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The urgency of now- Building recovery-oriented, community-based mental health services in China

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The urgency of now: Building recovery-oriented, community mental health services in China

Abstract

For the first time in history, China has a mental health legal framework. People in China now expect a better life and more accessible, better-quality healthcare services for their loved ones. Development of community mental health services (CMHS) is at a crossroads. We review the current state of CMHS in China and propose four strategic directions for future development: building on the strengths of the “686 Project,” improving skill levels of the mental health workforce, especially by training in recovery approach, empowering families and caregivers to support individuals with severe mental illness and finally using information and communications technology to promote self-help and reduce the stigma associated with psychiatric disorders.

Background

China has 1.3 billion people, approximately one-fifth of the world's population. A recent study estimated that 173 million Chinese citizens suffer from diagnosable mental disorders, of whom 158 million have never received any treatment (1). Furthermore, approximately 16 million Chinese citizens are affected by severe mental illness (2). In-patient treatment is neither affordable nor professionally desirable for such a large number of people. Yet resources to treat, support, and care for people with mental illness in the community are lacking.

The development of community mental health services (CMHS) in China is now at a crossroads, marked in late 2012 by two signposts. First, in his inaugural speech as the new General Secretary of the Communist Party of China at the Great Hall of the People in Beijing on November 15th 2012, Xi Jinping mentioned the Chinese people (人民, rénmin) 19 times. In particular, he said that “our people love life and expect better education, more stable jobs, better income, more reliable social security, medical care of a higher standard...The people's yearning for a good and beautiful life is the goal we must strive for.” In March, 2013, Mr. Xi was elected president of the People's Republic of China by the National People's Congress. While his words are aspirational, it will take more than noble sentiments to turn it into a program of sustained action to benefit people affected by mental illness and their families. Another signpost, and a rather more concrete one, is the approval of the *National Mental Health Law* (NMHL) by the Standing Committee of the 11th National People's Congress on October 26th 2012, a full 27 years after it was first proposed. The implementation of the new law has required careful planning and monitoring (3), and it has highlighted the urgent need to properly develop CMHS.

China's overall improvement in standard of living means that Chinese citizens now have higher expectations for the care of their loved ones. Reliance on hospital services as the solution to severe mental illness has never been viable in the People's Republic of China (PRC) because of the cost. In contrast, community care offers a more affordable option. The concept of community care can be traced back to 1958, when the first national meeting on the prevention of psychiatric illness took place. Almost five decades later, the *National Mental Health Project of China 2002-2010* stated that “community care will take over...from traditional hospital care in the 21st

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3 century” (4). The figure of 16 million Chinese citizens with severe mental illness is expected to
4 grow; most people with severe mental illness in the PRC go without any treatment at all (2, 5).
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9 Before China’s economic reform in 1979, Chinese citizens were covered by the Cooperative
10 Medical System (CMS) in rural areas and the Government Insurance Scheme and Labor
11 Insurance Scheme in urban areas. After the reform, the funding base of the nation’s near-
12 universal coverage schemes was no longer available; it was replaced by a city-based social health
13 insurance scheme. The collapse of the CMS left up to 90% of rural Chinese uninsured (6). The
14 collapse is also at least part of the reason why at least a quarter of the Chinese general population
15 with moderate and severe mental disorder have never received treatment (1). Apart from the
16 problems with the wider insurance system, mental health services also face their own challenges,
17 such as implementation of the newly adopted mental health legislation, the huge resource
18 disparity between provinces and cities, and lack of community treatment approaches uniquely
19 suited to the Chinese population (7-9). Presently, China has only 4,000 fully qualified, licensed
20 psychiatrists (8). The discussion must begin now. For a review of the current state of mental
21 health services in China, and the challenges they face, see the commentary by Xiang and
22 colleagues (8), as well as earlier work by Philips and Pearson (10).
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35 It is clear that CMHS is still in the early stage of development in China for reasons of history and
36 resources, as in many low- and middle-income countries (7). This open forum paper provides a
37 review of what has been achieved so far and the scale of the work that remains to be done. **Table**
38 **1** provides a “strengths, weaknesses, opportunities, and threats” (SWOT) analysis to summarize
39 the general development of CMHS in China. Details of the SWOT analysis are omitted here but
40 may be seen in the online supplemental material.
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47 **Recommendations for building the future of CMHS in China**

