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Research Progress on the Current Status of Health Management of Patients with Severe Mental Disorders

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Abstract: As a chronic disease with a prolonged course, high recurrence rate, and serious impairment of social function, severe mental disorder has become a global public health problem and social governance problem. Based on the theoretical perspectives of multicenter governance and collaborative governance theory, this paper systematically sorts out the current status of policy systems, resource allocation, service models, and social support for the health management of patients with severe mental disorders at home and abroad. The study finds that China has initially built a community-based and multi-departmental comprehensive management service system, but it still faces challenges in policy implementation, resource allocation, and social support. In the future, officials should strengthen the collaborative governance mechanism, optimize resource allocation, promote the construction of digital management and destigmatization of social support systems, and improve the accuracy and humanization of health management.

Keywords: Severe mental disorders; Health management; Collaborative governance; Social support; Multi-center governance

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1. Introduction

Severe mental disorders include six diseases, including schizophrenia, paranoid psychosis, and schizoaffective disorder, which have the characteristics of a high disability rate, high recurrence rate, and high social risk, and have become a major global public health problem and social governance problem [1]. With the rapid development of China's social economy and the acceleration of the pace of life, mental health problems are becoming increasingly prominent, and the number of patients with severe mental disorders is increasing year by year. According to research reports, the prevalence of mental disorders among Chinese adults has reached 17.50%, the lifetime prevalence rate has reached 16.6%, and the number of registered patients with severe mental disorders has reached 15 million, which has brought a heavy burden to patients' families and society [2]. Since the management

of patients with severe mental disorders was included in the national basic public health service project in 2009, China has gradually built a community-based, family-based, and multi-departmental comprehensive management service model. However, with the continuous growth of social demand, the current management model still faces many challenges in policy implementation, departmental coordination, resource allocation, and social support. This paper aims to systematically review the research progress on the health management of patients with severe mental disorders at home and abroad, analyze the current situation and challenges of the current management model, and provide a reference for improving the health management level of patients with severe mental disorders in China.

2. The current situation of theoretical application

2.1. Polycentric governance theory

Polycentric governance theory emphasizes the existence of multiple power centers and decision-making centers in public affairs management, which jointly provide public services through competition, collaboration, and interaction [3]. In the health management of patients with severe mental disorders, the government is responsible for policy formulation and resource allocation as the core body, while non-governmental organizations, enterprises, communities, and families are important supplements, participating in management by providing professional services, daily care, and community support. This model helps improve management efficiency and meet the diverse health needs of patients [4].

2.2. Collaborative governance theory

Collaborative governance theory emphasizes the collaboration and linkage between multiple subjects in public affairs [5]. The complexity, long-term, and cross-border nature of health management of patients with severe mental disorders make it difficult for a single government department to respond independently. This theory provides a theoretical basis for building a comprehensive management service model of "government-led, departmental collaboration, and social participation", and requires breaking down information barriers between departments such as health, public security, civil affairs, and the Disabled Persons' Federation, integrating multiple resources, and forming a joint force for governance [6].

2.3. Social support theory

Social support theory emphasizes providing material and spiritual support to vulnerable groups through formal and informal social networks to reduce their living pressure and promote social integration [7]. In the management of patients with severe mental disorders, it is reflected in the economic implementation of the "award instead of compensation" policy and medical expense reimbursement, regular follow-up and medication guidance by the health service center, and the establishment of multi-departmental linkage to deal with emergencies [8].

2.4. Welfare governance theory

Welfare governance theory focuses on the multiple supply subjects of social welfare and their interactions, emphasizing the collaboration and balance between the government, the market, social organizations, and families in welfare supply [9]. In the health management of patients with severe mental disorders, this theory advocates the construction of a government-led welfare supply system with the participation of the market, social organizations, and families, and ensures that patients receive basic health protection through policy guidance, financial support, and supervision and management [10].

