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An Integrated System of Community Services for the Rehabilitation of Chronic Psychiatric Patients in Shenyang, China

XISHI WANG
(translated by Michael R. Phillips)

The evolution of the Zhengyang Community Mental Health Rehabilitation Centre described in this paper proves that community-based mental health services initiated and developed by enthusiastic and committed community members can be successful in the Chinese setting. The most important step is to utilise community resources to secure a stable source of income, preferably by establishing a profitable welfare enterprise that can both finance the provision of other services and provide work for mentally ill clients who cannot obtain regular employment. The ultimate goal is to reintroduce as many clients back into the community as possible, so a range of services is needed: supervision of medication, social skills training, occupational rehabilitation, and, most importantly, work placement. The vitality of the organisation depends on its flexibility and responsiveness to the changing needs of patients; it must use its experience to guide policy decisions about the development of new services and the alteration or termination of existing services.

Recent changes in the medical model of care have led to corresponding changes in the management of mentally ill patients. The traditional biomedical model emphasises high-technology in-patient care for mentally ill patients, but the emerging biopsychosocial model has encouraged the development of community-based facilities that provide rehabilitation services. In developing countries, however, there are limited government funds to finance community services, and so the evolution of these services has depended heavily on the enthusiasm and creativity of grass-roots organisations. This paper describes one successful model of community mental health services – the Zhengyang Community Mental Health Rehabilitation Centre – that was initiated and elaborated by local community organisations in one of the neighbourhoods in Shenyang. (Shenyang, in Liaoning Province in north-eastern China, is the fourth largest city in the country; to serve its population of 5.6 million, it has 15 psychiatric hospitals with a total of 3500 beds; that is, 6.3 beds per 10 000 population.)

Development of the Zhengyang Community Mental Health Rehabilitation Centre

Sociodemographic characteristics of Zhengyang Neighbourhood

The Zhengyang Neighbourhood is a subdistrict of the Shenhe District, a flourishing commercial district of Shenyang. According to a census taken on 30 November 1988, the 18 subneighbourhoods and 164 enterprises within the administrative boundaries of the Zhengyang Neighbourhood have a total population of 28 430. The male/female ratio in the population is 1:1.03; 9.8% of the population are 60 years of age or older; and 96.3% of the population are Han race. There are 8993 households, with an average of 3.2 persons per household; 69.3% of the households are nuclear families, 29.5% are extended families (three generations in one household), and 1.1% are joint families (two or more married siblings and their spouses living in one household). The economic level of these households is fairly good: in 1988, the mean per capita monthly income in 27% of the households was over 60 Renminbi (Rmb) (about $US 13), in 66% it was 40–60 Rmb, and in 7% less than 40 Rmb. Government subsidies, such as health insurance for workers in government industries or other social support programmes, are provided to 65.2% of these households, and 23.8% receive financial support from family sources outside the household. Marital status of the population is similar to that in other urban areas in China: 63% are married; 32% are not married; and 0.9% are divorced. Among persons over 16 years of age, 42.3% are industrial workers; 33.5% are service personnel; 9.1% are retired, discharged, or seeking work; 5.5% are technicians; 5.0% are administrative personnel; and 4.6% are housewives. The educational level of the population is typical of working-class districts in urban China: 2% are university graduates, 27% are middle-school graduates, 18% are elementary-school graduates, and 53% have not completed elementary school.

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Mental health characteristics of the neighbourhood

Using the methodology and diagnostic criteria of the national epidemiological study of mental illness (Co-ordinating Group, 1986*a*,*b*), we did a complete household survey of the Zhengyang Neighbourhood in November 1988. In total, there were 182 persons with serious mental illlnesses identified (6.4 per 1000), including 93 persons with schizophrenia (3.27 per 1000), 41 with moderate to severe mental retardation (1.44 per 1000), and 34 with senile dementia (1.20 per 1000). From 1975 to 1990, the yearly incidence of schizophrenia in the community ranged from 0.12 per 1000 to 0.39 per 1000 (mean 0.19 per 1000). There are also more than 70 persons with other types of disability (crippled, blind, deaf, etc.) in the neighbourhood.

