Mental Health and Rights

The development of community mental health networks in four provinces of China

ASSOCIAZIONE ITALIANA AMICI DI RAOUL FOLLEREAU - AIFO

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Contents

Acronyms

AIFO: Italian Association of Friends of Raoul Follereau

CMHU: Community Mental Health Unit

CoPerSaMM: Permanent Conference for Mental Health in the World

CRPD: Convention on the Rights of Persons with Disabilities

CSM: Mental Health Centre

CSO: Civil Society Organisation

DSM: Department of Mental Health

mhGAP: Mental Health Gap Action Programme

WHO: World Health Organisation

NGO: Non-government Organisation

UNO: United Nations Organisation

PUIMH: Peking University Institute of Mental Health

ROU: Residential Open Unit

SoliS: Solidarity and Service

SWOT: Strengths, Weaknesses, Opportunities and Threats

Introduction

Between 2011 and 2017, two separate and successive programmes took place within the framework of the series of cooperation programmes co-financed by the European Union: "Community Based Psychiatry: promoting the integration of mental health care into primary health services in three districts of China" (2011-2014), followed by "Strengthening role and capacity of Chinese Non-state Actors towards rightful inclusion in the society of people with mental health conditions" (2014-2017). Both programmes were promoted by AIFO, SoliS and their partners, and focused on the promotion of community mental health in China. This document presents the results, experiences and practices of six years of work, the knowledge obtained and the lessons learned, with particular reference to the recently completed second three-year period.

1.1 – The role players in the initiative

The Italian Association **Friends of Raoul Follereau (AIFO)** is an international non-government association established in 1961, which is inspired by the work of the French journalist Raoul Follereau (AIFO 2012). Initially set up to halt the spread of leprosy, it gradually extended its areas of action to disability in general and integration with the primary care network, with investments in community rehabilitation in particular. In the course of the years, it has built up considerable experience in psychosocial disabilities and mental health. With a view to achieving its objectives, AIFO works with other NGOs and government institutions, with which it shares common goals and practices (AIFO 2015).

AIFO is currently working on projects in 15 countries, mainly in South America and Asia. Its operations in China are deep-rooted. Since 1989, the association has been active at local level in the area of base health assistance and the rehabilitation of disabled people, including those with mental health problems. Over the last three years, AIFO has coordinated the second of the projects co-financed by the EU, linked to the development of community mental health practices and culture in China (AIFO 2017).

Over the six years of the programmes, the work at local level took place in partnership with the **Peking University Institute of Mental Health**/The Sixth Hospital of Peking University (PUIMH), which is one of the most important Chinese institutions operating in research and training in the care and rehabilitation of people with mental health problems. The Italian partner was the **Solidarietà e Servizio** (SoliS) Association, a long term collaborator of Aifo, the sponsor of the first project, which is closely linked to the second one in terms of logistics and cultural inspiration. SoliS brought to the project the specific know-how developed by it in the course of the years dedicated to rehabilitation of psychosocial disabilities (SoliS 2017).

In the area of training, and with particular reference to deinstitutionalisation the development of community mental health models, mainly of a cooperative nature, and user empowerment aimed at the modification of the "psychiatric paradigm", the associations collaborated with the **Mental Health Conference in a No-profit setting**, set up in 2010, whose promoters include the closest collaborators of Franco Basaglia, along with other technical specialists and members of the public, who offered culture and policy support for the transformation processes which in Italy coincided with law 180 on the closure of psychiatric hospitals and the processes of deinstitutionalisation. The activities of CoPerSaMM have always been aimed towards the development of a culture critical of the health and social institutions and policies, in defence of the most vulnerable social groups and against institutions which exclude them (CoPerSaMM 2017).

At local level, the work carried out by the local **Aid and Service** association, which operates in the Yanqing area in the district of Beijing, was very important in promoting social and community welfare. Its contribution was decisive in the creation of a network of local associations and bodies dedicated to the promotion of community mental health.

In addition to these main contributors, many institutional operators from the health and other sectors collaborated at local level and helped make it possible to implement the activities involved in the project.

- Aid and Service - general information [online] (url http://www.wholeheartedchina.com/?p=94) (accessed January 14, 2017)
- AIFO (2015) Italy Annual Report 2014, AIFO Bologna : 2-20
- AIFO - general information [online] (url http://www.aifo.it/progetti-nel-mondo/area-geografica/asia) (accessed January 14, 2017)
- CoPerSaMM - general information [online] (url http://www.confbasaglia.org/la-conferenza/) (accessed January 14, 2017)
- Solis - general information [online] (url http://www.solidarietaeservizio.it/ita/progetti-nel-mondo/asia/cina-24.html) (accessed January 14, 2017)

Legislative Framework

In the course of the six years of the projects, we had to deal with the considerable differences between the legislative framework applicable to the Chinese health system and those prevalent in the European countries, and in Italy in particular, where there have been radical changes at legislative level over the years with respect to the 20th century model of large psychiatric hospitals.

2.1 – Mental health in China

From the second half of the twentieth century up to contemporary times, outside the big Chinese cities and metropolitan areas, the prevalence of a traditional conception of medicine has blurred the difference between mental disturbances and physical illnesses and disabilities (in accordance with the principles of traditional Chinese medicine), and "psychiatry" was mainly limited to playing a role of social control (PARK 2005). People with psychological problems were historically seen as a threat, and the high level of stigma contributed to the concealment of the condition, reduced economic investment to the minimum and silenced all discussion of the rights of people with psychosocial disabilities.

From the fifties up to the era of privatisation, the organisation of the mental health services was therefore based on the dichotomy between inclusion in generic primary care institutions (in rural areas) and psychiatric hospitals (in the urban zones). In the course of the years, these institutions, initially set up in the main urban centres and later increasing in size, underwent changes and reforms, especially after the changes which took place in the economic system by means of market liberalisation. At the end of the nineties, the main consequences of the radical reforms of the health system after privatisation were on the one hand the gradual reduction in the number and capacity of the psychiatric hospitals, for reasons of a merely economic nature, without implementing new organisational strategies (LIU 2011), and the virtual disappearance of mental health assistance in rural areas on the other (PARK 2005).

However, some of the major changes also had repercussions in the mental health sector. The approval of the first national plan for mental health in 2002 opened the way to the

creation of an authentic legislation on this matter, with the setting up of an effective network of mental health services and the training and preparation of the service operators.

Shortly afterwards, in 2004, "programme 686", which took its name from the initial financing initiative[1], and was gradually extended in the course of the years, was the first real project for the training of operators, definition of standard therapeutic procedures and implementation of services aimed at the entire population with mental health problems (severe disturbances). The fragility of the operator training programmes was particularly alarming. In the first decade of the 21st century, there were just over 16,000 psychiatrists in China[2], with a dramatic shortage of specialist and trained personnel (LIU 2011). The programme, which was implemented in 30 cities and 30 rural areas in 2005, was extended to 160 cities within the space of only 5 years, covering 330 million inhabitants (GOUNON 2016).

Slowly but surely, then, there was a growing interest in mental health in the country in the course of the previous decade, partly as a response to cultural and social changes.

The estimate of the overall burden of mental disturbances on the society had intensified in the course of the years, from the low figures contained in the WHO research reports presented at the start of the new century (DEMYTTENAERE 2004) to the higher levels of the more recent research, which place mental health problems among the main causes of long term disabilities. Of the first 20 causes of long term disabilities, seven[3] are mental health disturbances (YANG 2013).

