Table 3. The core components of shared care models for severe and persistent mental disorders

	COPERATIVE STUDIES PROGRAM 430 Bauer 2009	**Simon 2006**	**OPUS Bertelson 2008**	**MENTAL HEALTH LINK Byng 2004**	**Druss 2001**	**Gilmer 2010**
Process of care	Specialty mental health team (.5 fulltime-equivalent (FTE) nurse and a .25 FTE psychiatrist)	Nurse care managers with at least 5 years of clinical psychiatric experience	Assertive Community Treatment, family treatment and social skills training	Facilitation based QI programme designed to improve communication between general practice and community mental health and improve systems of care within general practice (including roles of link worker and psychiatrist)	Integrated primary care and mental health clinic	Full service partnerships and subsidised housing and full fidelity Assertive Community Treatment by team- based services with a focus on rehabilitation and recovery
Condition	Bipolar disorder and associated co-morbidities including: substance use disorders, anxiety disorders, any current psychiatric co-morbidity and active medical co-morbidity requiring treatment	Bipolar spectrum disorder diagnosed during previous 12 months (bipolar disorder type I or type II, schizoaffective disorder, or cyclothymia).	1st episode psychosis	Long term mental illness - chronic psychosis, and disabling neuroses	SMI & homeless; co-morbid drug and alcohol abuse.	SMI (schizophrenia, bipolar disorder, or major depression)
Length of follow up	3 years	2 years	2 and 5 years	1 year	1 year	2 years
Screening	yes	yes	yes	yes	no	unclear
Additional training for staff	yes	yes	yes – staffed trained to deliver early intervention program	yes – training of research facilitators	no	no
Treatment algorithm	yes – used to promote identification and treatment by outlining medications to use without sequencing individual agents	yes	no	no	no	unclear
Formal stepped care	no	yes	no – team assessed as to when patients were ready for a specific treatment modality	no	no	unclear

Enhanced communication between health providers	no	yes- contact tracking, structured assessment, and standardised feedback reports to providers	unclear	yes – formal communication guidelines around referral, discharge and professional roles and patient management	yes - e-mail, telephone, and face-to-face discussion	unclear
Care management location	outpatient clinic	behavioural health clinics	primary care office or in patient's home or other places in the community	general practice	primary care clinic and mental health clinic adjoining	community
Patient education/self management	yes	yes	yes – focus on problem solving and development of skills to cope with illness	no	yes	no
Case management	yes	yes	yes- team based	yes	yes	yes
Specialist supervision	yes	yes - weekly	yes	yes	yes	yes
Care coordination	yes - scheduling appointments and follow-up for missed appointments, and with mental health and medical-surgical providers	yes	yes – across team and social services and other involved institutions	yes	yes - scheduling appointments and follow-up of missed appointments between the two clinics	unclear
Follow up provided to patient	yes	yes	yes	yes	yes	yes
Crisis support	yes	yes	yes – crisis plan developed with each patient. Patients given out of hours contact number for response the following day	unclear	unclear	yes – 24/7
Standardised outcome measure	yes	yes	yes	yes	yes	yes

The core components of shared care models for severe and/or persistent mental disorders (contd)

Process of care	**Harrison-Read 2002** Enhanced Community Management/Assertive Community Treatment	**Lester 2003** Patient-held record	**ACCESS Rosenheck 2002** Integration of service systems with outreach and case management	**Rosenheck 2003** Housing + Intensive Case Management	**van Orden 2009** Collaborative care involving access to a mental health worker in primary care	**Warner 2000** Shared care record
Condition	"Heavy users" of psychiatric services	Schizophrenia	SMI and associated co-morbidities + homelessness	Psychiatric and/or substance abuse disorders	Mental disorder (not described)	Long term mental illness- psychosis, personality disorder or other condition requiring long term supervision
Length of follow-up	2 years	1 year	5 years	1 year	1 year	1 year
Screening	no	no	yes	unclear	yes	Patients selected at hospital discharge
Additional training for staff	unclear	yes – in use of the record	yes – inter-agency	yes – with written materials		no
Treatment algorithm	unclear	no	unclear	no		no
Formal stepped care	unclear	no	unclear	no		no
Enhanced communication between health providers	yes	yes – shared care record and flagging of patient records in both general practice and specialist settings	yes	yes – inter-agency agreement	yes	yes – shared care record linked to other communication processes
Care management location	community	general practice and community	community	community	general practice/primary care	general practice and community
Patient education/self management	unclear	no	unclear	no	yes - CBT	no –instruction on use of the booklet only
Case management	yes	unclear	yes	yes	?	unclear
Specialist supervision	yes	unclear	yes	unclear	yes	unclear
Care coordination	yes	unclear	yes	yes	no – referral only	unclear
Follow up provided to patient	unclear	unclear	yes	unclear	unclear	unclear
Crisis support	no	unclear	unclear	yes	unclear	unclear
Standardised outcome measure	yes	yes	yes	yes	yes	yes