British Journal of Psychiatry (1994), **165**(suppl. 24), 11–18

The Social Context of Psychiatric Rehabilitation in China

VERONICA PEARSON and MICHAEL R. PHILLIPS

A Western psychiatrist visiting a ward, out-patient department, or sheltered workshop in China would find much that was familiar, not only in terms of clinical syndromes and medication usage but also in the paucity of resources, problems with administrative hierarchies, and lack of status accorded by medical colleagues to psychiatry. Chinese psychiatric patients able to converse with their Western counterparts would discover that they shared much of the experience in common: stigma, problems with employment, and difficulties in finding a marital partner. Patients' relatives from East and West, likewise, would be able to recite a litany of similar concerns and complaints: the need for guidance and advice in handling disturbed behaviour at home, the gossip of neighbours, and the fear of another relapse.

There are clearly many similarities in the treatment and experience of mental illness across cultures. But, at the same time, all societies develop unique ways of understanding and managing mental illness that make sense within their particular culture and that are feasible given the socioeconomic constraints of the community. It is the aim of this chapter to describe the social context within which psychiatric care in China is provided. This may help the reader both to discern what is different and to understand why it is different.

Psychiatric rehabilitation with Chinese characteristics

Prior to the founding of the People's Republic in 1949, there had been a small but growing number of social workers and psychologists working with the mentally ill (Lyman, 1939). However, in the mid-1950s China banned the teaching of social sciences (Chin & Chin, 1969; Wong, 1992), and so these clinical disciplines died out. Among other things, this has meant that approaches to the treatment of the mentally ill developed without the tempering effect of a psychosocial perspective. It may well be that in the chaos that characterised the years from 1956 to 1976, biological explanations of behaviour were a good deal safer than psychosocial ones because emphasising the role of social factors could be construed as a criticism of the state. Psychiatry and psychiatrists did not fare well in the Cultural Revolution (1966–1976); this may have made them even more sensitive to the potential 'political' interpretation of their work. Inevitably, this lack (or active avoidance) of psychosocial understandings of human behaviour affected the development of psychiatric rehabilitation. Rehabilitation, when done at all, was largely limited to providing 'work therapy' for chronically institutionalised patients to encourage them to 'participate in socialist construction'; it was not aimed at teaching patients new skills or at reintegrating them into society.

With the advent of the reform era in 1978, social sciences again became legitimate fields of enquiry, though researchers still needed to avoid politically sensitive issues. In parallel with this change in the intellectual firmament, a small number of psychiatrists began to consider non-biological explanations for mental illnesses and experimented with more imaginative methods of psychiatric rehabilitation. This slow emergence of the field of psychiatric rehabilitation has dramatically accelerated over the last five years because of the impetus that Deng Pufang (Deng Xiaoping's oldest son) has brought to the whole area of disability (Tian *et al*, this supplement). It did not take psychiatrists, even the most uncompromisingly biological psychiatrists, very long to see that this was a bandwagon on the move. Hitching themselves to this bandwagon by labelling their activities – whatever they were – as 'rehabilitation' provided political support and access to resources that would not otherwise be available. For the less cautious psychiatrists curious about trying new ideas, 'rehabilitation' has become a catch-phrase with positive connotations that serves as a justification for the innovative and untried.

The Chinese conceptualisation of rehabilitation

In China there is no generally accepted professional definition of psychiatric rehabilitation. The official construction of disability is, however, formulated in the recently promulgated Law of the People's Republic of China on the Protection of Disabled

Persons, which defines (Article 2) a disabled person as one who

> "suffers from abnormalities or loss of a certain organ or function, psychologically or physiologically, or in anatomical structure and has lost wholly or in part the ability to perform an activity in the way considered normal."

Further, the law (Article 13) states that

> "The state and society shall adopt measures of rehabilitation to help disabled persons regain normal functions or compensate for lost functions, thus enhancing their ability to participate in social life."

The legislation is framed in terms of people suffering from a physical disability, but it does specifically include those with psychiatric disabilities. It is rather vague about what rehabilitation may reasonably achieve, but there is an acceptance of participation as a goal and of developing compensatory skills, both of which would be familiar aims to those working in rehabilitation settings in the West. When asked to provide a more precise definition of psychiatric rehabilitation, two leading Chinese psychiatrists stated that any techniques that contributed to the goal of reintegrating the patient into normal society could fall under the rubric of psychiatric rehabilitation.