The epidemiological variation described in the course of the previous decade had to be considered alongside the process of economic growth, which progressively, even though with a clear disparity between the highly urbanised centres and the rural areas, shifted health requirements from the infective diseases towards the pathologies and disturbances more typical of higher income countries, such as cardiovascular problems, tumours and the various acquired disabilities, including psychosocial disturbances. The

[1] The initial financing for the project was 6.86 million CNY (LIU 2011)
[2] Around 1.2 per 100,000 inhabitants, as against the world average of 4.15 per 100,000 (LIU 2011)
[3] Major depression, alcohol-related disturbances, schizophrenia, anxiety-related disturbances, bipolar disorder, dysthymia, and drug use (YANG 2013)

speed of socioeconomic change itself was therefore a determining factor in the area of health, as testimony to the increasingly close link between the intense urbanisation of recent decades and the need to set up mental health services capable of dealing with the challenge of the times (CHEN 2015).

To convey an idea of the extent of this challenge, we need merely recall that it was estimated at the start of the decade that 173 million Chinese suffered from a psychological disturbance, and that only a very small minority of them (around 10%) received treatment (XIANG 2012), precisely because of the great geographical disparity between the metropolitan and rural areas, the shortage of personnel and the social stigma involved.

While China was one of the countries that was quick to sign the Convention for the Rights of Disabled People in 2008, and has made considerable progress in the implementation of the principles that it contains (ONE PLUS ONE 2012), by means of political and economic initiatives, in the area of mental health, on the other hand, the legislative initiative appeared to be at a standstill for several years, and even the statistical analysis of requirements was limited to national surveys dating back to the early nineties (XIANG 2012).

It was in this complex economic, political and social context, then, that the organic regulations on mental health were approved in 2012, representing a real turning point in the sector.

2.2 – A new law

In the spirit of the WHO guidelines, the main objective of mental health legislation is to protect, improve and sustain the wellbeing and mental health of the community. Those who suffer mental health problems have greater difficulty than other people in gaining access to the treatment they need, due to the stigma involved, economic marginalisation or other impediments linked to psychosocial disabilities. In addition, they often experience difficulty in exercising their rights and freedoms, both inside the health service and elsewhere (FREEMAN 2005).

The regulations currently in force in China are the result of a cultural debate which lasted for all of 27 years. Since 1985, the legislative proposals were reviewed on 15 different occasions, up to the most recent legislative initiative, which was finally approved by the National People's Congress on 26 October 2012, and came into force in May of the following year (XIANG 2012).

It consists of 85 articles, subdivided into 7 parts, which systematically cover the areas of prevention, diagnosis, treatment and rehabilitation of mental health disorders, and which refer in particular to the use of mandatory treatments. There are also two sections dedicated to legal shortcomings and the specific measures necessary to implement the regulations (CHEN 2012).

The aims of the regulations, as described in article, which clearly take up the international guidelines, are the promotion of mental health, the definition of the service standards and the protection of the civil rights of those with psychosocial disabilities. Article 4 refers to the safeguard of the dignity, physical health and property of people with psychological disturbances, and the regulations in general appear to make a significant effort to build up a legislative framework on mental health, by focusing on respect of the rights of those involved.

More specifically, in terms of respect for human rights, concepts such as individual liberty, freedom of choice, privacy and protection against discrimination are referred to in the regulations, in such a way that they can be compared with other regulations aimed at the development of policies regarding civil rights. If we analyse the regulations with the support of Equiframe[4], we can give them a rating of *moderate*[5]. The regulations include many key concepts within the area of human rights (with a quality coefficient of 76%), even though it falls short when it comes to explicitly naming a large number of groups with specific difficulties in gaining access to the services (there are no references to the large number of internal migrants, the elderly or ethnic minorities, for example) (HUSSEY 2016).

[4] Equiframe is a tool for the systematic comparison of policies, which can be used to assess the presence of 21 core concepts relating to human rights and references to 12 of the most vulnerable minoritary groups in terms of rights, and which provides a percentage points score which can be used to assess the quality of the legislative framework with respect to the standards laid down (AMIN 2011)

[5] The tool provides an overall points score subdivided into three levels - "high", "moderate" and "low" (HUSSEY 2016)

As well as its shortcomings in terms of general equity, the 2012 law can also be specifically analysed on the basis of these fundamental aspects:

- The introduction of legislation on voluntary and mandatory mental health treatments and restraint.

  Many articles (articles 30 and following) introduce the concept of voluntary treatment accepted by the patient and his or her guardian as a general method of admission to a psychiatric hospital. If however a person with mental health problems could pose a risk to others or cause harm or injury to himself, the possibility of enforced treatment remains, and the regulations have nothing to say on its duration. Mandatory treatment is however governed by the possibility of seeking a second medical opinion (article 32), on the basis of an assessment by two psychiatrists who did not take part in the initial psychiatric examination. The law also provides for a third level, where the assessment takes place by a commission certified as independent, consisting of at least two professionals. A distinction is also drawn between those who could cause harm to themselves (who may be discharged at the risk of the guardian) and those regarded as a threat to others, who have to be placed in custody by the forces of public order (article 35). The use of physical restraint is permitted "if no alternative measures are available", but this is specifically prohibited as a punitive measure. From this point of view, the regulations take a more solid approach to the rights of individuals in their relations with the institutions treating people with mental health problems.

- Definition of three areas of intervention in mental health: prevention, treatment and rehabilitation.

  The regulations define the area of intervention of prevention within the community, in the workplace, prisons and schools, and also focus on reinforcing the registration procedures for those with severe psychological disturbances. Up to 2016, more than 4 million people at national level were registered as suffering from disturbances of this nature (Article 24) (GOUNON 2016) .

  A major effort has been made to promote rehabilitation through the community (article 54), even though many of the articles appear to be mere declarations of

principle, such as the request made to employers to engage people with mental health problems and guarantee them equal rights and pay (article 58).

- Work in the community and promoting the integration of people with mental health.

  The attempt to shift the focus on mental health from psychiatric hospitals to the community is evident however in the many articles dedicated to encouraging institutions and society to act against stigmatisation in the community and promote the integration of people with mental health problems (GOUNON 2016).

The legislation in force since 2013 therefore represents an attempt to lay down the guidelines for the future organisation of mental health services in China, through an ambitious, durable instrument. The law addresses the question of human rights by creating the conditions for sustainability of the services aimed at the general public (LIU 2016) and promoting the activation of formal and informal institutional resources through a pragmatic approach which takes the modern evidence into account (PHILLIPS 2013).

The regulations are more of a general framework than a real and immediate instrument of change, however, in a health system in which very serious social, geographic and economic disparities remain. By way of example, in Shanghai in 2014, there were around 82 beds available in psychiatric hospitals for every 100,000 inhabitants, a level similar to that of Singapore, while in the northern province of Hebei the figure was 1 bed per 100,000 inhabitants.

Statistics on the mental health services in China in 2014 (PATEL 2017)	
Number of psychiatrists per 100,000 inhabitants	1.7
Number of mental health nurses per 100,000 inhabitants	3.1
Number of beds in psychiatric hospitals per 100,000 inhabitants	16.8
Total psychiatric hospitals	728
Average number of beds per psychiatric hospital	323

2.3 – The 2015-20 national plan

After the approval of the law, China found itself with a more effective means of facing the serious disparity in practices within the country, recruiting and training sector specialists and involving the institutions in the activities promoted by the new legislation.