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49 China’s current delivery of general health services relies heavily on primary healthcare, attached
50 to local community health centers in cities and township health centers in rural areas. Providers
51 of primary healthcare monitor and manage referrals to specialist care and hospitals. In contrast,
52 the delivery model of mental healthcare focuses on hospital-based or institution-based services
53 provided by three major ministries: the Ministry of Health, Ministry of Civil Affairs, and
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3 Ministry of Public Security (they operate the 25 Ankang Hospitals [which means “peace and
4 health” in Chinese] for individuals with mental illness, and some institutions are run as prison-
5 hospitals under the local Public Security Bureau; also see Table 1, “Opportunities” column).
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10 Mental health has been recognized as a significant public health issue in China since 2004 (7).
11 CMHS was found to be effective in supporting individuals and their families in recovery from
12 mental illness covering diverse cultural and linguistic backgrounds (11). A systematic review has
13 concluded that CMHS methods (such as intensive case management) are more effective than
14 standard care (such as hospital-based outpatient services) in terms of acceptance of treatment and
15 reduction of hospital admissions, drop-outs, deaths by suicide, and healthcare costs (12). Since
16 the 1960s, different CMHS models have been implemented in the PRC in urban (such as three-
17 tier primary prevention and treatment networks and guardianship networks) and rural areas (such
18 as psychiatric rehabilitation villages) (13). Broadly speaking, the most popular model in China is
19 the prevention and treatment network involving integrated services across the three tiers of city,
20 neighborhood, and street (14).
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31 We base the suggestions for the development of CMHS through the next century on two very
32 hopeful assumptions. First, considerably more resources will be available, with better funding for
33 services and a reduction in the resource gap between cities and rural areas. Second, the central
34 government will take a strong leadership role in steering the development of CMHS across the
35 country.
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42 **1. Building on strengths of the “686 Project.”** Skill levels of the mental health workforce in
43 China must be significantly improved. We can learn a great deal here from the “686 Project” for
44 three reasons (Table 1, “Opportunities” column). First, it is modeled on the World Health
45 Organization’s recommended framework for integrating hospital-based services with CMHS (7,
46 15). **Indeed, CMHS has to be effectively integrated with hospital-based services, and mental
47 health services have to be an integral part of general health systems. People with mental illness
48 and their families are often frustrated at being offered treatment by different providers that do not
49 communicate with each other and having to negotiate the many gaps in between them by
50 themselves.** Second, it has an existing “train the trainers” infrastructure (e.g., 382,000 individuals
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3 were trained by the end of 2011) readily transferable to other locations, and its delivery has
4 demonstrated characteristics that seem to suit the ideology and belief systems of Chinese culture.
5 Third, the Project has secured government investment. The central government has invested an
6 additional RMB 220 million (US\$32.2 million) since its inception in December 2004 with a seed
7 grant of RMB 6.86 million. By November 2011, 1.83 million citizens with severe mental illness
8 were treated through the Project, which covered 766 sites in 170 cities with a total catchment
9 population of 43 million people (8, 15).
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18 **2. Moving towards a recovery approach.** Furthermore, we also propose training for CMHS staff
19 (such as mental health doctors, social workers, nurses, and occupational therapists) in the
20 recovery approach. We suggest that the recovery approach resonates strongly with traditional
21 Chinese culture and is highly consistent with the values embedded within the “686 Project,” such
22 as paying more attention to the person’s level of functioning and strengths, rather than
23 disabilities and psychopathology (15). The recovery approach emphasizes self-confidence (自信),
24 self-help (自助), and self-sufficiency (自給自足). It is not a model of service delivery as such,
25 but an encompassing ethos or approach that can be applied to any model (including any
26 indigenous health initiatives) that focuses on the strengths and resources of service users and
27 their communities, as well as mental health services (16).
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37 The recovery approach draws on a series of principles and theories (such as partnership,
38 capacity-building of local service providers, and strategies to instill hope) based on three decades’
39 worth of studies and clinical evidence, most of which has been collected in places such as the US,
40 UK, Australia, and (more recently) Hong Kong (17, 18). From this empirical base, various
41 international practice guidelines for supporting recovery have been developed, primarily in
42 community settings (19). Examples of specific recovery practices are peer-support services,
43 strengths-based case management, and the Wellness Recovery Action Plan (illness self-
44 management).