Community recognition of the problems of mentally ill persons

Before community mental health services were provided, most persons with mental illness in the community stayed at home all day with nothing to do because they were unable to obtain regular employment; over time, their lives became progressively more restricted, they became physically listless, and many of them regressed to a vegetative state. These individuals were the 'silent majority'; it was the bizarre and occasionally disruptive behaviour of a few of the community's mentally ill individuals that led to the recognition of the magnitude of the problem by community members. Everyone knew of the desperate conditions of at least one or two mentally disabled persons in the community: the mentally retarded woman who spent most of the time aimlessly wandering the streets and who once got lost for ten days until a frantic search by her family members located her; or the middle-aged schizophrenic housewife who caused traffic jams because she shuffled along the main streets opening her clothes to reveal her breasts.

These problems were prevalent throughout the city, but there were no community organisations able to provide desperately needed support services to these mentally ill persons and their families. Psychiatric hospital admission provided a temporary respite for the community and the families, but it did not provide a definite cure for the patients. In April 1975, the city government called a meeting of local administrators from around the city to discuss the problem. It was agreed that something had to be done to reduce the social disruption caused by these patients, to lighten the burden borne by the families, and to forestall the chronic deterioration of these disabled persons' social functioning. As a result of this meeting, the Shenyang City government sent directives to all 77 neighbourhoods in the city instructing them to establish mental health service centres, but it did not provide them with any money or other resources with which to do this. All 77 neighbourhoods attempted to comply, but most of the centres never really got off the ground; only 15 neighbourhoods developed mental illness prevention stations.

The Zhengyang Neighbourhood Committee (that is, the grass-roots administrative body) took up the challenge. They actively solicited support from the community, from government officials, and from the local office of the Ministry of Civil Affairs (the Chinese ministry of social welfare). They borrowed a 20 m^2 room from a local factory and instructed three 'barefoot' doctors from the neighbourhood's primary care health clinics to open a psychiatric out-patient service and to provide day treatment (mostly recreational activities) to five of the most severely disruptive mentally ill persons in the community. This was the beginning of the Zhengyang Mental Illness Prevention Station – the forerunner of the Mental Health Rehabilitation Centre. Within the first three months the Neighbourhood Committee acquired another three rooms, increased their day-patient load to ten clients and started an occupational therapy programme. The 'barefoot' doctors who ran the Centre subsequently got 3–12 months mental health training at a psychiatric hospital. Eventually the Neighbourhood Committee convinced the city psychiatric hospital to assign psychiatrists for 6–12-month rotations to the Centre; they provided training and medical back-up for the management of the clients' medication.

Developing an economic base for the Centre

Like other types of community welfare service, community-based mental health services depend on a stable source of funding. Developing countries such as China have limited resources for welfare services and so community services that do not become economically independent will, sooner or later, wither and die. It became clear that this would be the fate of the Community Mental Health Rehabilitation Centre unless we took rapid action to establish an economic base that could reliably provide the monies needed to sustain the Centre. It was also clear that a treatment programme based on medication and recreation alone would not produce the best outcome, and so the idea of an income-generating occupational therapy programme

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was born. It took much time and effort to convince the local factories to provide secondary-processing work for our clients, but with persistence we were able to get the work we needed. During 1975–1979 the occupational therapy programme generated a total income of 80 000 Rmb. (The official rate of conversion in 1975 was 1 Rmb = $US 0.66, in 1979 it was 1 Rmb = $US 0.64, and in 1990, 1 Rmb = $US 0.21.)

