

The Awareness of Missing Exit Mechanism in China's Serious Mental Disorder Management Systems: The Occupational Experience of Community Mental Health Workers in China

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Short Report

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Abstract

Background

China's Serious Mental Disorder Management Systems (SMDMS) is among the world's largest community-based mental health programs, providing longitudinal management for more than 6.4 million individuals. Although the system has substantially improved treatment access and continuity of care, one critical structural feature remains unexamined: there is no clearly defined exit mechanism by which individuals may leave the system following diagnostic revision or sustained recovery. Little is known about frontline community workers' understanding of this policy or their occupational experiences within the SMDMS.

Methods

We conducted a cross-sectional survey of all 265 community workers responsible for community management of serious mental disorder (SMD) management in one district in Guangdong Province, China. The sample comprised 233 healthcare professionals and 32 community social workers. The survey assessed knowledge of the current management system, occupational experiences, attitudes toward patients, perceptions of service effectiveness, and job satisfaction.

Results

Overall, 66.4% of respondents correctly recognized that SMDMS lacks a formal exit mechanism. Nearly ninety percent (88.3%) reported having experienced discourteous treatment from patients or family members, and over half (53.2%) indicated that such encounters resulted in at least mild to moderate anxiety. Although most respondents believed the program substantially improved patients' functioning (82.6%) and relieved treatment burden (89.8%), only 42.6% expressed overall job satisfaction, with 40.4% remaining neutral.

Conclusion

Frontline community workers perceived the SMDMS as clinically beneficial but reported substantial occupational challenges and identified important gaps in the current policy framework. The absence of a transparent review and exit mechanism warrants further examination as China continues to develop recovery-oriented, rights-based community mental health services.

1 Introduction

Since the early 21st century, mainland China has promoted the management of serious mental disorders (SMDs) within the community, gradually establishing a comprehensive Serious Mental Disorder Management Systems (SMDMS). The SMDMS has played a central role in ensuring access to treatment for individuals with SMDs in the community, safeguarding their treatment rights, reducing violent or disruptive behaviors associated with acute psychiatric episodes^{5,6,7,8,9,10,25,26}. After nearly two decades of implementation, the system has achieved substantial progress; however, important areas still require strengthening.

SMDs are characterized by pronounced symptoms that substantially impair social functioning and are often accompanied by limited insight or an inability to care for oneself.¹ In 2009, the National Health Commission of China (NHCC) issued *the Standard of Management and Treatment for Severe Mental Disorder* (the Standards)¹ and later revised in 2018. As a central guiding document for the management and treatment of patients with SMDs in mainland China, it laid the institutional foundation for the community-based service system.

The SMDMS represents the largest program of its kind worldwide. As of 2020, the national registry exceeded 6.43 million patients under active community management.² In accordance with the Standards, the Fourth People's Hospital of Shunde District—the designated psychiatric institution for Shunde District in Foshan City, Guangdong Province—is responsible for the management of SMDs treatment services in the district. In the course of our work, a critical systematic gap was identified: the absence of an exit mechanism in community management.

Mainland China requires reporting and registration system of individuals with SMDs. Through the National Information System for SMDs, psychiatric institutions must report and register all patients diagnosed with any of the six major categories of SMDs—schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, epilepsy-associated mental disorder, and intellectual disability co-occurring mental disorders. In addition, institutions must also report patients who meet the criteria specified in Item 2, Paragraph 2, Article 30 of *the Mental Health Law of the People's Republic of China* and have been diagnosed and assessed as having a SMD. Based on the patient's current residence, the case is then assigned to the relevant primary-level healthcare institution for registration and inclusion in the SMDMS.^{1,3,4} In practice, once any of the above diagnoses is made, psychiatrists are required to file a mandatory report, and the primary-level healthcare institution automatically enrolls the patient in community management. Enrollment is permanent and there no mechanism or process for patients to withdrawal or leave. This contradiction frequently leads to complaints from patients or family members directed at reporting psychiatrists and has become a common source of physician–patient.²⁷