The tool in question is the National Mental Health Working Plan (2015-2020), which was approved in June 2015 (XIONG 2016) and contains a number of important new provisions and commitments:

- Intervention on the most common mental health problems

  Unlike the framework law, which mainly focuses on severe psychological disturbances, the plan also attributes importance to work on the common psychological and behavioural problems (XIONG 2016), and focuses in particular on the prevention and treatment of a number of mental health problems which it defines as priority objectives - depression, autism and dementia (LANCET 2015).
- Commitment to the treatment of the more severe disturbances

  In the case of severe mental disturbances, the objective declared in the registration plan is to make contact with 80% of the population suffering from schizophrenia by the end of the 5-year period (XIONG 2016).
- Promotion of community mental health

  On the matter of long term rehabilitation, the aim of the plan is to extend the presence of community based public rehabilitation structures to 70% of the provinces, with a view to reaching at least 50% of users (XIONG 2016).
- Investment in training

  The highly ambitious programme for dealing with the shortage of personnel aims at nearly doubling the number of registered psychiatrists (bringing it up to 40,000 by 2020), but this may be difficult to achieve, as the budget set aside for such a complex training programme is not immediately clear. At the moment, training is carried out by the Chinese Psychiatrists Association, which organises courses for 1000 people per year (GOUNON 2016). Without a reinforcement of the programme, it is difficult to imagine how the aim of more than doubling the existing training capacity can be achieved.

- Primary prevention

  Other important points in the programme are the implementation of telephone help lines and crisis operating teams in all the provinces, and the setting up of a psychological support network in the schools (HUA 2015).

On the matter of economic sustainability, the programme instructs all the administrative levels to identify a budget (XIONG 2016), with a view to ensuring the procurement of the funds necessary to implement the mental health services, and to encourage the procurement of funding through public and private collaboration mechanisms.

2.4 – Consideration

Overall and at legislative level, in the last five years China has shown that it is prepared to take up the challenge created by the internal, social and health changes in the area of mental health, by making a systematic attempt to define its commitment to achieve the requirements of the modern international standards.

There are still many obstacles and complexities in the way, however. There is still an enormous disparity in the country's services and infrastructures between the more densely populated coastal area, which includes the main cities, and the rural areas and interiors, as well as a significant socioeconomic barrier in terms of access to treatment and rehabilitation, while the attempt to get rid of the stigma of mental disease is still in the early stages.

The training of personnel is one of the main challenges for the future. In China, 29% of psychiatrists undergo only 3 years of postgraduate training (LIU 2016), and the training processes are still insufficient for the requirements of the population (GOUNON 2016).

The public sector is the main supplier of mental health services. It directly controls 86% of beds and 70% of all mental health structures (LIU 2016), but so far the decision expressed in the regulations to invest in the creation of community based centres has only had a minor impact on the dominant presence of psychiatric hospitals, which absorb the majority of the personnel and total funding, and look set to continue to play the leading role in care and treatment. The part played in mental health in the future by the

associations and non-state operators may turn out to be crucial for the promotion of sustainable long term policies focusing on rights.

Within this context, the merit of the initial phase of the project run by AIFO and its partners was the creation of the drive towards experimental approaches to community mental health care. In the second phase, the focus shifted to the reinforcement of the capacities of the stakeholders and non-state operators to take part in the processes of evolution and promotion of mental health in China.

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The Project

This section offers a brief summary of the first three years of the project and presents the programme for the second three years, whose results will be examined in greater detail, with a description of the experiences obtained in the various provinces involved.

3.1 – The first three years, 2011-14

In 2011, SoliS and its partners began their activities in community mental health with a project entitled Community-based Psychiatry: promoting the integration of mental health care into primary health services in three districts of China, whose aim was to promote the setting up of community mental health services in three local health districts situated in different geographic areas of China.

The territories involved were very different from each other: Haidian, an urban district of Beijing with 3 million inhabitants, Nanguan, a district of the city of Changchun, in Jilin province, and the city of Tongling, in Anhui province (SAULLO et al 2014).

From March 2011 to February 2014, the programme promoted the creation and implementation of two different types of community mental health services (LORATO et al 2014):

- The Community Mental Health Units (CMHU): these are local units mainly located in primary care centres, offering a network of essential services within the territory. As in the case of Italian community mental health, these day centres offer therapy, assistance and rehabilitation, and are dedicated to assessment, monitoring, pharmacological treatment and social rehabilitation, involving education and support in the homes of the subjects. In the future, the CMHUs could become the first point of contact for those expressing a need for care and to be listened to, and at the same time the place of assessment and the setting up of care, thus reducing the need for psychiatric treatment in hospitals.

- The Residential Open Units (ROU): these are residential units which offer community and social rehabilitation for people who have suffered severe mental disturbances over medium to long periods (6-12 months). The ROUs are an attempt to experiment with community residence situations for small numbers of people, aimed at offering solutions other than long term internment in a psychiatric hospital. The ROU residents play an active part in the running of the small community, and are free to go out and receive visitors, work and engage in hobbies.

CMHUs opened in the 2011-14 period (SAULLO 2014)				
	HAIDIAN	NANGUAN	TONGLING	TOTALE
CMHUs in 2014	26	2	4	32
CMHUs opened by the project	14	2	4	20
Users registered i the 20 new CMHUs	3083	230	149	3462

The demanding process of opening a CMHU was certainly unable to have much impact on the central role played by the psychiatric hospitals, and these units have not escaped criticism, especially in terms of personnel training, the exclusive nature of the units and the poor opening hours. However, the new type of service does appear to have had a positive effect on the users and operators, by introducing awareness of a new model and the possibility of bringing good practices into mental health services (SAULLO 2014).

ROUs opened in the 2011-14 period (SAULLO 2014)				
	HAIDIAN	NANGUAN	TONGLING	TOTAL
ROUs active in 2014	5	1	1	7
Places occupied/ total places	55/65	4/4	10/10	69/79

The opening of the ROUs was even more complex and difficult. The rigidity of the regulations and the considerable resistance at institutional level limited the number of units effectively opened in the three year period, even though some of the activities, including the residential programmes, deserve a special mention, due to the fact that they were able to operate in spite of the difficulties involved in establishing themselves in a complex context dominated by institutional structures.

The case of Villa Rosa is an example of a long term community experiment within a substantially rural setting on the outskirts of Beijing. Set up in 2009 on the initiative of AIFO and SoliS, Villa Rosa was the key experiment for the project, providing a location in which it was possible for the operators, guests and their family members to collaborate (SoliS 2017).

During the first three years, it was very important to offer the operators and other stakeholders the chance to undergo training in Italy, in the form of a visit to the mental health service structures of Brindisi and Trieste, and a series of courses on community mental health techniques and policies. The direct experience of a situation in which deinstitutionalisation has brought about a radical change to the model was an opportunity to begin to see institutional practices in a critical light, which in turn was necessary as a means of sowing the seeds for effective reform. At the level of local training, a model was introduced in which the shared experiences of operators, users and family members contributed to the creation of common knowledge and the breaking down of the stigma surrounding mental illness.

By March 2014, we could therefore say that the objective of setting up experimental community health services in three districts of China was achieved. The value of these

activities consists not only of the practical and assistance aspects, but also the possibility that the critical reflections on mental health matters by the managers, operators, users and family members involved might lead to an extension of the experiment.

Within this operating context, and given the urgent need for training, for the critical reflections to be extended to a broader group of subjects, and for new provinces to become involved in the project, AIFO and its partners obtained funding for a second project entitled "Strengthening the role and capacity of Chinese non-state operators towards rightful inclusion in the society of people with mental health conditions", again financed by the European Union (SoliS 2016).