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53 Nevertheless, it is important to investigate how recovery is redefined by—and negotiated
54 within—a Chinese cultural and practice context and how acceptable it is for more traditionally
55 trained medical staff. What are the factors that facilitate or hinder recovery for individuals at
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3 different stages of their journey in the modern cultural landscape of China, where mental illness
4 remains taboo and only limited resources are allocated to CMHS? By gaining further insight and
5 knowledge about the meaning of recovery for Chinese service users and how these are similar to
6 or different from ideas of recovery espoused by mental health staff (20), more culturally
7 applicable CMHS can be developed, which will better address service users' needs.
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14 **3. The continuing role of families.** As well as building staff skills, we must also empower
15 families and caregivers to support individuals with severe mental illness, especially in rural areas.
16 Caregiving is absolutely central to who we are as human beings. For a number of reasons,
17 supporting family-based caregiving is also a strategic intervention. First, up to 80% of
18 individuals with mental illness in China (especially in rural areas) are looked after by family
19 members at home, by choice or otherwise (13). This will increase as the NMHL is implemented.
20 Second, the burden of caregiving in the Chinese context and the related feelings of strain (caused
21 by factors such as the significant cost), coupled with family dysfunction (for example, high
22 levels of expressed emotion and negative affective style) often have a combined negative effect
23 on outcomes, although the mechanism of influence remains unclear. Third, there is increasing
24 evidence for the effectiveness of family-based interventions embedded within CMHS, in terms
25 of relapse prevention and improved clinical outcomes (21). In such interventions, family
26 members are supported through home visits where service users' wellbeing and adherence to
27 interventions are reinforced and their ongoing supply of medication ensured.
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41 **4. Using information and communications technology (ICT) to promote self-help and**
42 **destigmatization.** The number of internet users in China has risen to 538 million, and the number
43 of mobile internet users has grown rapidly to 388 million (22). We must make better use of ICT
44 to promote self-help and reduce the stigma associated with severe mental illness. China has a
45 vast population of diverse cultures and dialects spread over a wide geographical area. We should
46 not underestimate the potential to use ICT in mental health interventions in the Web 2.0 era. ICT
47 applications (such as those available on 3G phones) and Chinese social networking sites (such as
48 Tencent QQ, Renren, and Weibo) can help fight the stigma of mental illness, combat
49 discrimination, and create new platforms for computer-literate people, particularly the younger
50 generation (23), who are affected by mild or sub-clinical mental health problems.
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5 Using social networking to find out how someone with personal experience of mental illness has
6 learned to function again and find a new role in life may inspire others and help combat stigma.
7 Computer-automated, mobile, apps-based assessments, and behavioral-change interventions are
8 also being implemented around the world, and guidelines for developing computer-based adjunct
9 psychotherapy are being established (24). Preliminary results from the Organization for
10 Economic Cooperation and Development countries indicate that ICT improves service quality,
11 with little corresponding increase in cost or clinicians' time; however, limited evidence has so far
12 been gathered in developing countries, including China. Furthermore, despite their good
13 intentions, both clinicians and computer programmers often neglect the subtly different needs of
14 individuals from non-European cultural backgrounds when designing high-powered, technology-
15 based programs for use in the developing world.
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26 Of course, the critical question is how all these proposed changes will be financed. To
27 complicate the matter further, presently less than 4% (Table 1, "Weakness" column) of the total
28 health budget was spent on mental healthcare (most went to hospital-based services, not
29 community-based services). In contrast, mental health cost took up about 20% of total health
30 expenses (25). On the other hand, the promising sign is that the government is planning to
31 increase the health budget from 3-4% of the total health budget in 2010 to 7-8% by 2015 and is
32 planning to ensure that up to 55% of health dollars will be spent on public and rural health in
33 particular (26). Perhaps the unprecedented challenge in human history is not only to fund huge
34 and complex healthcare reforms for the 1.3 billion people in China but to find the path(s) to
35 achieving its stated goals (6). These are the questions or challenges for which we do not
36 necessarily have the answer, but they speak to the urgent need for clinicians, policy planners,
37 researchers, service users, and caregivers alike to begin a dialogue and work together at this
38 seminal moment for the development of community-based mental healthcare in China. We must
39 open the forum now for further discussion.
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51 52 53 **Conclusion**