The absence of an exit mechanism, combined with increasing new cases, has led to a steadily expanding registry—with increasing numbers entering the system and fewer leaving except death.^{5,6,7,8} This trend has triggered cascading consequences. Government agencies must continually increase dedicated funding and workforce, and introduce supportive policies. At the same time, it poses a greater and more immediate challenge to the workload of local

community mental health prevention and management teams, which are already constrained by limited professional manpower. Existing studies have shown that high-performance targets, low professional recognition, low remuneration, and high emotional exhaustion are likely to trigger a series of reactions, including job burnout and physical and mental exhaustion.^{11,12,13,14,15,23} In the long run, this not only adversely affects the physical and mental health of staff, but also undermines team morale, reduces job satisfaction, diminishes work motivation and career aspirations, and negatively impacts service quality, thus forming a vicious cycle.

Despite the extensive reach of the SMDMS for SMDs, the implications of operating without an exit mechanism remain largely unexamined. Existing studies have not addressed how this structural gap affects system burden, clinical practice, or community service capacity. To fill this gap, the present study evaluates the occupational experience of frontline community mental health workers, with focus on the impact of the no-exit policy within SMDMS and identifies areas for improving program sustainability.

2 Methods

2.1 Survey Questionnaire

A self-administered questionnaire developed for this study was administered online via a WeChat Mini-Program (a lightweight application embedded in the WeChat platform that runs without separate installation). It assessed awareness of an exit mechanism in the Standards (2018 Edition), perceived relief of patients' treatment burden, perceived impact on patients' social functioning, and overall job satisfaction, with response categories as shown in Table 1. Respondents also reported whether they had experienced discourteous treatment from patients or family members and, if so, whether this caused anxiety. Between July and August 2024, the online questionnaire was distributed, which participants could access by scanning a QR code for the online questionnaire. Before completing the questionnaire, participants were required to read the informed consent statement within the Mini-Program and tick a box to indicate whether they agreed to participate in this study.

2.2 Participants

Between 2022 and 2024, in Shunde District, Foshan City, Guangdong Province, 10 community health service centers (CHCs) undertook the public health program for community-based management and treatment of SMDs, and 7 social work agencies provided auxiliary follow-up and rehabilitation services for SMDs at the township/subdistrict level. These institution staff included general practitioners, traditional Chinese medicine practitioners, assistant physicians, pharmacists, nurses, psychiatric social workers, and others. Participants were recruited from all 10 CHCs and all 7 social work agencies providing SMD community management in the district. All questionnaires were returned and valid.

2.3 Statistical Analysis

Categorical variables were summarized as frequencies and percentages, and the continuous variable was summarized as mean and standard deviation. Data cleaning was performed using WPS Office 2024, and all statistical analyses were conducted using R software version 4.5.3.

3 Results

3.1 Demographic Characteristics

All 265 frontline personnel engaged in community-based management of SMDs in Shunde District responded to an anonymous online survey. The sample comprised 233 healthcare professionals and 32 community social workers. Mean length of service was 2.5 years ($M = 2.52$, $SD = 0.98$). With respect to professional tenure, 45 respondents (16.98%) had served less than 1 year, 220 (83.02%) had served more than 1 year—of whom 22 (8.30%) had accumulated 10 or more years of experience.

3.2 Questionnaire Responses

- 3.2.1 When asked "Do the Standards (2018 Edition) provide an exit mechanism for individuals under management?", 66.42% (176 respondents) correctly recognized that the current system lacks such a mechanism, while 33.58% were unaware of its absence. (Table 1)
- 3.2.2 When asked to rate their overall job satisfaction with the SMDMS they provide, 16.98% of respondents reported varying degrees of dissatisfaction, 40.38% reported a neutral level of satisfaction, and 42.64% reported satisfaction. (Table 1)
- 3.2.3 Nearly ninety percent (88.3%) reported having experienced discourteous treatment from patients or family members during their work, and more than half (53.2%) reported that these encounters produced at least mild to moderate anxiety.