3.2 – The second three years, 2014-17

The initial intentions for the second project involved two central aspects. On the one hand, the continuation and reinforcement of the previous project, focusing the attention on the promotion of new services and support for those already operating in the districts of Tongling and Nanguan, with the opening of new units in Harbin and Yanqing, and on the other, the setting up of a network of non-state entities and bodies to promote community mental health projects and policies.

The objectives can be summed up as follows (IZQUIERDO RODRIGUEZ 2016):

- To facilitate the integration of mental health services into the primary care network, through the promotion of the CMHUs
- To facilitate rehabilitation and social and occupational inclusion for people with mental health problems, by means of social cooperation and other methods, with a view to promoting inclusive enterprises
- To empower the users and their family members to set up their own organisations and sustain the advocacy process
- To spread and promote good community mental health practices through a network involving research institutes and scientific centres
- To improve the supply of information to the general public on community mental health services and how they operate

To these general objectives it was also necessary to add the attempt to set up an innovative network of non-state organisations operating within the territory, with the explicit aim of proposing a change of model in the area of mental health. The starting point here was the involvement in the project of local partners with the specific research and development skills in community mental health services. The work therefore began with the reinforcement of the skills and capacities of the local partners, Aid and Service and PUIMH, which were called upon to play a key role in the setting up of a local network for the promotion of mental health. This commitment affected all the project activities, and involved the setting up of a website for the coordination of the work and the creation of a platform through which the work of all those involved could be seen as part of the general whole.

These objectives involved the implementation of a considerable number of actions over the three year period, subdivided into the following areas (AIFO 2013):

- Creation and reinforcement of the capacities of the local operators

  Chinese society has many figures, institutional and otherwise, who require training and an improved ability to engage in discussions on the key subjects of deinstitutionalisation, community mental health, and the adoption of models based on a non-custodial approach to psychiatric treatment, in a situation in which the mentally ill are no longer seen as a threat to society. The aim is to encourage the development of entities and associations which are able to act as catalysts in the development of mental health policies and practices which are consistent with the most advanced possibilities made available by national legislation and the international convention on the rights of disabled people.

  This area also includes seminars for the training of the operators, users and their family members who work in and make use of the mental health services whose activities were promoted by the initiative.

  Training was one of the most important aspects of the project. It took place under the supervision of experts in the key practices of community mental health, with experience of deinstitutionalisation and the setting up and implementation of emancipation and inclusion processes and programmes (CoPerSaMM 2017).

- Support for autonomous livelihood planning

  This is a group of activities aimed at creating a context in which people are able to integrate as effectively as possible into the social fabric, in spite of the difficulties faced by them. The view taken was that it was important to invest resources in the creation and implementation of existing inclusion programmes and for experiments in new, income generating "social enterprises", in which people with mental disturbances could take part. Better social integration and earnings capacity for people with mental health problems are crucial for the improvement of their health and living conditions, and this is one of the WHO guidelines for the development of the sector (WHO 2001).

- Advocacy

  Ensuring the long term sustainability of high cultural impact initiatives such as that carried out by AIFO in China means dealing with a complex, multi-faceted society, its culture and its points of resistance to change. The organisation of workshops for professionals, local authorities and disabled people, the creation of self-help groups and the promotion of associations of users and their family members are some of the activities aimed at rooting a culture of mental health in Chinese society, removing the stigma surrounding mental illness and encouraging inclusive practices. The promotion of associations of users and their family members is the fundamental factor in the development of innovative policies in the area of disability (WHO 2003).

- Research, information and networking

  The final task was the creation of a network linking academic and other institutions, aimed at research in community mental health and the spread of information on the good practices implemented in the programmes. This involved the setting up of a website (wholeheartedchina.com, 2017) and the distribution of videos, documents and products for the international exchange of ideas and experiences developed over the three year period.

The sections which follow describe some of the main activities in terms of training in the field and overseas. We will then dedicate a specific section to each district involved, with

a view to taking a closer look at the nature of the programme and the differences in its application within the various territories.

3.3 – Training activities in China

As discussed in the previous sections, China has a huge training deficit in the area of mental health in general and community mental health in particular. With few exceptions, the operators come from the public sector, and are mainly involved in custodial treatment based on psychiatric hospitals. One of the fundamental aims of the programme was, and still is, to guarantee the development of a culture of deinstitutionalisation and adequate training in community mental health for the operators and other stakeholders.

- Seminars on deinstitutionalisation

  Two important seminars were organised on the question of deinstitutionalisation (AIFO 2015, AIFO 2016), in October 2014 and October 2015. The seminars took place in Beijing, and were attended by dozens of participants, experts from PUIMH and Italy (CoPerSaMM), the directors of the district health structures involved, local authorities and institutional representatives, along with operators, associations and other stakeholders. During the events, it was possible to reflect on the notion of deinstitutionalisation by examining the experiences of the process in Italy, in both organisational and regulatory terms, and assessing the effects of the change of model on the activities of policy makers, mental health operators, users and their family members, not only in health terms but also, and above all, in relation to social inclusion and the setting up of associations, as well as the challenge of creating and sustaining income generating enterprises which recruit people with psychosocial disabilities (CARENA et al 2014).

  In Italy, the process of deinstitutionalisation speeded up considerably after the approval of law 180/78 on the closure of psychiatric hospitals and the inclusion of people with mental disturbances in civil society. From that time onwards, the country developed a community-based mental health service model, not without

its difficulties but with a number of points of excellence, which are in the avant-garde in the attempt to construct mental health models which focus on individual rights. The seminar was therefore the ideal occasion for the discussion of another piece of legislation which brought about a cultural change - the new mental health law approved in China a few years previously, which opens the way to a mixed model, in the hope that the vision based on hospital and custodial treatment will be abandoned in favour of community-oriented mental health services.

- Training courses for operators and users

  Specific training courses for the operators involved in the projects were organised in Harbin and Yanqing (AIFO 2015, AIFO 2016). In both cities, the project was the first experience of community health for the vast majority of those involved. Most of the ROU and CMHU personnel took part in the courses, along with the users and their family members. Acknowledging the experience of the users as a resource for the service as a whole and extending it into the area of training represents an attempt to promote a different organisational model. For this precise reason, the users and their family members accounted for nearly half of those attending the courses. The contribution in both years from PUIMH trainers created continuity in the learning process, with the introduction of matters with a powerful impact in daily life, such as relations with family members, group management and support for research.

- Training in the field

  Training was organised in March and October 2015 for the operators, users and their family members in the four districts. The training initiative involved around 30 people in each district, and was aimed at improving the management and effectiveness of the services implemented in the territories. The trainers were selected by Aid and Service and had previously been involved in Villa Rosa, the first ROU of the project, currently based in Yanqing. The course programme focused mainly on everyday life in the ROUs (AIFO 2016).

- PUIMH support visits

  Three experts from the University of Peking (two operators and an expert user) visited the four districts to assess the progress being made and discuss the

services already set up with the operators, users and their family members. A total of six visits took place in 2015, two to Harbin and Yanqing and one to Tongling and Changchun.

- Visits by Italian experts

  Once a year in 2014 and 2015, Italian experts with specific skills in community mental health, the promotion of user and family associations and the management of cooperatives and social enterprises visited the districts, with a view to sustaining the initiatives and assessing the strong points and critical factors emerging during the implementation of the project, and to provide further training and knowledge through specific seminars. After each visit, the experts presented brief reports, which will be used to describe the progress made in the single units involved in the project over the three year period.

