Editors' Introduction to Section III: Rehabilitation Interventions in Urban Communities

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The four papers in this section describe examples of the succcessful and innovative community mental health programmes that have developed in some large cities in China over the past 15 years. They should not, however, be considered representative of what is happening in the rest of the country. Community-based mental health services in China are primarily a phenomenon of large municipalities with populations of over one million. In small and medium-sized cities, where 58% of China's urban residents dwell (National Statistics Bureau, 1990), community services, if any, are limited to medically oriented out-patient clinics in psychiatric hospitals that focus on treating symptoms, not on rehabilitation. Most rural areas have no services at all.

The goals of the community services that have evolved in the large cities and the methods adopted to provide the services are, as in other societies, a reflection of the community's priorities and of the available resources. From the perspective of Chinese communities, the goals of these services are to ensure access to medical treatment, to provide employment, and to prevent social disruption. Lack of funds and of trained personnel have been the major blocks to achieving these goals. Given the extremely limited funding available from the central government for welfare services, financial support for community mental health services must be provided by local communities, work units, and patients' families (through fee-charging). The obvious outcome of this is that affluent communities are much more likely to have comprehensive services, though this is not always the case. The lack of mental health professionals in the community has two effects: (a) some community services are provided from out-patient departments in psychiatric hospitals and, thus, tend to emphasise medication management over psychosocial intervention; and (b) the truly community-based services have depended heavily on volunteers and on untrained cadres from the local offices of the Ministry of Civil Affairs, who may or may not receive professional guidance from hospital-based clinicians.

Given these goals and these resource limitations, there are three primary types of community service available in large Chinese cities: (a) diagnostic and medication follow-up services provided by hospital clinicians who either work in hospital out-patient departments or, less commonly, visit patients' homes (the 'home beds' programmes); (b) occupational rehabilitation and employment in sheltered workshops, in welfare factories (that get tax incentives if they have 35% disabled workers), and in on-site workshops that some large enterprises have established for their mentally ill employees; and (c) management and supervision of patients' daily activities by community members who form 'guardianship networks'. Improving the quality of life of the mentally ill is not a primary goal of community services in China, and so recreational, social, and educational activities are of secondary importance: there are few day hospitals and no drop-in centres or clubhouses. Housing for the mentally ill remains the responsibility of family members and so – with the exception of one nine-bed 'night hospital' in Shanghai – communities do not provide intermediate-care residential facilities or accommodation for independent living.

Three issues may strike the Western reader. First, the paramount importance of maintaining public order. This is one manifestation of the traditional concern of Chinese governments and of the Chinese people about the deleterious effect of social unrest on a community's economic progress and on its social harmony. As stated by Zhang, Yan & Phillips (this supplement), some local governments in China are prepared to support services that treat and supervise psychiatric patients in the community because this is considered an effective way to minimise social unrest. Although it might be phrased a little differently, this is not an unfamiliar issue in Western countries. However, in the West it is usually coupled with an expression of concern for the patient's right to achieve some degree of self-actualisation and to live a life which is inherently satisfying. In China, the concern is rather a different one. It is to rehabilitate patients so they can return to their place in the hierarchy of social relationships, become productive, and, thus, contribute to society.

The second issue is the centrality of work in the concept of rehabilitation. Western rehabilitation practitioners believe that providing work for people recovering from a psychiatric disorder is important

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for self-esteem, for structuring the individual's time and space, for providing a normal social role, and for expanding social contacts (Bachrach, 1992). In the Chinese context, work has other resonances with which we are not so familiar. One of the fundamental tenets of Chinese communism is that all citizens must participate in construction of a socialist society by contributing their labour; the implication is that persons who do not work are not worthy of the support of the state. Confucian ethics, which still have considerable influence in China, dictate that individuals must contribute to the advancement of the family; adults who do not work and are financially dependent on parents or spouses thus fail to meet the basic requirements of their social role and, thus, have no place in the dense network of social relationships that define an individual's identity in Chinese culture. Moreover, in the urban Chinese setting, access to most forms of welfare is limited to those who work because workplaces regulate health insurance, old age pensions, housing, nursery care, and so on. Thus someone without a job is not only socially and politically inferior but also lacks access to many necessities of daily life. Given this primacy of employment in the social identity and social welfare of the individual, it is not surprising that Chinese rehabilitation efforts focus on occupational training and work.