Table 1 Survey results of community mental health workers in Shunde District (N = 265)

Survey item	Response category	Number Percent, %
1 To the best of your knowledge, does the Standards (2018 Edition) provide an exit mechanism for individuals under management?	Yes	8933.58
	No	17666.42
2 To the best of your knowledge, to what extent do the current SMDMS relieve the treatment burden on patients?	Relieve 80% or more (the vast majority of treatment problems can be resolved)	4818.11
	Relieve 60%–80% (most treatment problems can be resolved)	10539.62
	Relieve 40%–60% (a relatively large proportion of treatment problems can be resolved)	8532.08
	Relieve 20%–40% (a small proportion of treatment problems can be resolved)	2710.19
3 To the best of your knowledge, what is the overall impact of the SMDMS on the social functioning of patients with mental disorders (e.g., work, family roles, interpersonal relationships, neighborhood interactions, participation in group activities)?	Greatly promoted and improved	3814.34
	Moderately promoted and improved	18168.30
	No impact	124.53
	Caused considerable stress and difficulties	2910.94
	Caused severe stress and difficulties	51.89
4 Please rate your overall job satisfaction with the SMDMS you provide. Would you say you are	Very dissatisfied	62.26
	Somewhat dissatisfied	3914.72
	Neutral	10740.38
	Somewhat satisfied	10138.11
	Very satisfied	124.53

4 Discussion

The establishment of the SMDMS in China has provided treatment coverage for a tremendous number of patients with mental disorders and has contributed substantially to their recovery. At its inception, the system addressed three major concerns: violent or disruptive behaviors, which were a primary concern of government agencies; barriers to access treatment, which were major concerns for patients and families; and poor treatment adherence, a primary concern of treatment providers.² Our findings lend support to this view. However, our findings suggest that the current situation is less encouraging.

In the current SMDMS system, once registered, patients remain in the system indefinitely, and they cannot withdraw regardless of their recovery status.²² Although the NHCC has issued specific guidelines on case reporting for SMDs^{1,4}, these documents do not specify whether registered patients may withdraw or how they exit the system. As a result, even when a patient has been misdiagnosed or has recovered after treatment, it remains difficult for them to leave the system. Patients or their families have complained that personal health information was shared among primary-level healthcare institutions despite their explicit refusal to be registered in community management.²⁷

Requests to leave the management and treatment system generally fall into two categories. The first involves patients with limited insight, which itself is a clinical issue and does not justify removal from the system. However, if neither misdiagnosis nor recovery after treatment can serve grounds for withdrawal, then the system no longer fully serves the purpose for which it was originally established. Our survey found that most staff (88.3%) reported having experienced discourteous treatment from patients or family members during their work, and over half (53.2%) indicated that such encounters resulted in at least mild to moderate anxiety.

Currently, psychiatric diagnosis still relies largely on clinical judgment rather than objective laboratory tests, making some degree of misdiagnosis inevitable. Additionally, the dynamic nature of mental disorder also means diagnostic revision is necessary.^{24,29} A population-based multi-stage stratified cluster sampling survey in Hunan Province showed that the diagnostic concordance rate for the six categories of SMDs was only 39.9%¹⁶; Wang et al. also reported a misdiagnosis rate of 10.12% for schizophrenia in primary-level healthcare institutions using ICD-10 diagnostic criteria.¹⁷ In addition, due to effective treatment, many patients may achieve sustained recovery. Contemporary psychiatric care increasingly recognizes recovery as a dynamic process rather than a permanent disease state. A management system that recognizes entry into care but not clinically justified exit risks becoming inconsistent with recovery-oriented principles.^{28,30} Both recovered patients and those who were misdiagnosed should therefore have a reasonable pathway to withdraw from the SMDMS. Rather than weakening community management, introducing an exit mechanism could strengthen it. Nationally standardized criteria for periodic reassessment, independent review following diagnostic revision or sustained recovery, and a formal appeals process would preserve the public health functions of the current system while aligning practice more closely with contemporary principles of recovery-oriented and rights-based psychiatric