3.4 – Training in Italy

The programme enabled the operators, managers, politicians and representatives of civil society in the districts involved to come into direct contact with Italian mental health services and receive training in Italy, with the collaboration of operators specialising in community work. The visit concentrated on Brindisi in Puglia and, above all, Trieste in Friuli Venezia Giulia. Two groups took part in the spring 2014 course, with representatives from Harbin and Yanqing, and in 2015 a group of operators, users, family members and representatives of the base associations from Harbin returned to Trieste for a second contact with the Italian services.

The Italian mental health services underwent enormous changes after the start-up of the deinstitutionalisation process in the seventies. Currently, on the basis of the 1999-2000 Objective Mental Health Protection Project 1999 - 2000, the Department of Mental Health (DSM) is the organisational model for psychiatric assistance for the adult population (DELL'ACQUA 2009).

The DSM is the series of operating structures and activities which responds to the mental health needs of the population of a given territory. The size of a territory covered by a

DSM is variable, but it normally coincides with that covered by a local health trust (PICCIONE 1995). The structures making up the DSM are:

- the Mental Health Centre (CSM), which is the cornerstone of the system, with responsibility for care, therapy and rehabilitation for all those with mental health requirements. The opening hours vary considerably from one region to another, but the national directives state that the CSM has to be available for outpatient and home visits at least 12 hours a day, 6 days a week (DELL'ACQUA 2009). In some areas, the central role played by the CSM as a "low threshold" structure capable of identifying needs and providing the therapy and rehabilitation required has led to models in which the CSM, open 24 hours a day, 7 days a week, also provides temporary hospitality for those requiring protection and special assistance. This is the case in particular in the Friuli Venezia Giulia region, where the model is based on the experience of Trieste, the cradle of Italian deinstitutionalisation. The 24 hour CSM provides 6 – 8 beds for users in crisis, and the personnel also offer psychiatric assistance to those users (DELL'ACQUA 2009).
- the Psychiatric Diagnosis and Care Service, located within general hospitals to supply a response to acute situations. In various Italian centres, this structure is used to treat users in crisis. For many centres, it plays a fundamental role in the service network (GENERAL HEALTHCARE DEPARTMENT, 2016).
- the intermediate rehabilitation structures, consisting of day and community centres and home groups, and dealing mainly with residential needs.

In 2015, more than 1,200 territorial services, more than 2,200 residential structures and 900 semi-residential structures were in operation (GENERAL HEALTHCARE DEPARTMENT, 2016).

On 31 December 2014, the public psychiatric operating units in Italy had a workforce of 29,260. 16.9% of the total consists of doctors (psychiatrists and other specialists), with coverage of around 8 per 100,00 inhabitants. Nursing personnel make up the bulk of the workforce (45.8%), followed by social health operators, accounting for nearly 10.6%, psychologists (7.6%), occupational educators and psychiatric rehabilitation technicians

(6.5%) and, finally, social workers, with 4.4% (GENERAL HEALTHCARE DEPARTMENT, 2016).

The reason for a visit to Italy therefore derives from the need to demonstrate the workings of a system which has gone beyond psychiatric hospitals and which has set up a network of territorial services which have been in operation for several years. During the visit, meetings were arranged with the political and institutional representatives of the cities, regions and health trusts, as well as contacts with the associations involved in the promotion of civil rights and mental health. Visits were also paid to Italian mental health service centres, with discussions on how these are organised and the principles on which they are founded.

The Department of Mental Health of Trieste, where visits took place in 2014[6] and 2015, is one of the most advanced examples of the application of the Italian model of community mental health. Set up in 1981, its origins are rooted directly in the closure of the local psychiatric hospital, promoted by Basaglia and his collaborators between 1971 and 1977. It currently consists of 4 mental health centres, one psychiatric diagnosis and care service, the rehabilitation and residence service, the university psychiatric clinic, and the departmental nursing service, as well as housing the WHO collaborator centre (Department of Mental Health, 2017). The entire department follows a policy based on strong territorial commitment aimed at recovery, zero restraint and an open door philosophy.

During their time in Trieste, the visitors came into contact with the operating mechanisms of the department, visited the mental health centres, spoke with the operators and representatives of the user and family associations, attended seminars on deinstitutionalisation, self-help, work, resources, budgets and other matters, and were able to experience real life rather than theoretical situations.

The visits to Italy were therefore an opportunity for the participants to evolve towards a position more favourable to the change of model. They also received training through which the Chinese stakeholders were able to view some of the most advanced work being done on community mental health at first hand.

[6] In 2014, the Department of Mental Health of Brindisi was also visited.

3.5 – Considerations

This general presentation has focused strongly on the role played by the training offered during the project. The processes of deinstitutionalisation are inherently interwoven with the capacity to create awareness within the technical, policy and user contexts of the need to change the model and set up the practices required as a result.

Both the local operators and trainers acknowledged the importance of the visit to the Italian services as an opportunity for new awareness, with particular reference to the rights of people with mental disturbances, all of which forms part of the tradition of *Come and see Trieste* as the main means of knowledge of the practices of deinstitutionalisation (COLUCCI 2001).

We should also emphasise the huge commitment to training in each of the four districts where specific activities were implemented, while the progress made in the development of community mental health varied from one district to another.

In the sections which follow, we will present some of the main results achieved by the project in the single districts, based on the local reports and expert assessment. We will pay particular attention to the support supplied to the new structure and the creation of organisations to enable the users and their family members to take part in the therapeutic projects and policy decisions.

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Tongling

Tongling is a city of medium size (730,000 inhabitants), situated in the province of Anhui, through which the River Yangtze flows. The city is built on the riverside and there are renowned tourist destinations nearby (Tongling 2017). The city is famous for copper mining and processing, and the entire province has mining traditions linked to iron ore and coal extraction (Anhui 2017). By comparison with the neighbouring provinces, Anhui has not experienced the rapid economic growth of the eastern part of China, and the per capita GDP is only a third of that of the nearby Zhejiang and Jiangsu provinces (Anhui 2017).

Along with Chanchun, this is one of the two areas in which AIFO and its partners have been operating for the longest period of time - 6 years in total.

4.1 – The services developed

In the urban area, it was possible to set up 4 CMHUs and 1 ROU in the first three year period, thanks to the contribution of general practitioners and the commitment of the psychiatrists and operators at Tongling Third People's Hospital.

The ROU located within the psychiatric hospital complex is able to accommodate a maximum of 10 people, all men. The ROU is run by two nurses and a number of volunteers, some of whom were previously users of the mental health service. However, the difficulties in terms of shortage of human resources, selection of spaces and economic support made it impossible to set up a second residential unit outside the hospital complex (TONG et al 2015).

During the second three year period, two additional CMHUs were completed, to back up those in operation since 2013. The two new units have more than 200 registered users (TONGLING GROUP 2015), and the operating personnel were selected with the assistance of a number of village doctors. The specialist commitment to the territorial services is still very limited, however, with a psychiatrist from the hospital visiting the CMHU once a month (COLIZZI 2015).

Unfortunately, the problem of the location of ROU has not been resolved, and is typical of many of our experiences in Chinese districts. The opening of residences outside the hospital complex comes up against strong resistance, due to the stigma felt by society and the operators, which creates obstacles to the removal of mental health care from the traditional institutions. This was particularly evident in Tongling, where these views, in combination with the chronic shortage of dedicated personnel, put a halt to the setting up of a second ROU and limited the extension of the programme.

4.2 – Participation and inclusion

The commitment to training and the training courses organised in the field in Tongling, as in the other districts, was intense, and enabled us to continue the training programmes set up during the first three year period. In March 2015, a group of operators paid a visit to Harbin to take part in a joint training course on occupational and social inclusion. This was also attended by a number of local businesspeople, who were interested in the implications of the new regulations (AIFO 2016; DEL GIUDICE 2015).

