Serrano-Blanco A, Palao DJ, Luciano JV, Pinto-Meza A, Lujan L, Fernandez A, et al. Prevalence of mental disorders in primary care: results from the diagnosis and treatment of mental disorders in primary care study (DASMAP). Soc Psychiatry Psychiatr Epidemiol. 2010;45(2):201-10.
9. Olivera J, Benabarre S, Lorente T, Rodriguez M, Pelegrin C, Calvo JM, et al. Prevalence of psychiatric symptoms and mental disorders detected in primary care in an elderly Spanish population. The PSICOTARD Study: preliminary findings. Int J Geriatr Psychiatry. 2008;23(9):915-21.
10. Landa González N, Goñi Saries A, García de Jalón Aramayo E, LUE. Concordancia en el diagnóstico entre Atención Primaria y Salud Mental. Atención Primaria. 2008;40:285-90.
11. Richardson LP, Russo JE, Lozano P, McCauley E, Katon W. Factors associated with detection and receipt of treatment for youth with depression and anxiety disorders. Acad Pediatr. 2010;10(1):36-40.
12. World Health Organization. Prevention of Mental Disorders. Effective Interventions and Policy Options. Summary Report. http://whqlibdoc.who.int/publications/2004/924159215X.pd . 2004. WHO. Ref Type: Electronic Citation
13. Rotge JY, Tignol J, Aouizerate B. Improving the management of depression in primary care: review and prospects. Encephale. 2007;33(4 Pt 1):552-60.
14. Adli M, Bauer M, Rush AJ. Algorithms and collaborative-care systems for depression: are they effective and why? A systematic review. Biol Psychiatry. 2006;59(11):1029-38.
15. Kates N, Mach M. Chronic disease management for depression

in primary care: a summary of the current literature and implications for practice. Can J Psychiatry. 2007;52(2):77-85.
16. Spitzer RL, Kroenke K, et al. Health related quality of life in primary care patients with mental disorders. JAMA : The Journal of the American Medical Association. 1995;274:1511-7.
17. Philbick JT, Connelly JE, et al. The prevalence of mental disorders in rural office practice. J Gen Intern Med. 1996;1:9-15.
18. Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, Hagedorn H, et al. Integration of mental health/substance abuse and primary care. Evid Rep Technol Assess (Full Rep) 2008;(173):1-362.
19. Williams JW Jr, Gerrity M, Holsinger T, Dobscha S, Gaynes B, Dietrich A. Systematic review of multifaceted interventions to improve depression care. Gen Hosp Psychiatry. 2007;29(2):91-116.
20. Richards DA, Lovell K, Gilbody S, Gask L, Torgerson D, Barkham M, et al. Collaborative care for depression in UK primary care: a randomized controlled trial. Psychol Med. 2008;38(2):279-87.
21. Richards DA, Hughes-Morley A, Hayes RA, Araya R, Barkham M, Bland JM, et al. Collaborative Depression Trial (CADET): multi-centre randomised controlled trial of collaborative care for depression--study protocol. BMC Health Serv Res. 2009;9:188.
22. Buszewicz MJ, Chew-Graham C. Improving the detection and management of anxiety disorders in primary care. Br J Gen Pract. 2011;61(589):489-90.
23. Agius M, Murphy CL, Zaman R. Does shared care help in the treatment of depression? Psychiatr Danub. 2010; 22(Suppl 1):S18-S22.
24. Harter M, Bermejo I, Ollenschlager G, Schneider F, Gaebel W, Hegerl U, et al. Improving quality of care for depression: the German Action Programme for the implementation of evidence-based guidelines. Int J Qual Health Care, 2006;18(2):113-9.
25. Akbari A, Mayhew A, Al Alawi MA, Grimshaw J, Winkens R, Glidewell E, et al. Interventions to improve outpatient referrals from primary care to secondary care. Cochrane Database Syst Rev. 2008;(4):CD005471.
26. Craven MA, Bland R. Better practices in collaborative mental health care: an analysis of the evidence base. Can J Psychiatry. 2006;51(6 Suppl 1):7S-72S.
27. Rost K. Disability from depression: the public health challenge to primary care. Nord J Psychiatry. 2009;63(1):17-21.
28. Katon W, Guico-Pabia CJ. Improving quality of depression care using organized systems of care: a review of the literature. Prim Care Companion CNS Disord. 2011;13(1).
29. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. Br J Psychiatry. 2006;189:484-93.
30. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med. 2006;166(21):2314-21.
31. Simon GE, Katon WJ, VonKorff M, Unutzer J, Lin EH, Walker EA, et al. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. Am J Psychiatry. 2001;158(10):1638-44.
32. Simon GE, Manning WG, Katzelnick DJ, Pearson SD, Henk HJ, Helstad CS. Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. Arch Gen Psychiatry. 2001;58(2):181-7.
33. Simon GE, Von Korff M, Ludman EJ, Katon WJ, Rutter C, Unutzer J, et al. Cost-effectiveness of a program to prevent depression relapse in primary care. Med Care. 2002;40(10):941-50.
34. Simon GE, Katon WJ, Lin EH, Rutter C, Manning WG, Von Korff M, et al. Cost-effectiveness of systematic depression treatment among people with diabetes mellitus. Arch Gen Psychiatry. 2007;64(1):65-72.
35. Unutzer J, Katon WJ, Fan MY, Schoenbaum MC, Lin EH, Della Penna RD, et al. Long-term cost effects of collaborative care for late-life depression. Am J Manag Care. 2008;14(2):95-100.
36. Katon WJ, Russo JE, Von Korff M, Lin EH, Ludman E, Ciechanowski PS. Long-term effects on medical costs of improving depression outcomes in patients with depression and diabetes. Diabetes Care. 2008;31(6):1155-9.
37. Baca E, Lázaro J. Hechos y valores en Psiquiatría. Madrid: Triacastela, 2002.
38. Ferrandiz Santos J, Rodriguez Balo A. El Diseño de la Calidad. La Gestión por Procesos. JANO 2004; 66(1):520.
39. Veltri S, Bronzetti G, Sicoli G. Reporting intellectual capital in health care organizations: specifics, lessons learned, and future research perspectives. J Health Care Finance. 2011;38(2):79-96.
40. Landry R, Amara N, Pablos-Mendes A, Shademani R, Gold I. The knowledge-value chain: A conceptual framework for knowledge translation in health. Bull World Health Organ. 2006;84(8):597-602.
41. Maj M. Are psychiatrists an endangered species? World Psychiatry. 2010;9(1):1-2.
42. Collopy BT. Clinical indicators in accreditation: an effective stimulus to improve patient care. Int J Qual Health Care. 2000;12(3):211-6.
43. Klazinga N, Fischer C, ten Asbroek A. Health services research related to performance indicators and benchmarking in Europe. J Health Serv Res Policy. 2011;16(Suppl 2):38-47.
44. Hetrick S, Parker A, Hickie I, Purcell R, Yung A, McGorry P. Early identification and intervention in depressive disorders: towards a clinical staging model. Psychother Psychosom. 2008;77(5):263-70.
45. Jenkins R. Supporting governments to adopt mental health policies. World Psychiatry. 2003;2(1):14-9.
46. Evans-Lacko S, Jarrett M, McCrone P, Thornicroft G. Facilitators and barriers to implementing clinical care pathways. BMC Health Serv Res. 2010;10:182.