care.^{28,30} Given the substantial annual investment of human and financial resources by the state in this system, allowing justified exits could reduce government expenditure, alleviate the workload and financial burden, and may also minimize the patient-doctor disputes. It may also reduce self-stigma and facilitate better social reintegration.^{20,21,30}

Tang et al. noted that “It is worth reflecting on why a well-intentioned system has not only dissuaded many patients from participating but has also become a source of patient-doctor conflicts.” They further argued that any restrictions on patients’ rights should be carefully considered, well defined and regularly re-assessed, with a focus on protecting both the rights of individuals and the well-being of the community.¹⁸ At its core, SMDMS is a type of community psychiatry service and should remain open to scholarly discussion and scientific research. However, the absence of an exit mechanism has rarely been raised, much less critically examined.

Recovery-oriented mental health care aims to support not only symptom reduction but also autonomy, participation, and the least restrictive care necessary. Consistent with the World Health Organization (WHO) rights-based recommendations, community mental health services should ensure supported decision-making, respect for dignity, and regular review of restrictions.²⁸ Within this framework, indefinite administrative enrollment without a clear review or discharge process raises concerns. Psychiatric diagnoses can change over time, leading some individuals with revised diagnoses to remain registered indefinitely. Many patients achieve long-term recovery, making permanent registration inconsistent with recovery principles. Moreover, the absence of an exit pathway may discourage service engagement and strain relationships among patients, families, and providers.

In fact, some of the diagnoses in the six categories do not fully align with the definition of SMDs in the Standards. For example, for bipolar disorder, the SMDMS includes the International Classification of Diseases, 10th Revision (ICD-10) code “F30.0 Hypomania”. However, the majority of patients with hypomania do not lead to severe disruption of work or result in social rejection.¹⁹ Conversely, some other disorders that meet the definition of SMDs are not subject to mandatory management, such as severe depressive episodes with psychotic symptoms.

Because this is a pioneering topic, there were no comparable precedents to guide the study design or questionnaire development. As a result, the survey did not sufficiently explore certain areas—such as pay levels of frontline staff, job burnout, stigma and discrimination, and the cost-effectiveness of community management, all of which are limitations of this study. Additionally, our study lacks data from the perspective of patients and their families. Although the sample was obtained by convenience sampling, it was drawn from all service units in the district and achieved a 100% response rate, which supports broad coverage of the district’s frontline SMD workforce. Nevertheless, in the absence of a formal sampling frame, quantitative claims of representativeness should be interpreted cautiously, and the findings may not be generalizable to other regions of China.

In conclusion, as a government-supported community mental health system that has been implemented for more than two decades, the SMDMS has demonstrated substantial benefits and considerable social value. Nevertheless, in light of current operational realities, we believe it is important to critically re-examine and reflect on all aspects of the system, with the goal of further refining it to function in a more evidence-based, efficient, and rights-based, person-centered manner.

Abbreviations

SMDMS: Serious Mental Disorder Management Systems

SMD: serious mental disorder

NHCC: National Health Commission of China

CHCs: community health service centers

WHO: World Health Organization

ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Revision

Declarations

6 Funding

This study received no specific funding.

7 Ethics approval and consent to participate

The design and data collection procedures were approved by the Shunde Fourth People’s Hospital (approval number 20240604). The study was performed in accordance with the Declaration of Helsinki. Informed consents were obtained from all participants before completing the survey, and all of them could withdraw from the survey at any time without any reason. Data were processed at a restricted location using a personal unidentifiable code for each subject.

8 Consent for publication

Not applicable.

9 Competing interests

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