The local start-up of user participation was very difficult, however. In March 2015, no effective work with the family areas or on self-help had taken place (DEL GIUDICE 2015). During the spring of that year, however, after a manager had been put in place, a working plan was drawn up with a precise series of time limits, aimed at setting up a user and family organisation. This later acquired its own internal structure and became able to promote initiatives and projects. In October 2015, it had a large number of members (40 in total, including 16 family members, 13 patients, 3 business people and 7 district operators, in addition to the coordinator), even though the participation is still insufficient and the initiative has little impact on the local society (COLIZZI 2015).

Specific projects aimed at social and occupational inclusion do not appear to have been implemented in the Tongling project, and in this sense the Italian experts have identified a number of cultural difficulties. The operators present the activities by patients to support the hospital personnel or other simple tasks as "work", to be carried out in exchange for modest payments (DEL GIUDICE 2015). By way of a countertrend, there are signs of direct commitment on the part of the Federation for Disabled People to sustain

the recruitment of disabled people in the workplace, even though the percentages applicable to people with mental disabilities are not clear (COLIZZI 2015).

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Changchun

Changchun is a large city in Jilin province, in north eastern China. The city, whose name means "eternal spring", became a major industrial and metalworking centre in the 20th century, with a number of automotive installations (Changchun 2017). Due to the local abundance of raw materials, it was able to undergo rapid economic growth after the reforms of the eighties, which is still going ahead today (Jilin 2017).

Changchun is one of the two areas where AIFO and its partners have been operating since 2011, when the training activities and promotion of new services began.

5.1 - The services developed

During the first three years of the project, two CMHUs and one ROU were opened, this latter in Changchun psychiatric hospital (SAULLO 2014), as is the normal practice, for the reasons described above. Attention has been paid however to the decor of the rooms in the ROU and an attempt has been made to give them a community atmosphere.

During the second three year period, an additional ROU and CMHU were opened. The CMHUs state that they make home visits (the number is variable and depends on the nature of the psychological disturbance), but problems remain in setting up a dedicated team. The long term strategy declared is in any case to continuing to open community mental health services and to stop all increases in the number of hospital beds (DEL GIUDICE 2016). However, this requires the use of premises and personnel from the primary care network, whose training still appears to be insufficient.

Among the critical factors which have emerged, the territorial rehabilitation services contine to be based solely on socialising and entertainment (PUIMH 2015), without focusing on life planning or at least on the achievement or recovery of specific abilities.

The new ROU, located outside the hospital, has space for 4 guests and can be defined as an "intermediate structure" acting more as a day centre used in the mornings by various people using it as a social centre. It acts as a residential unit only on occasions, to deal with situations at risk of crisis, and is able to house a user accompanied by a family member for a short period of time (COLIZZI 2015).

While the functions which appear to have been taken on by the Changchun ROU are useful for the purpose of the development of territorial services, we have to consider to what extent a structure of this kind may be useful. Within this context, it becomes an intermediate, or post-critical structure rather than a residential unit used to facilitate the discharge of long term patients from a psychiatric hospital. While on the one hand the commitment to opening a ROU outside the psychiatric hospital has been achieved, on the other it fails to resolve the problem of how to deal with those leaving long term hospitalisation.

5.2 - Participation and inclusion

Six years after the start-up of the project, various activities have been implemented in the district aimed at bringing about user and family member participation and social inclusion. Some of the managers and technical specialists who have come into contact with the project have been directly involved in drafting the regulations for the application of the mental health law (DEL GIUDICE 2016).

More than 50 people attended the meeting organised on the subject of employment, including three small business owners. This demonstrates the careful attention paid to the question of social rehabilitation (COLIZZI 2015). A small cafeteria has been in operation in the entrance hall of the hospital for some time, run by two users who are able to share the takings, even though it seems that this can only partially be defined as real paid employment (DEL GIUDICE 2016), while the other initiatives appear to be aimed more at the acquisition of skills within the context of the day to day running of the hospital than occupational rehabilitation.

The organisation set up during the three year period, on the initiative of one operator in particular, had several dozen members from the outset, but it requires continuous

technical assistance to make up for the low levels of participation and the difficulties experienced by users and operators alike to imagine the significance and potential of organisations of this kind (COLIZZI 2015; PUIHM 2015). At the present time, after the specific training organised during the project, it seems that a number of activities have been implemented, linked to the holiday calender in particular, with some attention paid to the supply of information on mental health matters (DEL GIUDICE 2016).

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Harbin

Harbin is a city in the province of Heilongjiang, in the extreme north east of China, rich in oil resources, with a very severe climate and on the border with Russia (Heilongjiang 2017). The city has a population in the region of 10 million, and its industries underwent rapid development as of the foundation of the People's Republic of China (Harbin 2017).

6.1 - Training in Italy

Training has been a decisive factor for the project in Harbin, partly because it was the first one of its kind for the operators and users involved, and partly because of the specific strategy set up at local level, with the development of a disabled peoples' organisation, followed by the setting up of a foundation which was able to finance training for seven people in Italy, which took place in July 2015 (COLIZZI 2015). The Harbin was therefore able to take advantage of two separate visits to Italy and specific training with Italian experts on deinstitutionalisation, with a significant impact on personal growth and in terms of knowledge within the groups of operators and users, and the creation of cultural and cooperative links (HARBIN GROUP 2015).

6.2 - The services developed

Harbin is a major metropolis in which psychiatric treatment takes place in large hospitals. There are 4 main psychiatric hospitals in the city, one under the control of the department of internal affairs, one dedicated to forensic psychiatry, and two run directly by the health services, one focusing on acute cases and the other on long term patients, with a total of 2,000 beds. Obviously, beds are also available in the general hospitals and there are a few private clinics. However, the territory of Harbin is very large and it can take hours to reach the nearest psychiatric hospital from the point furthest from the centre (DEL GIUDICE 2016).

In a situation so hugely biased towards institutional psychiatry, the three year experiment enabled small pockets of community-based mental health services to develop, in the form of CMHUs located within primary care centres and 2 ROUs.

The initial intentions of the local managers were for the first ROU to be of a temporary nature, as an experimental unit situated within the administrative area of a hospital (DEL GIUDICE 2015, COLIZZI 2015), while the second is outside the hospital, in a residential district, with only a few places available and run as a group apartment (DEL GIUDICE 2016). The projects here appear to be more long term, and the unit is frequented by day by people belonging to the local self-help group. This seems to be the best example of a residential structure in which an attempt has been made to recreate a domestic atmosphere.

The CMHU developments, and more particularly the new one, which was opened in Harbin after the second trip to Trieste, are a major advancement with respect to other initiatives. The new unit is open every day, and it has a common area and a more comfortable room where the intention is to receive people on a day hospital basis.

6.3 - Participation and inclusion

The first organisation of family members was opened very quickly in Harbin. Since its creation on 30 December 2014 (DEL GIUDICE 2016), hundreds of family members have attended meetings annd training sessions within the organisation, which has also set up the Heilongjiang Bozhu Aid Foundation for Persons with Mental Disorders in Poverty. Among its mental health promotion activities, this foundation has co-financed training in Italy and set up relations with other cultural bodies operating in the area of mental health. In October 2015, it signed a collaboration and consultancy agreement with CoPerSaMM.