3. The current situation of the management model

3.1. Foreign management model

(1) The "Assertive Community Treatment" model (ACT) in the United States is one of the most widely used community mental illness management models in the world, mainly for patients with recurrent diseases and severe impairment of social function. The model team includes psychiatrists, nurses, social workers, psychological counselors, and other multidisciplinary personnel, and the service location extends to the community and family, covering various aspects such as housing, medication, and daily life, and has been widely used in 35 states in the United States [11–12]. (2) The French "zoning" service model divides communities according to geography, and community mental health institutions provide regular door-to-door services, forming a pattern of "small hospitals and large communities" to promote the diversification of mental health service methods. Under this model, the number of beds in mental health institutions decreased significantly, while the number of community beds increased, but the cost was higher [13–14]. (3) Australia's "community-oriented" service model emphasizes resource integration and patient participation, and patients are recuperating at home and in the community except in the acute stage, and hospital service costs only account for about 20% of the total cost of mental health services. This model is characterized by the full integration of resources, patient participation in the formulation of treatment plans, and the participation of general practitioners in community mental health services [15]. (4) The Canadian "community medication management" model consists of a management team composed of psychiatrists, nurses, social workers, peer supporters, etc., who are responsible for treatment and rehabilitation, ensuring the stability of patients' conditions and laying the foundation for community rehabilitation [16].

3.2. Domestic management model

(1) The comprehensive community prevention and treatment model emphasizes the integration of medical, rehabilitation, psychological, and social support resources at the community level, and promotes the recovery of patients' social functions through the establishment of care and support groups, health education, and rehabilitation training [17]. (2) The "hospital-community-family" integrated management model consists of a team composed of psychiatrists, nurses, community prevention doctors, social workers, and psychotherapists to carry out patient enrollment files, family education, community science popularization, and family visits, which significantly improves patients' medication compliance and quality of life [18]. (3) The PCMP model uses telemedicine to realize online and offline joint follow-up between precision prevention doctors and psychiatrists, improving follow-up satisfaction and service efficiency, but it is highly dependent on network coverage and professional talents [19]. (4) The family doctor contracted service model provides regular follow-up, health guidance, medication supervision, and psychological support through personalized health management, and improves patients' medication rate, face-to-face visit rate, and health management compliance [20]. (5) The drug management model based on the CLES model helps patients develop regular medication habits and promote community rehabilitation through four sections: consultation, learning, implementation, and reinforcement [21].

4. Policy evolution and institutional guarantee status

4.1. Comparison of domestic and foreign legislation and policies

Foreign legislation on the management of patients with mental disorders started earlier. The United States has successively promulgated the National Mental Health Act, the Community Mental Health Act, and the Mental Health Equality Act, which clarify that the level of coverage of mental health insurance shall not be lower than that

of other medical insurances [22]. The UK provides free mental health services to all residents through the National Health Service Act [23]. Japan has a well-established diagnosis system and treatment standards for mental disorders, and the patient's family only bears 10% to 20% of the treatment cost [24]. Since 2008, China has successively issued laws and regulations such as the "China Mental Health Work Plan", "Guiding Outline for the Development of the National Mental Health Work System", and the "Mental Health Law of the People's Republic of China", gradually promoting the transformation of the management of patients with mental disorders from restrictive to community rehabilitation [25]. The promulgation of the Mental Health Law provides legal protection for patients' medical assistance, living allowances, and nursing subsidies [26].

4.2. Current status of medical security

China has improved the accessibility of services for patients with severe mental disorders through the central subsidy, local management, and treatment project for severe mental illness ("686" project) [27]. Since 2009, patients with severe mental illness have been included in community management and included in the scope of free government public services. At present, China has formed a security system that combines medical insurance, medical assistance, and assistance subsidies, which has effectively alleviated the financial burden of patients [28].

4.3. Construction of a multi-departmental collaborative governance mechanism

Domestic scholars generally believe that the management of patients with severe mental disorders requires the effective cooperation of multiple subjects. Various regions have explored the "five-in-one" grassroots linkage mechanism and realized the transformation from disease control to collaborative management [29]. For example, a county in Hubei Province, under the leadership of the Political and Legal Committee, cooperated with finance, civil affairs, public security, the disabled persons' federation, medical insurance, and other departments to establish a comprehensive management team and a care and assistance group to strengthen patient control [30].