The success of the income-producing occupational therapy programme led us to think of establishing our own welfare factory. To provide employment opportunities for mentally disabled individuals, it would, necessarily, have to be a labour-intensive factory in which the work was relatively simple and non-strenuous. Using some of the monies saved from the occupational therapy programme, five rooms provided by the housing department, and three rooms provided by the Neighbourhood Committee, we opened the Shenyang City Ticket Printing Factory in 1979. About half the work-force at this welfare factory were mentally disabled persons and the remainder were persons without disabilities, mostly young people without other work. The aims were to provide occupational rehabilitation for mentally disabled persons at the factory and to augment the factory's regular work-force by employing the disabled persons who had successfully completed their rehabilitation training but were unable to obtain employment in other factories. Most of the disabled persons involved in the occupational rehabilitation programme who eventually became regular workers at the factory were chronic schizophrenic patients or mentally retarded individuals, but some persons with physical disabilities were also employed.

The advantage of having both disabled and non-disabled workers was that the non-disabled workers could do the more technically sophisticated jobs and the jobs that required high social functioning skills (such as getting orders and purchasing supplies for the factory), while the disabled workers did most of the less-complex jobs. Another advantage was that national regulations promulgated in 1980 stipulate that if 50% or more of a factory's work-force is disabled it can operate completely tax-free, and if over 35% of the work-force is disabled all income taxes are rebated. Given that taxes on state firms are 55% of profits, this tax exemption greatly increased the enterprise's chances for survival.

The welfare factory became a vigorous enterprise that expanded rapidly – our theatre tickets and other types of ticket are used throughout the country. The economic surplus of the factory provided a continuous source of funds for the development of the Rehabilitation Centre. In the period 1979–1990 the factory generated a total income of 13.5 million Rmb, of which 3.1 million Rmb was profit; over this time the factory gave 700 000 Rmb to the Centre to assist in the development of its programmes. With these monies we were able to expand and renovate our facilities, hire additional medical personnel, purchase equipment, and develop a comprehensive range of rehabilitative services. The medical staff attached to the Centre increased from 4 to 26; they now include one senior doctor, one vice-senior doctor, one attending doctor, three resident doctors, and 20 nurses. The space used by the Centre increased from one low-quality, 20 m^2 room to 46 rooms plus a three-storey building with a total space of 850 m^2. Except for two medical workers paid by the government, the Centre and the factory do not receive any funds from the government (though the factory does operate tax-free). Moreover, in the period 1986–1990, the income generated by the user fees of the expanded services provided by the Centre (independent of the facotry's income) was 610 000 Rmb.

Services currently provided by the Centre

The broad goals of the Centre are to provide for the treatment, rehabilitation, social skills training, and, if possible, employment of persons with mental illnesses in the community. To achieve these goals we have developed a comprehensive range of integrated services; typically, clients use different services at different stages of their illnesses.

In-patient services

A 65-bed in-patient facility was added to the Centre in 1987. There is an open-door policy at the hospital, which is quite uncommon in China. Patients are encouraged to wear their own clothing, to manage their own pocket money, and to be as independent as possible. Their treatment includes medication, psychological therapy, recreation therapy, and rehabilitation. In total there have been 418 admissions to the facility since it opened; 85% of the patients are schizophrenic and, interestingly, 80% of the patients are not from the Zhengyang Neighbourhood. Most patients are admitted for about three months at a cost of 300 Rmb per month (150 Rmb if the person has no health insurance): this is considerably less expensive than a stay in a city-level psychiatric hospital.

Out-patient services

Clinic services and follow-up home services are provided by five members of staff. One psychiatrist

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works full-time in the Centre's out-patient clinic. He is responsible for the diagnoses and treatment of new patients and the follow-up of patients discharged from hospital. On average there are 13 out-patient visits per day. The other four staff members are responsible for making regular home visits to stable mentally ill individuals who are unable or unwilling to come to the clinic, and to clients who are enrolled in the Centre's other programmes (e.g. day treatment and welfare factory). In total, 2818 home visits were made in 1990; 85% of these visits were to the homes of schizophrenic patients and 20% were to homes outside the Zhengyang Neighbourhood. The charge for each visit (independent of drug costs) is 0.30 Rmb.