Despite this global approach, the majority of the limited psychiatric rehabilitation services available in China are provided in hospitals because of the lack of mental health facilities in communities. Considering psychiatric disabilities the product of a disease process, most Chinese psychiatrists see hospitalisation as part of the solution, not as part of the problem; they show little awareness of the iatrogenic effects of long-term hospitalisation frequently reported in the West (Barton, 1959; Goffman, 1961; Wing & Brown, 1971). There is compassion, at least among some psychiatrists, for wasted lives, and a desire that psychiatric patients, like other citizens, should be able to make a contribution to society (a fundamental tenet of socialist belief), but few see community rehabilitation as a viable method of achieving this goal.

Goals of psychiatric rehabilitation in China

Given the huge social and economic differences between China and the West, the goals and methods of British and American models of psychiatric rehabilitation (described in Wing & Morris, 1981; Anthony & Liberman, 1986; Shepherd, 1991; Watts & Bennett, 1991; Pilling, 1991) are not appropriate in China. As Pilling (1991, p. 13) points out:

> "Our understanding of the process of rehabilitation varies not only with the tasks presented to a service but also in response to prevailing economic and social conditions of the society in which the service operates."

One of the social factors that affects the psychiatric rehabilitation needs of a community is the perception of symptoms by community members. Pilling points out that most rehabilitation interventions are concerned with negative symptoms such as self-neglect and withdrawal. While self-neglect is viewed as undesirable in China in much the same way as it would be elsewhere, withdrawal is not. Being quiet and unobtrusive and keeping your thoughts and emotions to yourself are valued types of behaviour in Chinese society that do not raise the same concern or criticism as they would in Western cultures (Kleinman, 1986). On the other hand, sensitivity to the family's social status (i.e. 'face') makes Chinese families less tolerant of unusual or socially disruptive behaviour than their Western counterparts. Nagaswami (1993) found similar attitudes in families of Indian psychiatric patients in the Madras area.

Most psychiatric rehabilitation programmes in China focus almost exclusively on occupational rehabilitation. This is partly due to the lack of psychosocial expertise in rehabilitation practitioners, but a more fundamental reason is that the paramount goal of rehabilitation – reintegration into society – is impossible without employment. A jobless person in China is cut off from resources that make ordinary life tenable: in rural areas, work is necessary for basic sustenance; in urban areas, it also provides access to other resources like housing, medical insurance, and retirement pensions (Chan & Chow, 1992). This emphasis on work is enshrined in the 1982 Constitution, which states that it is the right and duty of every citizen to work (Article 42).

Work (or meaningful daily occupation) is also a core component of psychiatric rehabilitation in Western countries, but for different reasons. In the UK (Wansborough, 1981; Bennett, 1991) the focus of occupational rehabilitation is on the patient's self-actualisation; in China the ill individual attains social worth by working and, thus, contributing to society. The skills training aspect of work and social life, often associated with American approaches to rehabilitation, has not yet made any inroads into the Chinese practice of rehabilitation. This is partly due to the lack of expertise in psychology and the emphasis on collective, not individual, approaches to rehabilitation, but it is also related to differences

in employment practices: the social skills of finding and keeping a job are less important in a society where all rural jobs and most urban jobs are allocated for life.

The Western practice of preparing people with a long-term psychiatric illness to live independently has no relevance in China, because the socially valued position is to live with family members. Thus the issue of providing independent accommodation, which is so central to concepts of rehabilitation in the West, is rarely raised in China (Pearson, 1992). The primary social goal of the relatively few rehabilitation programmes that go beyond occupational training is to help the individual adapt to the psychosocial demands of the family environment and, conversely, to help other family members adapt to the needs of the ill individual.

The centrality of the family

The Chinese government vigorously supports the central role of the family in the provision of welfare, despite the fact that strong family interdependence is contrary to the tenets of communism which assume that an individual's strongest allegiance is to the state, not the family. Unable to provide sufficient resources to care for the large numbers of disabled citizens, the government has formalised a long-standing tenet of Chinese culture – that the family 'takes care of its own' – in the 1980 Marriage Law. Articles 14 and 15 of the Law clearly lay down the obligation of spouses, parents, and children to offer each other support and assistance during times of incapacity, which would also include mental illness. Many family members want to do this because it feels right, but it is also true that for most people there is no alternative.