5. Resource allocation and service status

5.1. Allocation of medical resources

By the end of 2021, there were 5,936 mental health medical service institutions and more than 50,000 registered psychiatric practitioners, an increase of 205% and 144% respectively compared with 2010 [31]. However, there is still a regional imbalance in resource allocation. Studies in Guizhou Province and Chongqing City have shown that although the number of mental health institutions has increased significantly, health resources are relatively scarce and unevenly distributed, and the allocation of human resources is at a warning level [32–33].

5.2. Patient screening and filing

China has achieved "early detection, early diagnosis, and early treatment" of patients with severe mental disorders through family detection, screening of intensive prevention personnel, and police detection [34]. Shouguang City explored the establishment of electronic files for severely mentally ill people, implemented dynamic management, clarified the scope of filing, hierarchical diagnosis and treatment, and cost-sharing mechanisms, providing useful experience for patient management [35].

5.3. Patients are treated in the hospital

Drug treatment is the basic treatment for severe mental disorders. By the end of 2020, the standardized medication

rate of patients with severe mental disorders nationwide was 87.83%, and the regular medication rate was 68.84%, showing an increasing trend year by year [36]. Non-pharmacological treatment methods such as group psychotherapy, cognitive behavioral therapy, comprehensive behavioral therapy, and industrial and recreational therapy have also been widely used in clinical practice, significantly improving patients' clinical symptoms and social functioning [37–40].

5.4. Rehabilitation and follow-up of discharged patients

Community rehabilitation is an important way for patients with mental disorders to return to society. In China, a dual follow-up mechanism linking the supervising physician in the ward and the community doctor has been established to achieve continuous management of patients after discharge [41]. The active community treatment model has been piloted in many places, with a multidisciplinary team providing personalized and in-depth community interventions to patients [42].

6. The current situation of family social support and self-perception

6.1. Family support and care burden

About 90% of people with severe mental illness receive support from their families [43]. Family support was significantly associated with patient adherence to treatment. However, family members of patients with mental disorders bear a higher care burden than those with other chronic diseases, and family support may weaken as the disease progresses [44–45]. The state has alleviated the burden on families through a hierarchical and classified subsidy and assistance system [46].

6.2. Social support

Social support is closely related to the quality of life of patients [47]. China has built a diversified social support network by mobilizing social forces, advocating volunteer service, and guiding social workers to participate [48]. Community rehabilitation services include regular medication practice, life skills training, social skills training, vocational skills training, etc., to create conditions for patients to return to society [49].

6.3. Stigma and social discrimination

Stigma is an important factor affecting the treatment and rehabilitation of patients with severe mental disorders. Domestic and international studies have shown that patients with severe mental disorders generally have moderate to high self-stigma, which seriously affects their social function and quality of life [50–51]. A high level of social discrimination perception predicts an increase in stigma pressure, leading to social withdrawal and poor treatment compliance [52–53]. Therefore, it is particularly important to carry out anti-disease stigma publicity and education, and create an inclusive and friendly social environment.

7. Conclusions and prospects

In summary, the health management of patients with severe mental disorders in China has made great progress in policy system construction, service model innovation, and financial investment, and a multi-center governance pattern has been initially formed. However, compared with the strategic goals of Healthy China and the needs of the people, there are still problems such as uneven distribution of resources, shortage of professionals, barriers

to departmental coordination, and serious social discrimination. Future research and practice should focus on: first, optimize resource allocation and make up for the shortcomings of the grassroots level; second, deepen the collaborative governance mechanism and break down information barriers; third, promote digital health management methods; Fourth, build a destigmatized social support network to reduce the burden on families. Through multi-dimensional measures, the health management level and quality of life of patients with severe mental disorders have been comprehensively improved.

Disclosure statement

The authors declare no conflict of interest.

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