The third issue is the surprising lack of family-based services in this family-centred society. The dominant role of the family in the care of mentally ill persons in China and the failure of mental health professionals to provide adequate support to family members was described earlier (Pearson & Phillips, this supplement, section I). Mental health workers in China have no training and little interest in the psychosocial aspects of care, so most of them are unaware of the contribution that family relationships can make to either a negative or positive outcome of the illness. Some Chinese psychiatrists are familiar with Western work on expressed emotion in families (Kuipers & Bebbington, 1988), but cultural differences have made replication of these studies difficult in China. In a few localities there is a dawning recognition that families will need assistance to continue to shoulder the heavy responsibility of caring for mentally ill individuals in the home; family educational programmes and family counselling services have just started to appear in the last two to three years.

The first paper in this section, by Zhang, Yan & Phillips, provides a detailed description of the 'Shanghai model' of community mental health services. This model – which includes out-patient medication follow-up, guardianship networks, and sheltered workshops – is widely acknowledged as the best in the country; a slight modification of the model is proposed for promulgation throughout the country in the mental health section of the *Work Programme for Disabled Persons During the Period of the 8th Five Year National Plan (1991–1995)* (State Council, 1992). Zhang, Yan & Phillips' paper describes the first prospective controlled trial on the efficacy of the Shanghai model of community care; it demonstrates that guardianship networks and sheltered workshops lead to improvements in social functioning and in both the positive and negative symptoms of schizophrenia. The authors also discuss the cultural and socioeconomic factors that mould mental health services in China and that make it impossible for Chinese practitioners to provide the individually tailored rehabilitation interventions favoured in the West.

The guardianship-network method of management described in the paper is unique to China. In its ideal form, each patient has a group of three individuals – a family member, a local health worker, and a local community member – who act like a team of non-professional case managers (Onyett, 1992). They ensure that the patient receives needed treatment and intercede on the patient's behalf when social problems arise. Guardianship networks, like the sheltered workshops, are heavily dependent on 'volunteers', who are assigned by the local residents' committee (the grass-roots political organisation); indeed, volunteers are what make this unique method of community mental health service feasible in China. But the social transformation of Chinese cities that has accompanied the recent economic reforms has decreased the power of the residents' committees over the lives of individual citizens; as local residents become more interested in pursuing personal gain than in providing community services, the continued viability of the guardianship networks and sheltered workshops may be threatened.

The second paper, by X. Wang, while more descriptive in nature than the others, gives a sense of what a local community can achieve when determination and initiative are harnessed to entrepreneurial spirit. Her welfare factory, which makes cinema tickets, employs people with a mental disability and has generated enough profit to open a small community psychiatric hospital and to finance the operation of a comprehensive range of community mental health services. These services are now so successful that they generate their own surplus, even though the charges are considerably less than those in government-run hospitals and clinics. Moreover, her centre charges patients without medical insurance only 50% of the regular charges for services, a practice widely employed before

the reform era that has long since been abandoned by most other health care institutions. Her work has received national recognition and accolades from visiting foreigners; but it has not, as yet, been possible to duplicate this model of service delivery elsewhere in China. Wang emphasises the importance of achieving economic self-sufficiency and of having all services administered locally by a single entity; this provides the flexibility needed to make changes in the pattern of services when there are changes in local social conditions or in the needs of local clients.

One unique aspect of Wang's welfare factory is that all disabled workers attend regular classes about complying with local laws, about maintaining a good work attitude, and about national and local politics. This is the only paper in the supplement to mention political thought and its place in the treatment and rehabilitation of the mentally ill. Since most workers in government-run enterprises attend an afternoon devoted to political education each week (the frequency of such meetings varies widely around the country), requiring disabled workers to do so is simply part of training them to be normal Chinese workers. Political education is not being used as a replacement for psychiatric treatment – a practice that occurred in some locations during the Cultural Revolution.