Given this sociopolitical environment, it is not surprising that well over 90% of the chronic schizophrenic patients in China live with family members (Phillips, 1993); the corresponding figure in Britain is 60% (Perring *et al*, 1990), and that in America is 40% (Torrey, 1988). This high rate of co-residence combined with the relative lack of community-based mental health services means that Chinese family members are, more so than their Western counterparts, the primary (and often only) care-givers for persons with chronic mental illnesses. Family members provide food and housing, act as intermediaries between the patient and other social actors, attempt to organise employment and marriage for the patient, and make all the health care decisions for the patient (Phillips, 1993). They decide which type of care provider will be sought (Western doctor, Chinese traditional doctor, or folk healer), and, if they deem hospitalisation necessary, it is they, not doctors, who make the final decision about when the patient is admitted and discharged. Family members often live-in with hospitalised relatives and will almost always accompany them for out-patient visits (it is quite common for family members to come to out-patient clinics for medication without the patient). Doctors sometimes refuse to treat patients who attend out-patient clinics without an accompanying relative.

One of the ways in which the social goals of families of the mentally ill in China differ most from those of their counterparts in the West is in the emphasis on obtaining a spouse for the patient. Marriage is so central to the concept of adulthood in China that unmarried persons over the age of 25 (who usually live with their parents) are considered social misfits. Despite official disapproval of the marriage of persons with serious mental illnesses, a major 'rehabilitation' objective for family members of unmarried mentally ill adults is to arrange a marriage (Phillips, 1993). At the same time, the social stigma associated with mental illness is so great that it makes finding a marriage partner very difficult if the prospective spouse knows about the condition. (It also makes it much harder for the siblings of the patient to find mates.) Various trade-offs occur; for example, a woman from the countryside may be willing to marry a mentally ill man from the town in order to obtain the much-valued urban residence permit (which allows one to work in the city). From the parents' point of view, it is part of their responsibility to see their child well married, but marriage may also be used to shift the burden of care for a mentally ill person on to the marital partner. Many people are lured into marriage without knowing the full extent of their partner's psychiatric history; predictably, the divorce rate of married schizophrenic patients is much higher than that in the general population (8.0% v. 0.8% in 1989; Phillips, 1993).

The centrality of family members in the care of the mentally ill would suggest that they should be key players in the provision of psychiatric rehabilitation, but this is not generally the case. Most Chinese psychiatrists, whose explanatory models are largely biological, are not interested in family dynamics. They do not explore the family factors contributing to the patient's dysfunctional behaviour; but at the same time this means that they do not increase the burden of family members by blaming them for the patient's problems. Currently, the general attitude among psychiatrists seems to be that families are expected to cope; the psychiatrists' advice to families regarding the management of

patients at home rarely goes beyond strict instructions to make sure that the patient keeps taking the medicine. Thus the intact Chinese family and its willingness to care for the patient constitutes a great resource (Leff, 1993; Pearson & Phillips, 1994) that is largely squandered. There is much scope for the kind of supportive, educational family intervention described by Xiong *et al* (1994).

The role of state services

> "Citizens of the People's Republic of China have the right to material assistance from the state and society when they are old, ill or disabled. The state develops the social insurance, social relief, and medical and health services that are required to enable citizens to enjoy this right . . . . The state and society help make arrangements for the work, livelihood, and education of the blind, deaf-mutes and other handicapped citizens." (Article 45, Constitution of the People's Republic of China, 1982)

This is, of course, a statement about an ideal rather than a description of reality. Nonetheless, it demonstrates the state's awareness of the needs of sick and vulnerable people and an acceptance that the state has a role in providing for them. It does, however, emphasise that 'society' – that is, families, work units, and community organisations – must share the responsibility for caring for the disabled.

State-run in-patient services for the mentally ill are provided by several different ministries: Public Health, Civil Affairs (i.e. welfare), Public Security (i.e. police), Defence, and others. Moreover, within each ministry the administration of a particular hospital could be at the national, provincial, municipal, county, or even enterprise level (Phillips, 1994). There is no central authority that co-ordinates the psychiatric services of these various ministries, so the exact numbers of psychiatric facilities and psychiatric beds are unknown. Official figures given in the *Annual Year Book of Health Statistics* (1993) are misleading because they only specifically identify the psychiatric hospitals under the auspices of the Ministry of Public Health. More detailed information provided in a monograph by the Psychological Medicine Research Centre of the West China University of Medical Sciences (1990) identified 473 psychiatric institutions under the Ministry of Public Health, 190 under the Ministry of Civil Affairs, 81 under the Ministry of Industry and Mining, 23 under the Ministry of Public Security, 24 run by the People's Liberation Army and associated organisations, and 12 under local collectives. These are free-standing hospitals; it is still relatively rare to have psychiatric wards attached to general hospitals, even newly built ones (Lin & Eisenberg, 1985). Virtually all of these hospitals are in urban and suburban settings; the largest concentration is in large urban centres. The monograph does not, unfortunately, specify the numbers of beds at these institutions nor does it include the large numbers of small for-profit hospitals that have sprung up over the last decade in response to the government's encouragement of private medicine. We estimate that within the state-run system there are 120 000–130 000 psychiatric beds, which, given the population of 1.16×10^9 comes to about 1.1 beds per 10 000 population.