Of all the organisations set up in the course of the project, the foundation is the most capable of carrying out advocacy initiatives. It is a non profit body accredited by government entities, and has 400 members, including psychology and psychiatry students, and one of its aims is to offer support for people who cannot afford medicines, by paying for the products on their behalf (DEL GIUDICE 2016).

Among the operations carried out in the course of the project, the self-help group which was set up after the trip to Italy on the initiative of a user has joined forces with the ROU in the residential zone. This is a very useful initiative which combines social events with the work done by volunteers from the group in the Buddhist canteen, where they receive visitors, do the cooking and serve the meals.

Still in the draft stage, but part of the declarations of intent, are a number of training and employment projects (DEL GIUDICE 2016) which could enable the users of the services to find paid jobs in the future.

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Yanqing

Yanqing country is a rural district of Beijing, situated in the north-western area of the municipality, with a total population of 270,000. The district is in a mountainous zone, rich in rivers and streams, and agriculture is an important part of its economy. In rural Yanqing, education and the availability of services fail to reach the levels of the urban districts (Yanqing 2017).

7.1 - The services developed

Villa Rosa, the model structure for the ROUs which the project set up in China, is in Yanqing. In operation for many years, this serves as a model for community mental health services in China. It occupies its current location thanks to the assistance of local institutions, following a number of transfers of premises, all of which were the result of difficulties experienced in placing it in residential areas. It consists of a number of structures, one for adults with mental health problems, a centre for orphaned children and a day centre for adult users. The project has opened another ROU in a village in the district, for resident guests who are offered assistance only during the day (DEL GIUDICE 2016).

The Yanqing CMHU is open 8 hours a day, 5 days a week, serves a population of 27,000 and has 192 registered users (DEL GIUDICE 2016). In this case too, there is a serious shortage of personnel. There is no dedicated psychiatrist, and the only specialist assistance is offered by two nurses with psychiatric training, backed up by general practitioners.

7.2 - Participation and inclusion

The organisation of family members is smaller than those in the other districts, but it appears to have succeeded in providing training for families, arranging discussions on its

activities and opportunities for entertainment and socialising (COLIZZI 2015). The organisation has also set up a self-help and support group. The meetings and other activities are subject to serious restrictions, however. They take place only in summer, with no events in winter. Other limitations are due to the fact that the majority of the members are involved in agriculture and have little time available for other activities (PUIMH 2015).

At occupational level, the results are promising, however. There is an agreement with a herbalist company, which enables the users to obtain experience in the cultivation of medicinal plants (COLIZZI 2015). Paid seasonal work is also available for short periods during the apple harvest (DEL GIUDICE 2016).

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Concluding Recommendations

In the previous sections, we described the major questions which AIFO and its partners have had to deal with and the results achieved in the four cities. There are significant differences between the four situations in application terms, and while there have been very interesting experiments and exemplary cases in terms of rehabilitation, there are also notable critical factors in terms of strategic vision and the ability to break away from the cultural models of traditional psychiatry.

There is still much to be done to transform the CMHUs into services capable of dealing effectively with the community health requirements, and the residential rehabilitation centres appear to be experiencing even greater difficulties than the demanding task of deinstitutionalisation.

In this concluding section, on the basis of an analysis of the comments by the Italian experts operating in the districts during the second three year period, we wish to present a number of recommendations for the implementation of a future project on community mental health in China, as well as points of practical guidance for the operators in the services already opened in the course of the project. Overall, these can be regarded as a possible route towards practices of deinstitutionalisation.

IMPLEMENTING THE SERVICES NETWORK

Deinstitutionalisation means more than taking the patients out of the psychiatric hospitals and closing them down, but also an important change in the way people with psychological disturbances are perceived. It involves scientific, legislative and administrative aspects, cultural reference codes and power-based relationships (ROTELLI 1988).

During the process, the object of psychiatry moves away from the mental illness and the notion that the patient is a potential threat to society to the suffering of the people concerned and their relations with society (ROTELLI 1988). A shift of this nature requires more than the simple closure of psychiatric hospitals. A whole network of alternative

services has to be invented, with their own structures, dedicated and suitably trained personnel and economic resources (WHO 2001). With the development of an extensive network of community-based mental health services capable of receiving and treating people with mental disturbances and supporting them and their family members in their daily lives, the need for psychiatric hospitals is increasingly reduced, even though a limited number of residential and semi-residential centres may continue to be necessary (WHO 2003). At the current time, unfortunately, community-based mental health activities account for only a part of the working practices of even trained personnel, who are obliged to focus on the dynamics of the hospital (such as hospital psychiatrists who work at territorial level on a rotation basis, where they replicate the approaches and styles of the hospital [Del Giudice 2016]). Identifying dedicated personnel and settings improves effectiveness in dealing with the demand and motivates the personnel towards a change in the model. **Over the next few years, then, the efforts have to focus on a dedication to implement multidisciplinary services and teams, with more and more personnel operating exclusively within this context.**

IDENTIFYING SUITABLE SPACES

The CMHUs and ROUs, like the other territorial mental health services, contribute to the definition of the change of model. Psychiatric hospitals are technological fortresses, places of custody, where the need for even the most minimal level of social interaction is not recognised and all relationships are seen in a negative light (Rotelli 2015). With respect to these radical criticisms, some of the leading players[7] in the deinstitutionalisation process in Trieste defined the concept of Social Habitat as a kind of search for a quality of life and a sense of health. **The mental health services, and those dedicated to rehabilitation in particular, always have to be situated outside the psychiatric hospitals** (while currently the ROUs are frequently situated within their complexes) and designed for purposes radically different from custody, in such a way as to resemble homes, where the users can manage their own time and space, build up skills, become independent and achieve emancipation, in a place which is no longer artificial, but a part of society.

[7] The reference is to Antonio Villas, the architect who contributed to the construction of innovative spaces during the early years of the Trieste experiment (Rotelli 2015).

TRAINING THE OPERATORS

In China, there is a great shortage of trained mental health operators, both at medical level (DEL GIUDICE 2016) and in the other areas of community-based mental health. Investing in training is one of the objectives of the national mental health plan, but this training does not currently appear to be focusing on territorial operating practices. The psychiatrists are few in number and based in the psychiatric hospitals. Some specialists, such as social rehabilitation operators, are virtually non-existent. Frequently, there are very few operators who are clearly dedicated to the development of self-help groups or organisations of family members and users (DEL GIUDICE 2015), which means that the few such groups which do exist have difficulty in operating, in the absence of the role of cultural catalyst played by trained operators. The training of local operators and organisation of suitable supervision systems (WHO 2008) are therefore key aspects for the spread of community mental health cultures and practices and the rapid increase in trained personnel. **One important application of this principle is the training of trainers, which involves a long period spent in community-based mental health service centres and full time placement in dedicated services following the training period.**

IMPROVED ACCESS

Community-based mental health services have to be available at local level, so that people do not have to travel long distances for an assessment (WHO 2003). Projects for the implementation of the services, in terms of the numbers of available and the opening times and days, have to escalate, to guarantee the presence of CMHUs or similar units at the service of a given territory and population, offering a whole range of services and with reasonable opening hours (COLIZZI 2015). Currently, the opening hours are restricted and poorly distributed, and some centres are open for only a few days a week. **The objective is to achieve the same levels of accessibility as fully territorial systems**. To give one example, The Italian Objective 1998-2000 Project for the CSM states that medical and nursing personnel have to be on hand throughout the opening times of 12 hours a day, 6 days a week (MINISTRY OF HEALTH, 1999).