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55 This forum paper demonstrates that mental health services in China have come a long way. In
56 conclusion, raising the skill standards of the Chinese mental health workforce (especially in the
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3 use of recovery approach), resourcing families, and making effective use of ICT are all essential
4 ingredients in developing CMHS. Finally, collaborating with local champions to train local
5 health workers can provide the critical infrastructure that will enable new CMHS initiatives to be
6 sustained beyond small pilot studies and limited grants.
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For Review Only

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Review Only

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Psychiatric Services: Open Forum (March 25th 2013 version, Table 1, online supplemental material) “The urgency of now: Building recovery-oriented, community mental health services in China”

Table 1

Strengths, Weaknesses, Opportunities and Threats analysis: CMHS in China (online supplemental material)

Strengths	Weaknesses
<ul style="list-style-type: none"> • <i>Financial resources and political stability.</i> Since the market reform process began in 1979, China has become the world’s second-largest economy while maintaining its political stability. <i>The new leadership of the ruling Chinese Communist Party was confirmed in the 12th National People’s Congress held in March 2013 in Beijing without incident, suggesting continued stability.</i> • <i>Mental health legislation.</i> For the first time in history China has a mental health legal framework; the newly passed National Mental Health Law will be implemented from May 1st 2013 (1). This new development brings both strengths and huge challenges. • <i>International collaboration.</i> Since the late 1980s, there have been many fruitful exchanges between China and Western countries, spanning various projects from clinical trials of new psychotropic drugs to pilot tests of community-based psychosocial interventions (such as clubhouses and work rehabilitation). These are expected to continue to inform the development of CMHS. • Increased awareness of mental health issues among senior officials. Terms such as “psychological health,” 	<ul style="list-style-type: none"> • <i>Grossly inadequate government investment.</i> Only 2.4% of the total health budget (some sources say only 1%) is spent on mental health (2). The equivalent figures (all 2005) for the neighboring countries/cities were 6.1% for Singapore (down to 4.1% in 2011; (3) and 8.7% for Hong Kong (up to 10.3% in 2011; (3). The figures are 6.0% in the US and 10.0% in the UK. The percentage of the mental health budget invested in CMHS is unclear. • <i>Unaffordable CMHS.</i> At least a quarter of those with a moderate and severe mental disorder have never received any treatment (4). The main reason for unaffordable access to healthcare in China is the lack of insurance coverage. Before China’s economic reform in 1979, Chinese citizens were covered by the Cooperative Medical System (CMS) in rural areas and the Government Insurance Scheme and Labor Insurance Scheme in urban areas. After the reform, the funding base of the nation’s near-universal coverage scheme was no longer available; it was replaced by a city-based social health insurance scheme that is financed by employer (6% of the employee’s wage) and employee (2% of their wage) contributions. The collapse of the CMS has left up to 90% of rural citizens uninsured- mainly low-wage farmers

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4 “psychological harmony,” and
5 “psychological wellbeing” (*xingfu gan*,
6 幸福感) are increasingly used in
7 government publications and official
8 pronouncements (26). Undoubtedly,
9 government officials will face the
10 challenge of promoting the ideology of
11 wellbeing as well as treating psychiatric
12 symptoms, lowering homicidal and
13 suicidal behaviors, and thus
14 maintaining social security and stability
15 (6).
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(5). Out-of-pocket payment as a share of total health spending increased from 20% in 1978 to approximately 60% in 2002, one of the highest payment shares compared to neighboring countries/cities (5). As a result, less than 15% of the population has health insurance that covers mental illness (2). The unaffordable CMHS was also explained by a disproportionately high unemployment rate among people with mental illness.

- *Uneven urban-rural distribution of resources.* After three decades of economic reform and hyper-growth, by the end of 2011 there were more people (691 million) living in urban areas than rural areas (657 million) for the first time in Chinese history. Although China’s urbanization program lifted more than 200 million people out of poverty, the country has the widest wealth gap between rural-urban areas in Asia, which means there are fewer resources to support people with mental illness in the community. This impacts the already very small mental health workforce (e.g., doctors and nurses) who have specialized skills and are working in the community, making them often less willing to work in rural areas.
- *Underdeveloped workforce.* Mental health work is not considered attractive, leading to problems with standards of training, understaffing, a generally underdeveloped workforce (6, 7); lacking, for example, doctors, nurses, social workers, occupational therapists, and counselors with specialist knowledge in mental health), and poor facilities. The underdeveloped workforce may be also attributable to the stigma associated with mental

illness and the government's meager investment in mental health compared to other specialties.