This low bed/population ratio indicates that China has avoided the mass institutionalisation of psychiatric patients that has so bedevilled the Western psychiatric system. This is, however, the result of economic constraints, not the result of conscious planning. Most Chinese psychiatrists consider psychiatric hospitals the most important form of mental health services and feel that there is an urgent need for an expansion of in-patient capacity. This view is supported by an official document produced in 1987 by the Ministries of Public Health, Civil Affairs, and Public Security entitled *Opinions about Strengthening Mental Health Work*; it states that over 80% of the mentally ill are not able to receive treatment and that over 95% cannot be admitted to hospital because of the shortage of psychiatric beds.

If the hospital system is so limited, do the facilities in the community compensate? Community mental health services are even less well co-ordinated than in-patient services, so there are no national statistics available; but the overall impression is that services are quite limited in all but the large urban centres (e.g. Shanghai, Beijing, Guangzhou, Shenyang) and virtually non-existent in the countryside. Shanghai is acknowledged throughout China to have the most comprehensive and integrated system of community care (Zhang, Yan & Phillips, this supplement). Based on the Shanghai experience, a theoretical model of community care suited to China's particular characteristics does exist (Pearson, 1992; Tian *et al*, this supplement), but the problem is one of dissemination and adoption. Where the services are good there seems to be one person (or a group of people) who, for whatever reason, approaches the task with enthusiasm and has a flair for it (X. Wang, this supplement). But such people are relatively rare; several of them are represented in this volume. In most urban locations, treatment and rehabilitation services are still centred in psychiatric hospitals. With a few notable exceptions, such as the Yantai project (Wang *et al*, this supplement), patients living in rural areas (75% of the population) are poorly

served: facilities are scarce, the doctors are not well-trained, and those in need are increasingly unable to pay the spiralling in-patient fees.

The economics of mental health care

It is a common misperception that health care in China is free, that there is an equivalent of the National Health Service. This has never been the case. China has received many justifiable plaudits for improving the health status of her people since 1949, but these improvements have been achieved largely through public health measures, not through the provision of curative health care (Lucas, 1982).

Prior to the reform era, government cadres received government-sponsored health insurance, urban workers in state-run enterprises received health insurance sponsored by their work unit, and rural residents received coverage for primary care services via the co-operative health insurance schemes that were financed by communes (Hillier & Jewell, 1983). The 'contract responsibility system' that was introduced in rural areas starting in 1978 and in urban areas starting in the early 1980s wrought fundamental changes to the provision of health care. This new system involves individuals, families, and companies taking responsibility for production; they have the opportunity of making higher incomes (or profits) but can no longer depend on the state to pay their capital costs or to cover operating losses. As rural households assumed responsibility for agricultural production, the commune system was destroyed and with it the financial backing for rural social welfare services, including rural health care (Hsiao, 1984; Hillier, 1988; Henderson, 1990; Gu *et al*, 1993). In urban areas the changes have been less drastic, but many industries are trying to increase their economic efficiency by tightening the eligibility criteria for health insurance, and the Ministry of Public Health is trying to limit health expenditures for government cadres by introducing co-payments and capitation. Peasants and the ever-increasing numbers of individual entrepreneurs and itinerant workers must now pay for health care on a fee-for-service basis. At present, only about 10–15% of the population is eligible for comprehensive health insurance that covers psychiatric hospitalisation (*China Daily*, 1992).