The staff of the out-patient service provide both medication management and counselling. The goals of medication management are to make it as convenient as possible for patients and their families to obtain medication and medical advice about the use and side-effects of the medication; to regulate drugs closely with the goal of maximising therapeutic effect while minimising side-effects; and to enhance patients' compliance with drugs by educating patients and their family members about the use of psychiatric medication. The aims of the symptom-focused counselling are to enhance compliance with treatment; to understand and resolve the psychosocial stresses related to the patient's illness; to address the negative thoughts and psychological attitudes that cause strong feelings of inferiority; and to reduce the socially inappropriate behaviour that makes it difficult for the patient to be accepted by others.

'Home beds'

For individuals who need urgent care because of acute symptoms but are unable or unwilling to go to hospital, we have established the home-bed programme. Clinicians make frequent home visits (weekly or, if necessarily, daily) to the clients enrolled in this programme for as long as is needed to control acute symptoms. After about 2–3 months, the patients can usually be transferred to the day treatment or out-patient programmes. At a cost of only 1.50 Rmb per visit, this service is significantly less expensive than in-patient care and, thus, reduces the economic burden to the family or to the patients' work-place (who must pay for a stay in hospital). From its inception in 1975 until the end of 1990, 204 patients participated in the home-bed programme; however, over the past few years almost all mentally ill individuals in our neighbourhood have received treatment in the other programmes provided at the Centre, so the need for home beds is diminishing. In 1990 there were only ten persons enrolled in the programme; 480 home visits were made to these clients over the year. The development and subsequent devolution of the home-beds programme is one example of the flexibility of treatment programmes that are organised at the grass-roots level.

Day treatment

Acutely ill individuals who have stabilised during a stay in hospital or during a course of home-bed treatment can, if they are willing, attend our day treatment clinic after discharge. About 85% of the clients in the day treatment programme are schizophrenic, but some mild and moderate mentally retarded clients also attend this clinic. They come to the clinic in the morning, have their noon meal and medication at the clinic, and return home in the evening. During the day they participate in cultural, sporting, and occupational activities. Regular visits to gardens and other sites of interest are also organised. These clients participate in behavioural therapy that attempts to change their lack of motivation, to improve their personal hygiene, to enhance their ability to discriminate between socially appropriate and inappropriate behaviour, and to promote good life habits and good health habits. In total, 347 persons have been enrolled in this programme since its inception in 1975; 150 (43%) of these clients were not from this neighbourhood. At first this service was free of charge, but in 1980 we started charging 40 Rmb per month (20 Rmb for those without medical insurance). Over recent years the demand for this service has decreased; in 1990 only nine patients were enrolled.

Occupational therapy

Before the welfare factory was opened in 1979, the occupational therapy workshop was the only form of rehabilitation provided by the Centre, but at present the workshop is primarily used as an ancillary service for the in-patient and day treatment programmes. Some of the current in-patients and day treatment clients attend the occupational therapy programme for two hours twice a week, where they do secondary processing for local factories. We start with simple manual tasks and gradually increase clients' capacity for physical and intellectual labour. Any income generated is spent on buying daily necessities for the clients who participate. There is no charge for participation. Approximately 70 clients attended this service during 1990.

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Employment in the welfare factory

A regular income and guaranteed social welfare benefits are essential to the long-term security of persons with psychiatric disabilities. Without them, mentally ill individuals remain dependent on family members or the state, and they are at greater risk for symptomatic relapse because they are forced into a devalued social role. In our Centre we exert great effort to get disabled persons back to their former job or, if they have never been employed, to find them suitable employment in the community. If this is not possible, we arrange a job in the welfare factory that is appropriate to the individual's level of functioning.