- *Inadequate baseline information.* We have a very limited understanding of the rehabilitation needs and caregiving burden of people with severe mental illness living in the community and their families. This is particularly true for groups with special needs, such as those who have never had treatment or who are homeless or suffering from addiction (8). There is also a lack of valid and up-to-date national data on the prevalence and incidence rates of psychiatric disorders. To fill this knowledge gap, the third author will be implementing two national projects in 2013: the National Epidemiological Survey of Mental Disorders and the Study of Disease Burden of Mental Disorders and Health Resource Utilization.

Opportunities

- *The government's new investment in health expenses.* Between 2003 and 2009, the central government increased its health budget from RMB 83.1 to 127.7 billion (also see "Opportunities" column). In April 2009, China launched its health-care reform plan to spend an additional RMB 850 billion (about US\$125 billion) "with the goal of provision of affordable and equitable basic health care for all by 2020" (9), p. 833) covering five areas: insurance coverage of more than 90% of the population, meeting everyone's primary needs of medicine nationwide, improving the primary care system and managing referrals to specialist care and hospitals, making public health services available for every Chinese

Threats

- *Rising level of stress and mental health problems.* Given the rapid modernization and urbanization of rural areas, the fast-paced lifestyle, and growth in competition at work and school, mental health problems are expected to rise. Local Chinese health authorities reported increased prevalence estimates of severe mental illness from 5.4% in 1970 to 11.1% in 1980 and 13.4% in 1990 (15). The burden of psychiatric care ranks first among illnesses. The cost of treating mental disorders is projected to account for a quarter of total expenditure on healthcare by 2020 (15).
 - *Transition from psychiatric hospitals to the community.* The NHML may result in large numbers of individuals being discharged from psychiatric institutions. It is likely
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citizen, and conducting public hospital reforms. The remaining challenge is to address the root problem of “rapid cost inflation caused by an irrational and wasteful health care delivery system” (p. 460), which is the very same issue confronting the United States on the other side of the Pacific (5).

- *Learning from existing programs.* One example is the successful “686 Project” in integrated mental healthcare. The lessons learned, such as the provision of basic psychiatric care in rural communities with support from specialists, will continue to inform the development of CMHS models that fit the specifics of Chinese culture and context (10).
- *The emergence of culturally responsive interventions.* Clinical trials over the last 20 years have demonstrated promising outcomes for some popular Chinese healing methods, such as mindfulness training (11) and qigong (12).
- *Potential to develop better community-based services.* In China, core mental health services (such as psychiatric hospitals) are provided by different ministries or agencies, including the Ministries of Health (65%), Civil Affairs (22%), and Public Security (3%). The rest goes to Industry, Mining and Railways; the People’s Liberation Army; and local collectives. The so-called “scarce resource but *oversupply*” (13) dilemma highlights the notion that mental health resources are scarce relative to demand, concentrated in big cities (common in developing countries; (14) and prohibitively expensive. Some studies put the psychiatric bed occupancy rate as low

even more pressure will be placed on families to look after severely ill people at home with little support or access to effective treatment.

- *Migrant workers’ needs.* An estimated 200 million migrants (most of whom have moved to the cities) have no health coverage at their work location and are not able to access services in the city if they hold a “hukou” (户口 or household registration) in a rural area (16). If nothing is done, this could lead to an increase in the number of untreated cases and a greater burden on the already overloaded mental health system.
- *Stigma and discrimination.* Chinese people place a heavy stigma on severe mental illness. A possible explanation is China’s collectivistic cultural orientation, in which conformity to norms is highly desirable and surveillance is high. Therefore mental illness or any deviant behavior is often devalued and stigmatized (17,18).

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as 40%. Effective co-ordination of CMHS across locations remains a pressing challenge.

- *Potential for better mental health literacy.* More than 6 million people graduate from Chinese universities per year, and more than 500 million use the Internet regularly and **may therefore access information on issues related to mental health (e.g., stress management, detecting early signs of depression).**

For Review Only

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