PROMOTING EQUALITY OF TREATMENT

The availability for all those requiring it of suitable treatment and support for psychological disturbances cannot depend only on the location of the care centre or its opening hours. In the case of severe mental illness above all, the problem experienced by people in recognising their own suffering and undergoing the treatment is a complex process. Access to care may also depend on the economic situation of the person requiring treatment. Currently, the Chinese health service does not always grant free access to treatment. But equal access is necessary for the development of a community-based mental health system, as it reduces the need for admission to a psychiatric hospital and enables even those who would otherwise have no access to treatment to recover their health. **More specifically, the medicines used to treat severe mental illnesses have to be supplied free of charge, or in any case in such a way as to guarantee that all those requiring them have full access to them.**

WORKING WITHIN THE SOCIAL SPHERE

Mental health service operators should not remain closed within their centres, even if these are located at territorial level. Getting to know the places where the people they are treating live, promoting home care and acting as an intermediary with family members, employers and neighbours are all an integral part of the work of a territorial mental health worker. It is in any case within society itself that the real need for mental health care of a population can be identified, by means of collaboration protocols with schools and other preventive activities aimed at the general public within meeting places and through the general channels of communication. Some of the territorial services examined during the project make regular home visits, even though these tend to be for monitoring and control purposes rather than procedures aimed at recovery and the promotion of autonomous decision making. **The service personnel have to pay regular home visits to people with severe psychological disturbance. These have to be stepped up during particularly difficult times, and it should also be possible to manage crisis situations in the home, by means of trained personnel, especially in the case of young people suffering their first experiences of psychosis** (DOAN 2007).

INTEGRATION WITH THE PRIMARY CARE NETWORK

The mental health services can integrate with the primary care network (WHO 2001). With integration of this kind, the services can be administered rapidly using the local spaces reserved for primary care. Territorial organisation facilitates exchanges and collaboration between different specialists, enables mental health requirements to be identified at an early stage in the process and allows the operators to reason in terms of continuity of service in their relations with the users (ROTELLI 2015). In many cases in China, there are primary care outpatients' departments in the towns which are able to deal with mental health issues. Generally, however, these are unable to provide treatment or specialist diagnosis (DEL GIUDICE 2016), and they mainly administer medicines and offer rehabilitation services. At the same time, the problems of diagnosis (to be entrusted to specialists, who are not currently dedicated to territorial activities) and the handling of acute situations have to be resolved, to avoid a situation in which inadequacy in these areas makes it necessary to turn to the psychiatric hospital (COLIZZI 2015). **Suitably trained doctors and motivated operators have to maintain constant relations with the primary care network, in such a way that the territorial services are the first to identify the patient's needs, diagnose the problem and administer the treatment, with the use of the psychiatric hospital reduced to the minimum.**

INTEGRATION WITH SOCIAL SERVICES

The integration of mental healthcare into a broader system of community welfare is an ambitious objective in quality terms (WHO 2003b). The promotion of the quality of life of people with mental health problems also requires acting on factors not strictly related to health alone. **Systems of income supplement, family support and assistance for parents have to be accessible to those with mental health problems, on the basis of their needs.**

CREATING SOCIAL INCLUSION

In China, a powerful stigma surrounds mental illness, in the community, workplace and among health workers. This makes it very difficult to develop systematic occupational projects for the recruitment of people with severe mental disturbances (DEL GIUDICE 2015). It is also important not to confuse assistance with the return to the workplace, which has to guarantee income and promote the role of a person with mental disturbances as a worker, with occupational therapy practices, which are widespread both within and outside psychiatric hospitals, and do not create a new role for the patient, enable him to earn a fair wage, or provide any prospects of employment. The challenge of identifying the best tools for enabling people with even severe psychological disturbances to return to work is one of the major commitments for future projects. The creation of a protected labour market to which people with psychosocial disabilities have access is a long term objective, but it is possible to contribute to it through the promotion of social enterprises, collaboration with associations and profit-making companies, and the implementation of mixed solutions, such as an employment exchange system. **This tool to promote the return to employment should have a specific maximum duration, of 24 months, for example, following which the person concerned should, at least potentially, be engaged by the host enterprise (DEL GIUDICE 2015)**. The resources for the setting up of this tool, with 4-5 exchanges per district initially, could be procured by means of positive relations with the disabled organisations, local institutions and the enterprises which are most sensitive to the problems.

INVOLVING THE STAKEHOLDERS

Improving the quality of community mental health services is a procedure interwoven with the formation of networks within the community. The stakeholders and family and user associations have to continue to contribute to the changes taking place, by means of consultation mechanisms whose aim can be summed up as “nothing about us without us” (WHO 2003b). More specifically, the family and user associations have to develop at local level (disabled people's organisations, or DPOs) by dedicating personnel to the promotion of user and family participation. **The DPOs have to be guaranteed the use of**

premises to hold their meetings, and mechanisms have to be set up for regular consultations on mental health matters with technical specialists and civil authorities. Self-help groups may be set up to encourage autonomous decision making by individuals and, more generally, the services have to promote empowerment and recovery through appropriate initiatives.

COMBATING THE STIGMA

The stigma is one of the biggest obstacles that the development of a rights-centred mental health system has to overcome. There are many people who contribute to the development and continuation of the stigma, including mental health operators themselves, with the use of terms and words of a powerful stigmatising content (SARTORIUS 2007), especially when closed, segregated institutions, organised around the notion that the patient is a threat, continue to exist. The stigma has an impact on people with mental health problems and acts as a barrier against inclusion and access to employment, and makes it difficult to exercise many rights. Taking action on this stigma is a complex process, which is partly the responsibility of all the community health practices, and partly consists of a series of autonomous actions geared towards the general public, technical specialists and policy makers, with a view to mitigating the stigma. The Chinese national plan involves a series of actions aimed at eliminating the cultural stigma, including work in the schools and the setting up of easily accessible information and listening tools, in the form of special help lines. Any future project for the development of community-based mental health services in China has to incorporate initiatives for the spread of non-stigmatising information on mental health, access to services and recovery, and promote critical reflections on these matters through the media.

REDUCING HOSPITAL ADMISSIONS

Psychiatric hospitals are costly, debilitating, increase the social stigma, absorb large quantities of personnel and determine their approaches to the work (WHO 2003). It would be unrealistic however to consider the possibility of closing them down

immediately, for both cultural and organisational reasons. To change the model, we have to implement community services, stop the use of psychiatric hospitals for new admissions, gradually release the long term patients from them, and shift the funding away from the hospital system to territorial level (WHO 2003). Each of those steps is complex and subject to specific obstacles. Reducing investments in the hospital system without supporting the families and setting up a protocol for the handling of acute situations is particularly complex.

The closure of the psychiatric hospitals is therefore the final stage in a long cultural, organisational and technical process. China has currently expressed its preference for the implementation of territorial services over an increase in the number of psychiatric hospital beds. Looking to the future, however, it will be necessary to consider the downsizing and transformation of the existing psychiatric hospitals. There is much to be done in China to bring this project about, in spite of the progress in recent years, at legislative level and in the economic investments. The results and good practices which have emerged from the EU financed projects which we have discussed here do however enable us to conclude on the positive note that the direction recently undertaken could be the start of a process in which the experiences of the Italian mental health services, in this new setting, so far away from their place of origin, could be one of the seeds for the development of good practices focusing on rights and aimed at eliminating the old, institution-based psychiatry.

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Appendix

1 – Summary table of the structures set up during the second three year period of the project

	Existing CMHUs	CMHUs opened	Existing ROUs	ROU opened
TONGLING	4	2	1	0
CHANGCHUN	2	1	1	1
HARBIN	0	1	0	2
YANQING	0	2	0	1