As part of the reforms, hospitals are expected to become economically self-sufficient. Government subsidies for the operating expenses of many hospitals are being reduced, and the hospitals are encouraged to make up the shortfall by increasing charges for services and by engaging in 'tertiary industry' (Huang & Cao, 1992) – that is, non-medical ventures such as leasing land to local farmers, selling produce, and opening restaurants and hotels (Pearson, 1991). The dramatic escalation of hospital charges has resulted in a rapid decrease in the accessibility of in-patient care. The monthly charge at state-run psychiatric hospitals is in the range 300–1500 Renminbi (Rmb) and averages about 600 Rmb (about $US 100). Thus the typical three-month stay for an acute psychotic episode costs 1800 Rmb, which is more than the annual per capita urban income of 1570 Rmb and more than twice the annual per capita rural income of 710 Rmb (State Statistical Bureau, 1992). Given this level of charges, it is not surprising that the health care utilisation patterns of self-pay patients are different from those of patients with government-sponsored or work unit-sponsored insurance. Many uninsured patients are simply unable to afford needed in-patient care, and those who are hospitalised wait until the symptoms are more severe before being admitted and are discharged earlier than insured patients. A large multi-centre study (Phillips *et al*, 1990) found that the average hospitalisation for uninsured schizophrenic patients was significantly shorter than that of insured schizophrenic patients (73 days versus 112 days).

Under the new contract responsibility system, doctors in state-run institutions continue to receive their basic salary from the government, but the size of their bonuses – that constitute up to 50% of their take-home pay – depends on the amount of income they generate. This creates a strong incentive for physicians to prolong hospitalisations, to practice polypharmacy (particularly with expensive traditional Chinese medications), and to administer unnecessary procedures such as the intravenous administration of neuroleptics, electroconvulsive therapy, and low-dose insulin 'hypoglycaemia therapy' (Phillips, 1994). Increased fee-charging is one of the incentives for introducing new in-patient rehabilitation services such as music therapy, recreation therapy, 'psychotherapy' (usually confined to exhorting patients to take their medicine), and other interventions that can be billed to the patient.

The rapid increase in the proportion of uninsured and in the cost of hospitalisation is particularly disadvantageous to individuals with chronic illnesses – such as schizophrenia – who require multiple prolonged admissions. Previously the psychiatric hospitals run by the Ministry of Civil Affairs were purely welfare institutions that provided services for the 'three-have-nots' (no money, no family, and no means of support), but now, under the pressure of economic reforms, they are rapidly losing their original mission and having to compete

with the Ministry of Public Health hospitals for paying patients; as of 1991, 59% of the patients in the Ministry's psychiatric hospitals were self-paying (Wong, 1994). Ministry officials see this as a benefit to the hospitals because they will receive more 'rewarding' patients to treat and standards in the hospitals will improve (Pearson, 1991). This may be so, but it begs the question of where do poor and chronically ill patients go?

Community care should be a viable option because it has clear financial advantages for the patient, the family, and the government (Xiong *et al*, 1994). However, it does not have the same capacity as hospitals to raise income through fee-charging. In the current economic climate this is a serious disadvantage, because clinicians are reluctant to work in settings that do not provide good bonuses and hospitals are disinclined to provide unprofitable community services that, if successful, will reduce the need for in-patient services.While the government encourages the development of community mental health services, it is not able to provide funding to go with its exhortations. For instance, chapter III, paragraph 6 of the *Work Programme for Disabled Persons During the Period of the 8th Five-Year National Development Plan 1991–1995* (State Council, 1992) says 'local governments at all levels are *requested* to increase budgetary allocations to rehabilitative service' (our emphasis).

The only obvious financial concession that the government makes for rehabilitation services is to provide income tax relief to enterprises that employ more than 35% disabled workers. Welfare factories run by the state, only a few of which are willing to hire psychiatric patients, benefit from additional relief from product tax, value-added tax, and turnover tax (Wong, 1990). Even then, many such enterprises make a loss and may not survive if the government continues to reduce its financial support for welfare services (Chan & Chow, 1992). Providers of community-based mental health services are expected to have therapeutic and rehabilitation skills and to be entrepreneurs of unusual talent. While some are able to rise to the challenge, it is unrealistic to expect the majority to do so.

The contract responsibility system has also made it more difficult to return rehabilitated workers to their former positions (Pearson, 1989) and to find work for previously unemployed persons who have recovered from a mental illness (Phillips, 1994). Before the contract responsibility system was introduced there was no pressure to make a profit, so workers were paid, however much work they did. This system was a good deal more accepting of individuals who, due to chronic illness, were unable to match the quantity and quality of work of other employees. In the current economic climate, however, many factories have prolonged apprenticeships that screen out persons with mental illnesses before they become permanent employees. Moreover, many factory managers prefer to keep permanent employees with mental illnesses at home on a disability pension rather than risk the ire of other workers who are concerned that the mentally ill person's poor work function will decrease co-workers' productivity bonuses.