Clients who have no acute psychiatric symptoms and who maintain some ability to work are provided industrial therapy at the welfare factory. (This is different from the occupational therapy workshop described above, which is for persons who still have acute psychiatric symptoms or who are unable to sustain any type of employment.) The industrial therapy focuses on training clients to perform the specific tasks required on the job and helping them adapt to the social environment of the workplace. If, after completion of a course of this therapy, we are unable to find them employment in the community, they are assigned a temporary position as an apprentice for one year at the welfare factory. On the successful completion of the apprenticeship they become permanent employees; clients whose work functioning remains poor after the apprenticeship continue working as paid temporary employees in the factory. The welfare factory currently (1990) has 204 workers, of whom 115 (56.4%) are regular workers and 89 (43.6%) are disabled workers; 47 of the disabled workers are permanent employees and 42 are temporary employees. The disabled workers include 25 schizophrenic clients, 45 mentally retarded clients, 6 clients with other mental disabilities, and 13 with physical disabilities.

Disabled workers make about 80–120 Rmb per month, depending on the duration of employment, which is similar to the salary of the non-disabled workers in the factory and comparable to the income of other industrial workers in the city (in 1990). They also receive a yearly bonus of about 100 Rmb. We have, moreover, set up life insurance (that pays for funeral expenses) and old age insurance (that ensures retirement benefits) for all disabled workers at the factory, as these issues are of particular concern to them.

Educational programmes for disabled workers in the welfare factory

Many persons with psychiatric disabilities have limited understanding of the world around them and, thus, have difficulty making appropriate judgements. These limitations affect their ability to become fully functioning members of the community. We believe that a comprehensive treatment model for clients with chronic mental disabilities must include an ongoing educational component. In our view this is different from rehabilitation; rehabilitation focuses on developing abilities, while educational programmes aim to impart knowledge. The specific educational courses taught must vary depending on the characteristics of the clients and the environment in which they are functioning. In our welfare factory we hold four types of course: basic education courses, courses on political thinking, courses on local laws and regulations, and courses on how to maintain a good attitude towards work.

Basic education skills

The disabled workers at the welfare factory are separated by ability into small groups that hold regular classes led by a tutor. The goal is to increase the basic reading, writing, and arithmetic skills of the mentally retarded clients and to reduce the progressive intellectual deterioration often seen in mentally ill clients. At the most basic level, they are trained to recognise and write simple characters and to do calculations with numbers under 100. For some of the mentally retarded clients even this is a difficult task, but frequent repetition usually results in some improvement. For disabled persons with a higher level of intellectual functioning, we use study manuals that are interesting but easy to understand. To increase clients' intellectual activities, they are also regularly given opportunities to read books and papers, listen to radio broadcasts, discuss current events, watch video tapes, and so forth.

Political thought

Political meetings that promulgate the principles and policies of the central government are a standard part of the social world of Chinese industrial workers. Disabled workers at our welfare factory, like the non-disabled workers, attend half-day political meetings every week. The Centre also subscribes to a large number of journals that discuss political issues in detail; these journals are available to workers whenever they want them. To increase our disabled workers' interest in the study of political problems, we organise public-speaking meetings, singing events (in which participants sing political songs), and competitions. For example, after the opening of the National Congress of the Chinese Communist Party, we hold competitions about information from the

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congress. Printed questions are distributed in advance and everyone is told that there will be prizes for correct answers. Many participants prepared by reviewing all the news reports about the Congress in detail; the competition is both fun and informative.

Legal issues

We use a variety of methods to teach our disabled workers about local laws and regulations. Sometimes they watch videos, sometimes they listen to analyses of specific cases by policemen from the local public security bureau, and sometimes they participate in competitions on knowledge about local laws and regulations. The variety of methods ensures that the content is interesting and that participants actually acquire the desired information.

