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Editors' Introduction to Section IV: Rehabilitation Interventions in Rural Communities

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Probably the greatest challenge for the Chinese health care system has been to find a way to provide health care for the 75% of the population that lives in rural areas. At a very early stage in the People's Republic of China the government decided to expend the limited resources available for rural health on preventive programmes such as childhood inoculations and mass-mobilisation campaigns to improve public hygiene. This policy was spectacularly successful for the control of many endemic and epidemic diseases, but it did not provide the curative services needed for the treatment of acute and chronic illnesses.

The major problem of developing rural medical services is placing well-qualified medical personnel in the countryside. Physicians avoid assignment to the countryside because the physical conditions are uncomfortable, the professional environment is poor, incomes are low, schooling for children is of low quality, and spouses object. Mao Zedong made the provision of health care to those living in rural areas the focus of his health policy; yet, even during his tenure in power, it was only after the imposition of draconian measures that doctors went to work in the villages. Currently, one of the major goals of the economic reforms is to give professional workers greater job mobility; this will make it even more difficult to get doctors to the countryside. Of course, Western health officials also face this problem when planning rural health care, but it is more crucial in China because of the much higher proportion of the population living in the countryside.

In the absence of well-qualified medical personnel in rural areas, China developed a three-tiered referral system based on local health workers who receive 3–12 months of medical training (called 'barefoot doctors' during the Cultural Revolution and currently called 'village doctors'). These village doctors are trained to recognise illnesses beyond their competence to treat and refer such patients to the better-trained doctors at the township hospital who, in turn, refer the most complicated cases to better-equipped county-level hospitals. Under the old commune-run co-operative health schemes all preventive services (e.g. inoculations, pre-natal care, and water treatment), most out-patient services, and some in-patient services were provided free of charge; but the dismantling of the communes in the reform era has destroyed the rural health insurance scheme (Gu *et al*, 1993), so most services are now provided on a fee-for-service basis. Moreover, the referral system has been seriously weakened because rich peasants now go directly to the most expensive service they can afford (often the county-level hospital or urban hospitals) and because the village doctors, most of whom are now private practitioners, are less willing to refer patients upwards.

This stratified referral system is (or was) relatively effective for acute physical illnesses, but it is not effective for the management of chronic illnesses, particularly chronic mental illnesses. In almost all of rural China none of the health professionals (village doctors, township-level hospital doctors, and county-level hospital doctors) have training in mental health, so persons with obvious mental disorders who present to the medical system are referred for admission to large psychiatric hospitals in urban centres. Travel to these centres is difficult (it may take several days for persons in remote regions); the cost of staying in hospital is high (it is not covered by co-operative health insurance schemes); and follow-up care after discharge from hospital is not available locally, so family members must return to the urban hospital to get prescription refills. It is not surprising that a high proportion of rural residents with mental illnesses are treated in the community by alternative healers such as shamans (Li & Phillips, 1990).

In this environment it may seem somewhat premature to talk about rural psychiatric rehabilitation programmes. The first goal, obviously, must be to provide basic diagnostic and treatment services and to make psychiatric medication available in the countryside. There are insufficient personnel and funds to establish a free-standing treatment system, so mental health services in rural areas must depend on grass-roots participation and must be grafted on to the currently available health care system. To date, only a few rural locations in China have set up such services, and most of them are suburban or

peri-urban localities that are relatively affluent and have good access to the consultative help of urban mental health professionals (Xiang *et al*, 1990). The goal of the China Disabled Persons' Federation, as stated in the *Work Programme for Disabled Persons During the Period of the 8th Five-Year National Development Plan (1991–1995)* (State Council, 1992), is to develop rural mental health programmes in 30 locations around the country and then to use these as prototypes for the national promulgation of services.

The currently operating rural mental health programmes and those envisioned by the 8th Five-Year Plan primarily focus on providing services to persons with chronic mental illness, so they inevitably have a rehabilitation component. The requirements for satisfactory psychosocial functioning in the rural environment are different from those in the urban environment, so the concept and practice of psychiatric rehabilitation is also different. The success of the rural programmes depends on the support of local health workers and on the active participation of family members, and thus an important component of the rural rehabilitation effort is the education of village doctors and family members (Shen *et al*, 1985). In rural areas, unlike urban areas, occupational rehabilitation is largely provided by family members, not by health workers. Under the new 'family responsibility system' in agriculture (by which the family's income depends on its agricultural output), families are motivated to maximally utilise the labour potential of disabled family members, so most mentally ill persons who retain some work ability are productively employed. The dispersed nature of the rural population makes collective recreational and social activities impractical, so these activities are not part of rural rehabilitation programmes, though in some programmes family members are instructed about the need to increase the scope of patients' social contacts.

The first paper in this section, by Wang *et al*, is the first detailed description available in English of the Yantai model of rural psychiatric care that has been famous in China for some while and has recently attracted the attention of the World Health Organization and the World Association of Psychosocial Rehabilitation as a model of rural mental health care that may be exportable to other predominantly rural, under-resourced countries. It is, by far, the largest rural mental health service in China: it serves a population of 6.3 million persons in 11 counties, 205 townships, and 7034 villages; it maintains a psychiatric registry of 16 623 mentally ill persons (including 11 725 schizophrenic patients); and it provides monthly home visits to 3347 patients. The model is based on small, county-level psychiatric hospitals that provide acute-care in-patient services and train physicians from township-level general hospitals to provide out-patient psychiatric services and to supervise the mental health work of village doctors. At each level there are management groups composed of health professionals and local officials; these groups oversee the services, co-ordinate the training of personnel, and mobilise needed administrative support.