Training of mental health workers

There are a number of points about the staffing of psychiatric services that are profoundly different from the situation obtaining in the West, including the virtually total absence of social workers, occupational therapists, and clinical psychologists. Services are staffed by physicians and nurses. There are two grades of doctor: the higher-level doctors study general medicine at medical university for five or six years; the lower-level study for three years at a health school. Most younger nurses get two or three years of training in a health school, but many of the older nurses have no formal nursing training and would be more correctly seen as nurses' aides. After graduation, neither doctors nor nurses are permitted to choose where they work, so those who come to psychiatry have been assigned to do so. Given the heavy social stigmatisation of the mentally ill, both doctors and nurses are extraordinarily reluctant to work in the psychiatric field; this creates problems of both knowledge and motivation, the effects of which permeate the system (Bueber, 1992, 1993).

General medical training contains little psychiatry (an average of two weeks in the five-year medical courses), and general nursing education contains no psychiatry at all. There is no national system of training in the specialism of psychiatry; most psychiatrists and psychiatric nurses obtain their training by observing more experienced staff after assignment to a psychiatric hospital at graduation. Regular in-service training via case conferences and weekly seminars occurs in some of the more academically oriented institutions, but this is rarely systematic or comprehensive. The training contains little – if any – material on the psychosocial aspects of care. After seven years of this apprenticeship-style training young doctors and nurses can sit standardised written exams (which contain little psychiatry) to be promoted to the level of an attending physician or senior nurse (Phillips, 1994).

These characteristics of the training of mental health workers have important implications for the provision of psychiatric rehabilitation. General

physicians and nurses have little or no psychiatric training so they are unable to perform basic psychiatric assessments and treatments; this lack of knowledge combined with their reluctance to treat psychiatric patients limits the development of community-based programmes. In the absence of other mental health care professionals, psychiatrists and psychiatric nurses must either directly provide the rehabilitation services or must supervise the training of those who provide the services. The generally low morale of mental health workers (because of the low status of their work) and their lack of expertise in psychosocial interventions seriously undermine the effectiveness of many rehabilitation programmes.

Conclusion

The years since 1978 have been a period of great change for Chinese society. Economic reforms and increased contact with the West have brought fundamental changes to the economic and social fabric of the community. Conditions are still in flux and will probably remain so for several years, so it is difficult to predict what the future holds for society as a whole and for psychiatry in particular.

The current socioeconomic environment in China is not particularly conducive to the development of comprehensive psychiatric rehabilitation services. Many factors impede the evolution of rehabilitation programmes: the lack of social workers, occupational therapists, and psychologists; the limited training of doctors and nurses in the methods of psychosocial intervention; the financial incentives that emphasise high-technology in-patient care; and the severe stigmatisation of the mentally ill. It is not surprising that the practice of psychiatric rehabilitation has not, as yet, become deep-rooted in the minds of most psychiatrists; they are still more oriented towards drug treatment and behavioural control. However, the successful rehabilitation programmes reported in this supplement are proof that innovation and energy can overcome these obstacles.

At the moment, the push towards rehabilitation seems to be largely a top-down movement. But that is often how things work in China. Without Deng Pufang, supported by a small number of top officials, and without the effort of a few very influential senior psychiatrists, psychiatric rehabilitation would have remained in the shadows of psychiatric practice, wholly eclipsed by the rush to emulate the high-status biological psychiatry of the West. There is now a window of opportunity; if the momentum is to be maintained, grass-roots mental health practitioners need to be converted. Much will depend on the energy and effectiveness of the new branches of the Rehabilitation Research Association for the Mentally Disabled at the provincial and municipal level; if they can productively co-ordinate their activities with the local 'three-men leading groups' responsible for psychiatric provision and implementation, it may be possible to obtain the financial and administrative support needed to provide high-quality psychiatric rehabilitation services.

One of the main issues will be the balance between hospital and community provision. For most rehabilitation practitioners in China the main goal of rehabilitation is to reintegrate patients into the community, which implies a non-hospital orientation to the provision of services. But most rehabilitation services are currently provided within hospitals because they are by far the most common facility available and are most likely to have staff who are familiar with the concept of rehabilitation. There is, moreover, a structural tension between hospital and community facilities. If community services are successful, the rate and duration of hospitalisation should drop; this could potentially cut down the income for hospitals and their staff. Currently, hospitals have the staff and most of the resources; it seems doubtful that the majority of them will give up their commanding position voluntarily.