Work attitudes

Some mentally ill individuals have difficulty persevering at work; over time they become less and less interested and their work function gradually deteriorates. To combat this problem, we hold regular classes on work attitudes that aim to inspire the disabled workers to feel proud of their work and to feel pride in and loyalty to their work site (the welfare factory). They are encouraged to participate in the country's 'four modernisations' (i.e. improvements in agriculture, industry, military preparedness, and science and technology) by putting their energy into their current work. In fact, much of the success of the welfare factory has depended on the spirit and energy of the disabled workers. Our workers exceed production plans month after month. Last summer there were frequent power cuts that made it almost impossible to complete our orders on schedule: several disabled workers spontaneously volunteered to work extra shifts during the hottest time of the year to get the task completed.

Outcome of the treatment programmes

Over the 15 years of the Centre's operation, it has been obvious to us – and to our clients – that the services provided are beneficial because we have vivid memories of the desperate state of the mentally ill in the community prior to the initiation of the programme in 1975. The Centre was not originally set up as a research project, and so we focused our energies on the development of a comprehensive range of services rather than on systematic assessment of the outcome of the various programmes. Moreover, the mix of clients (schizophrenic, mentally retarded, and others) and the variety of services utilised by each client made it extremely difficult to undertake formal, controlled trials of the programmes with blind evaluation of the outcome. We do, however, have some crude statistics on the outcome of the various programmes. In the following summary of these statistics the outcome is assessed by the treating clinicians (i.e. not blind); 'improved' clients are those who no longer experience acute symptoms of mental illness, and 'markedly improved' clients are those who are able to appropriately perform their social roles, albeit at a reduced level.

Day treatment. In total we have provided day treatment to 199 mentally ill clients from Zhengyang Neighbourhood; 165 (82.9%) had marked improvement in their psychosocial functioning. As to employment, 65 clients (32.7%) returned to previous jobs or were assigned to new jobs in the community, and a further 46 (23.1%) were assigned regular positions in the Centre's welfare factory. Virtually all mentally ill individuals in the community who retain some work function have been found employment.

Out-patient services. In a ten-month period over 1989 and 1990, 377 clients made 4528 visits to the out-patient clinic and were visited at home 204 times. On follow-up, most of these patients (85%) showed some improvement, and many (70%) showed marked improvement. The relapse rate of patients who use the out-patient services is about 7% per year.

Home beds. Of the 204 patients treated in the home-bed programme, 161 (78.9%) have shown marked improvement.

Schizophrenic patients' psychosocial outcome. In total, 114 chronic schizophrenic patients (including 21 patients from other neighbourhoods) participated in the Centre's programmes during the period from its inception in 1975 until 1985; on average, ten new patients were enrolled each year. The demographic characteristics of these patients at the time of enrolment were as follows: 74 (64.9%) were male and 40 (35.1%) were female; their mean age was 28.5 years (range 18–56); their mean duration of illness was 5.6 years (range 3.1–26.0 years); and their mean length of hospital stay was 6 months (range 3–12 months). The subtype of schizophrenia was disorganised subtype in 28 patients (24.6%), paranoid subtype in 36 (31.6%), catatonic subtype in 8 (7.0%), simple subtype in 12 (10.5%), and undifferentiated subtype in 30 (26.3%). Table 1 shows the change in psychosocial functioning of these patients from the time of enrolment in the Centre's programmes to the time of the last formal follow-up in 1986. Many patients were able to return to previous jobs, find new jobs, or do full-time housework. Those who retained some functioning but were unable to return to regular work were employed in the Centre's welfare factory. Eight

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Table 1
Social functioning of 114 chronic schizophrenic patients before and after enrolment in the programmes of the Zhengyang Community Mental Health Rehabilitation Centre (1975–1985)

Social functioning	Before enrolment[1]		After enrolment[2]	
	Number	%	Number	%
Workers able to do regular full-time work	12	10.5	45	39.5
Workers unable to do regular full-time work	47	41.2	21[3]	18.4
Housewives able to do all household work	11	9.6	17	14.9
Housewives able to do only some household work	19	16.7	15	13.2
Patients unable to care for themselves	25	21.9	8	7.0
Patients who died	–	–	8	7.0