The success of the Yantai model has hinged both on the strong commitment of the hospital-based psychiatrists to provide training and supervision to the non-psychiatric clinicians who dispense the services and on two innovative steps taken by the management groups. The first of these is that the quality of the mental health service was made one of the official criteria for assessing the quality of a community's overall health care; this ensures the active support of local officials whose reputations (and bonuses!) rest on the continued success of the programme. Secondly, the home-care programme and other out-patient mental health services were included with the package of preventive services provided by the state (i.e. inoculations, pre-natal care, etc.), so, unlike most other health services, they are provided free of charge to the consumer. The continued success and eventual promulgation of the Yantai model will require meeting several new challenges: maintaining hospital-based psychiatrists' enthusiasm for training and supervision of community providers as the success of the programme decreases hospital admissions and, hence, psychiatrists' bonuses; continuing to provide out-patient mental health services free, or at minimal charge, despite the recent health care reforms that are forcing many less-affluent communities to dispense preventive services on a fee-for-service basis; and expanding the range and quality of rehabilitative interventions provided by local clinicians.

In the second paper, Qiu & Lu assess the incremental value of adding a guardianship network to the existing mental health system (a three-tier system quite similar to the Yantai model) available in the relatively affluent rural counties of the Shanghai Municipality. Guardianship networks have been in existence in some of the larger cities, like Guangzhou and Shanghai, for some time (Zhang, Yan & Phillips, this supplement), but this is the first detailed report of their operation in rural areas. In this particular version of the guardianship network, someone – usually a family member – is assigned the responsibility of supervising various aspects of the patient's behaviour. They must ensure that the

patient takes medication regularly, prevent the patient from being socially disruptive, and report any signs of relapse to the village doctor or to the part-time psychiatrist in the township-level hospital. At one level, this would seem to be a way of making relatives take responsibility for the strict supervision of the patient; but they routinely have to do this anyway. The difference is that the guardianship network provides the relatives with several benefits that are not available from the standard medication follow-up clinics: regular (quarterly) education about the management of mentally ill persons, contact with a supportive group of other relatives of mentally ill individuals, and, most importantly, the active support of a management group that includes local police, village leaders, and doctors from the township hospitals. Thus the guardianship network in this rural setting is a support network for family members who are formally given the responsibility for the management of patients. The results show that this system of reciprocal obligation works to the advantage of the patients, the family, and the community. A variant of this model is being tested in one township in Jilin Province: the county health bureau pays families 400 Renminbi per year (a significant amount for rural families) to care for the patient at home and pays local health workers to monitor the patient and supervise his or her medication, but these payments are withheld if health workers report that the family has not done a good job, or if families report that the health workers' support has been inadequate.

The last paper, by Jin & Li, is remarkable for the sensitivity and sympathy it shows for the social and psychological consequences of mental illness and for the needs of patients confined to chronic-care institutions. Like most residents of chronic-care psychiatric institutions in China, the residents at their institution are there for life because they have nowhere else to go, so they emphasised making the environment as responsive to the needs and abilities of the residents as possible. In realigning their interventions to conform with a treatment philosophy that emphasises the personal dignity and basic human rights of patients, they transformed a chronic-care hospital into a thriving rural community. Many of their decisions reflect the same concerns that have been espoused by proponents of the therapeutic community movement in the West (Jones, 1979), although they came to these conclusions independently. In China such an approach is revolutionary: they are one of the few mental health institutions that provide open-door treatment and that allow patients to wear street clothing, and they are the only institution that has 'patient managers' and that allows high-functioning patients to marry and settle on the hospital grounds.

Two aspects of this programme are at odds with the current position of Western professionals. The most contentious issue is that those residents who wish to marry must be sterilised first. Given the Chinese preoccupation with the hereditable causes of mental illness and the clear government regulations limiting marriage of the mentally ill (Pearson, 1992), the staff have, in fact, been quite courageous in overcoming official objections to provide a life option for the high-functioning residents that is not available to patients in other chronic-care institutions. For Western observers the restriction of mentally ill persons' freedom to marry and bear children may be unacceptable, but in the context of Chinese society as a whole such practices are coherent with other forms of social engineering focused on population control (e.g. the one child per family policy) that place the perceived good of the collective over the rights or desires of the individual. Many Western experts (Torrey, 1988) also discourage childbirth in persons with chronic mental illnesses; the difference in China is that this has become government policy. But, as is always true in China, it is important to differentiate policy and practice; the large proportion of Chinese schizophrenic patients who marry and bear children – 50.4% and 41.2%, respectively, in a large sample of acutely hospitalised patients (Phillips, 1993; and unpublished data) – indicate that this particular policy is not rigorously enforced.

From the Western viewpoint, which currently emphasises integrating the mentally ill into 'normal' life, the therapeutic community described by Jin & Li may seem too isolationist. But there are no intermediate-care facilities in China and it is unlikely that there will be any in the foreseeable future, so the large and increasing numbers of abandoned long-stay patients are confined to chronic-care institutions. Most of these institutions are under-resourced custodial-care facilities where regressed patients live out empty and hopeless lives. Jin & Li demonstrate that this does not have to be the case.

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