Financial and personnel constraints are clearly the major factors influencing the development of psychiatric rehabilitation in China and will continue to be so for the foreseeable future. A major matter for concern is that few of the providers of psychiatric rehabilitation in China are aware of how patients' social environment affects rehabilitation. To make efficient use of funds and personnel, emphasis must be placed on specialised training that increases clinicians' awareness of the psychosocial determinants of outcome and that improves clinicians' ability to provide psychosocial interventions. For example, the accumulating indigenous evidence demonstrating the therapeutic and economic benefits of family education and support (Xiong *et al*, 1994; Zhang, Wang, Li & Phillips, this supplement) suggests that Chinese clinicians should learn to administer family-based interventions; family treatment is entirely compatible with the Chinese emphasis on family care and reduces the heavy financial burden that in-patient care places on so many people. Ultimately, policy-makers – who are concerned with reducing the societal burden of chronic mental illness – will have to consider the type and training of the rehabilitation personnel needed to adjust mental health services to the new environment created by economic reforms, higher expectations from the community, and the increasing level of unmet need.

References

ANTHONY, W. A. & LIBERMAN, R. P. (1986) The practice of psychiatric rehabilitation: historical, conceptual and research base. *Schizophrenia Bulletin*, **12**, 542–559.

BARTON, R. (1959) *Institutional Neurosis*. Bristol: John Wright.

BENNETT, D. (1991) The historical development of rehabilitation services. In *Theory and Practice of Psychiatric Rehabilitation* (2nd edn) (eds F. Watts & D. Bennett), pp. 15–42. Chichester: John Wiley.

BUEBER, M. (1992) Letter from China (No. 1). *Archives of Psychiatric Nursing*, **6**, 61–64.

—— (1993) Letter from China (No. 3). *Archives of Psychiatric Nursing*, **7**, 249–253.

CHAN, C. L. W. & CHOW, N. W. S. (1992) *More Welfare After Economic Reform? Welfare Development in the People's Republic of China*. Hong Kong: Centre for Urban Planning and Environmental Management.

CHIN, R. & CHIN, A. L. (1969) *Psychological Research in Communist China, 1949–1966*. Cambridge, Massachusetts: MIT Press.

CHINA DAILY (1992) Medical cost reforms (19 June, p. 3).

GOFFMAN, E. (1961) *Asylums*. London: Penguin.

GU, X. Y., BLOOM, G., TANG, S. L., *et al* (1993) Financing health care in rural China: preliminary report of a nationwide study. *Social Science and Medicine*, **36**, 385–391.

HENDERSON, G. (1990) Increased inequality in health care. In *Chinese Society on the Eve of Tiananmen: The Impact of Reform* (eds D. Davis & E. Vogel), pp. 263–282. Cambridge, Massachusetts: Harvard University Press.

HILLIER, S. (1988) Health and medicine in the 1980s. In *Reforming the Revolution: China In Transition* (eds R. Benewick & P. Wingrove), pp. 149–160. London: Macmillan.

—— & JEWELL, J. M. (1983) *Health Care and Traditional Chinese Medicine In China, 1800–1982*. London: Routledge & Kegan Paul.

HSIAO, W. (1984) Transformation of health care in China. *New England Journal of Medicine*, **310**, 932–936.

HUANG, C. & CAO, Y. (1992) Go into business health sector told. *China Daily* (26 June, p. 3).

KLEINMAN, A. (1986) *Social Origins of Distress and Disease; Depression, Neurasthenia and Pain in Modern China*. New Haven: Yale University Press.

LEFF, J. (1993) The rehabilitation of long term psychiatric patients in the community. In *Psychiatric Rehabilitation: The Asian Experience* (eds V. Pearson, N. Rhind, L. Barker, *et al*), pp. 66–80. Hong Kong: Centre for Social Sciences Research, University of Hong Kong.

LIN, T. Y. & EISENBERG, L. (1985) *Mental Health Planning for One Billion People*. Vancouver: University of British Columbia Press.

LUCAS, A. (1982) *Chinese Medical Modernization; Comparative Policy Continuities, 1930s–1980s*. New York: Praeger.

LYMAN, R. S. (1939) *Neuropsychiatry in China*. Peking: Henri Vetch.

MINISTRY OF PUBLIC HEALTH (1993) *China Health Statistics Annual* (In Chinese). Beijing: People's Health Publishing House.

NAGASWAMI, V. (1993) The influence of explanatory models of mental disorders on concepts and practice of psychosocial rehabilitation. In *Psychiatric Rehabilitation: The Asian Experience* (eds V. Pearson, N. Rhind, L. Barker, *et al*), pp. 48–65. Hong Kong: Centre for Social Sciences Research, University of Hong Kong.