1. All patients had had at least three years of illness at the time of enrolment in the Centre's programmes. On average, ten new patients were enrolled each year in the period 1975–1985.
2. As of the end of 1986.
3. These patients worked at the Centre's welfare factory.

of the patients died over the ten-year period; six from physical illnesses, one from drowning, and one while being treated in another psychiatric hospital. Only 18 of the patients (15.8%) required hospital readmission in the period 1975–1989; this is only 0.015 readmissions per person-year of post-enrolment follow-up (18/1171), which is very much lower than reported readmission rates of urban schizophrenic patients in other parts of China (Xiong *et al*, 1994).

Comment. Overall, these statistics on our case-series data indicate that patients who attend the various programmes run by the Centre achieve a satisfactory rehabilitative outcome. The resultant social and economic benefits for the patient, the family, and the community have led to the strong endorsement of the value of our work by the consumers of our services. For example, prior to enrolment in the home-bed programme, Mrs B had been ill for several years and unable to do housework; her daughter had to stay home from school to nurse her, and her husband had to take a great deal of time off work to help care for her. Six months after enrolment in the home-bed programme she was able to return to work. She has now been back at work for six years, her employers have increased her salary because of her good performance, and her husband says (with feeling): "You have treated a patient and liberated our entire household. Now our child can go to school, and I can go to work without worrying."

Discussion

Comprehensive community-based mental health services that integrate in-patient, out-patient, and rehabilitation programmes can largely eliminate the need for the rigid, locked-ward psychiatric hospitals that are still the dominant form of mental health service available in China. Our experience shows that community-based programmes which flexibly and creatively combine medication follow-up, rehabilitation, focused educational courses, and employment can achieve the best psychosocial outcome for individuals with chronic mental illnesses. By staying in the community, mentally ill individuals receive ongoing family and community support, and the psychosocial regression commonly seen in patients hospitalised for prolonged periods is avoided. Moreover, the disabled person's self-esteem and sense of personal dignity are enhanced by community-based, open-door treatment programmes that emphasise clients' independence in activities of daily living and their right to self-determination.

In our experience such programmes can, over time, change the attitude of the community, the family, and the disabled individual. The psychiatrically disabled will no longer be seen as persons afflicted with a lingering disease who are appropriately ostracised from normal social life; they will, rather, be seen as persons who are actively working to minimise the influence of the disability on their lives and to resume normal roles within their families and the community. In China, where unfounded fears about the mentally ill and misunderstanding of mental illnesses are still prevalent in all sectors of society, it will take concerted effort over a prolonged period to bring about this change in attitudes. But we think that the place to start is in the local community, and that the model of care we have evolved can achieve this goal.

The community services provided by our Centre were developed by grass-roots agencies in response to the expressed needs of disabled persons and their families. Our model of care has developed over time and continues to respond dynamically to changes in the characteristics of our clients and in the community at large. Our staff keep contact with the primary

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health care workers throughout the community, so we are certain that few, if any, new cases of mental illness escape our detection; virtually every mentally ill resident of our neighbourhood has participated in and benefited from at least one of our programmes. Despite the lack of rigorous scientific proof of the effectiveness of the Centre's programmes, the data we have collected confirm our observations that the programmes have resulted in a dramatic improvement in the psychosocial functioning of the mentally ill in our community. The strong support of the Centre's programmes by clients, family members, and the community confirm what our own observations suggest: the Centre is a resounding success.

Our work has received regional, national, and international recognition. This renown has led to over 800 requests for treatment from the desperate but hopeful relatives of mentally ill patients in other parts of the country. Given our limited staff and facilities, it is difficult for us to satisfy most of these requests, but the requests confirm us in our path and indicate the need to extend this model of care to other localities. Many communities in China have failed in their attempts to develop community-based mental health services because, we feel, the services lacked one or more of the three essential characteristics that have led to the success of our Centre: economic self-sufficiency, comprehensiveness, and flexibility.

Characteristics of successful community programmes

Economic self-sufficiency

Given the limited central resources available for welfare programmes, the Chinese government – like governments in most developing countries – is unable to provide long-term support for community-based mental health programmes. The survival and development of such programmes, therefore, depend on economic self-sufficiency. This, in turn, depends on the energy, perseverance, and creativity of the grass-roots organisations in the community. In our situation we utilised excess labour available in the community (i.e. unemployed, non-disabled persons) and took advantage of the government regulation granting tax-free status to enterprises employing more than 50% disabled workers to establish a highly successful welfare factory. This factory not only provided jobs for disabled persons who could not get other work, but also generated profits that made the development of comprehensive mental health services possible. Since the factory was supporting the Centre, these additional services were provided without significantly increasing the economic burden on the client or the family.

Comprehensiveness

Different types of patient and of family require different types of intervention, and so it is essential that there are various programmes simultaneously available for the community-based treatment of the mentally ill. A single-modality mental health service, such as the provision of drug follow-up in an out-patient clinic (the only community service available to most urban residents in China) will only reach a proportion of all the mentally ill individuals in the community, and it will only address one of the host of problems that the mentally ill and their family members must deal with. A comprehensive package of services that meets the multiplicity of needs of the mentally ill is much more likely to improve the overall level of mental health in the community. The well-publicised availability of a variety of methods of treatment in the local community greatly enhances the utilisation of services by families and decreases the number of severely ill patients who are confined to the home for years for fear that 'the neighbours will find out.' Sometimes these different services can be provided by different community agencies, but in developing countries like China that have few social services, it is preferable to have services provided and co-ordinated by a single agency, such as our Mental Health Rehabilitation Centre.

Different programmes address the different needs of the mentally ill. Outreach programmes must be developed to ensure that the clients and family members who are reluctant to come to a psychiatric clinic – a common problem in countries like China where mental illness is heavily stigmatised – receive needed treatment. Small in-patient facilities must be available for the short-term, community-based treatment of acute episodes of illness. Counselling services must be provided for the education and support of the families of the mentally ill. Life-skills training and recreational activities are needed to minimise clients' social isolation and psychosocial regression. And, most importantly, occupational training that leads to employment either in a regular enterprise or a welfare enterprise must be provided; the stable income and social welfare benefits provided by employment increase patients' status in the family and in the community, increase their sense of security and self-confidence, and, hence, decrease the likelihood of a recurrrence of their psychiatric symptoms.

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Flexibility

The professional level and technological sophistication of large, regional psychiatric hospitals are much greater than those of community-based facilities. But these large institutions are isolated from the community, have locked wards, and are expensive to operate. Moreover, the size of these institutions and their dependence on government financing limits their ability to respond to the changing service needs of the community. This is a serious problem in China because the rapid socioeconomic changes – such as changes in the size of families, in the proportion of elderly, and in the method of financing health care – necessitate similarly rapid changes in the types of mental health service provided. Small, community-based mental health services that are economically self-sufficient are better able to meet these challenges than large state-run institutions. Moreover, the organisation of all the community services within a single agency prevents serious turf battles between the providers of the different services and makes it much easier to terminate programmes that are no longer needed. Having a relatively small staff and not being dependent on government support, our Centre had the flexibility and executive authority needed to initiate, alter, and terminate programmes in response to the changing needs of patients and their families. This administrative flexibility fostered the rapid and vigorous development of the Centre.

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Xishi Wang, *Director, Zhengyang Community Mental Health Rehabilitation Centre, 1 Shun Yuan Lane, Zhengyang Street, Shenhe District, Shenyang, Liaoning 110011, PRC*

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