PEARSON, V. (1989) Making a virtue of necessity: hospital and community psychiatric care in China. *International Social Work*, **32**, 53–63.

—— (1991) *Mental Illness In The People's Republic: An Exploratory Study of Chinese Experience*. PhD thesis, University of York, UK.

—— (1992) Community and culture: a Chinese model of care for the mentally ill. *International Journal of Social Psychiatry*, **38**, 163–178.

—— & PHILLIPS, M. R. (1994) Psychiatric social work and socialism: problems and prospects in China. *Social Work*, **39**, 280–287.

PERRING, C., TWIGG, J. & AITKEN, K. (1990) *Families Caring for People Diagnosed as Mentally Ill: The Literature Re-examined*. London: HMSO.

PHILLIPS, M. R. (1993) Strategies used by Chinese families coping with schizophrenia. In *Chinese Families in the Post-Mao Era* (eds D. Davis & S. Harrell), pp. 277–306. Berkeley and Los Angeles: University of California Press.

—— (1994) The influence of social, political, and economic factors on the evolution of mental health services in China. Working Paper No. 20, Series on International Mental & Behavioral Health. Centre for the study of Culture and Medicine, Harvard University.

——, XIONG, W. & ZHAO, Z. A. (1990) *Issues Related to the Use of Assessment Instruments for Negative and Positive Psychiatric Symptoms* (in Chinese). Hubei: Science and Technology Press.

PILLING, S. (1991) *Rehabilitation and Community Care*. London: Routledge.

PSYCHOLOGICAL MEDICINE RESEARCH CENTRE OF THE WEST CHINA UNIVERSITY OF MEDICAL SCIENCES (1990) *National Listing of the Treatment, Educational, and Research Institutions for Mental Health* (in Chinese). Chengdu: Sichuan Psychological Association.

SHEPHERD, G. (1991) Psychiatric rehabilitation for the 1990s. In *Theory and Practice of Psychiatric Rehabilitation*, (2nd edn) (eds F. H. Watts & D. H. Bennett), pp. xiii–xlviii. Chichester: John Wiley.

STATE COUNCIL (1992) Work Programme for Disabled Persons During the Period of the 8th Five-Year National Development Plan (1991–1995). Beijing: Huaxia.

STATE STATISTICAL BUREAU OF THE PEOPLE'S REPUBLIC OF CHINA (1992) Statistical communiqué on national economic and social development in1991. *China Daily (Business Week)* (8–14 March, p. 4).

TORREY, E. F. (1988) *Surviving Schizophrenia: A Family Manual* (3rd edn). New York: Harper & Row.

WANSBOROUGH, S. N. (1981) The place of work in rehabilitation. In *Handbook of Psychiatric Rehabilitation Practice* (eds J. Wing & B. Morris), pp. 79–94. Oxford: Oxford University Press.

WATTS, F. N. & BENNETT, D. H. (1991) Introduction: the concept of rehabilitation. In *Theory and Practice of Psychiatric Rehabilitation* (2nd edn) (eds F. N. Watts & D. H. Bennett), pp. 3–14. Chichester: John Wiley.

WING, J. & BROWN, G. (1971) *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals 1960–68*. Cambridge: Cambridge University Press.

—— & MORRIS, B. (1981) Clinical basis of rehabilitation. In *Handbook of Psychiatric Rehabilitation Practice* (eds J. Wing & B. Morris), pp. 3–16. Oxford: Oxford University Press.

WONG, L. (1990) Rehabilitation services in China: policy and outcomes. *Asian Journal of Public Administration*, **12**, 196–213.

—— (1992) *Social Welfare Under Chinese Socialism – A Case Study of the Ministry of Civil Affairs*. PhD thesis, London School of Economics, UK.

—— (1994) Privatisation of social welfare in post-Mao China. *Asian Survey*, **34**, 307–325.

XIONG, W., PHILLIPS, M. R., HU, X., *et al* (1994) Family-based intervention for schizophrenic patients in China: a randomised controlled trial. *British Journal of Psychiatry*, **165**, 239–247.

Veronica Pearson, *University of Hong Kong*; Michael R. Phillips, *Shashi City Veterans Psychiatric Hospital, PRC, and Harvard Medical School, USA*

Correspondence: *Dr V. Pearson, Department of Social Work and Social Administration, University of Hong Kong, Pokfulam Road, Hong Kong*