Enterprise-based workshops for the mentally ill, described in the paper by Luo & Yu, is another form of community service that is unique to China. It has evolved in an environment where large enterprises provide an extremely comprehensive range of social welfare benefits to their employees and where factory managers are expected to help solve workers' physical and social problems (Chan & Chow, 1992). In addition, because of the 'iron rice bowl' policy (a job for life) that many enterprises still maintain, the factory cannot sack a mentally ill employee who no longer works to capacity. Most factory managers prefer to keep employees with chronic mental ilnesses at home on permanent disability pensions (about 60% of regular income), but some enterprises have been persuaded to be more creative in their approach to the problem.

As Luo & Yu show, there are considerable benefits for the patient, the family, and the factory when mentally ill employees are enrolled in an enterprise-based sheltered workshop after hospital discharge and then returned to their regular job following a four-month period of occupational rehabilitation. Some ex-patients prefer to go straight back to their regular job because of the higher income (workers in the sheltered workshop do not get bonuses) and, perhaps, because of the stigmatising nature of the sheltered workshop; but for the majority of ex-patients who are not able or not permitted to return to their regular job immediately after discharge from a psychiatric hospital, the workshop provides a structure to the day, close medical supervision, and a clear goal (return to regular work) that would be missing if they stayed at home on a disability pension. Unfortunately, the long-term viability of enterprise-based workshops is threatened by the recent economic reforms in China's industrial sector. Forced to become economically efficient, many larger enterprises no longer guarantee lifetime employment and are drastically cutting back on the welfare benefits they provide to employees; in this new environment, enterprise leaders will probably be increasingly reluctant to establish on-site workshops for mentally ill employees.

Both the Luo & Yu paper and the X. Wang paper highlight the gap between mental health policy and local implementation. Wang reports that in Shenyang only 15 of 77 neighbourhoods even attempted to set up the community mental health services stipulated by the municipal government, and Luo & Yu report that in Nanjing only 12 of the 80 large enterprises organised the sheltered workshops mandated in the municipal regulations. While local governments are prepared to urge enterprises or street-level organisations to provide services, they are often unable or unwilling to provide the resources needed to support the new initiatives. This is also the problem with the mental health policies and regulations passed by national, provincial, and county levels of government; there are no provisions for the enforcement and financing of the policies. Without economic or legal leverage, these policies are little more than exhortations that can be safely ignored. Such policies do, however, outline the ideal framework of services as envisioned by the various levels of government and provide an umbrella under which local communities can undertake mental health initiatives if they have sufficient motivation and resources to do so.

The last paper in the section, by Zhang, Wang, Li & Phillips is one of the studies generated by the World Health Organization's recent initiative to promote educational interventions for families of persons with severe mental illness in China (also see Wang et al, 1993). It reports the results of a randomised controlled trial that compared the 18-month outcome of first-break schizophrenic patients who received standard post-hospitalisation treatment plus a family intervention programme with that of patients who received only the standard treatment. For urban schizophrenic patients in China, standard post-hospitalisation treatment usually entails irregular visits by family members (often without the patient) to the out-patient department, where they see different

clinicians at each visit and are given a prescription after a cursory examination; if patients cease to attend, no attempt is made at follow-up or outreach.

The authors show that the addition of quarterly group or individual educational sessions for families combined with generalised emotional support can significantly improve the clinical outcome for patients. Stratified analysis of their results elegantly segregates the effects of drug compliance and family intervention: these two factors have independent and additive effects. Patients who were not compliant and did not receive the family intervention were 7.9 times more likely to be readmitted to hospital in the 18-month study period than patients who were drug-compliant and received the family intervention. Like the work by Xiong *et al* (1994), this study demonstrates that family interventions are a cost-effective method of improving clinical and social outcomes for schizophrenic patients in China.

Given the centrality of the family in the care of the mentally ill in China, psychiatric rehabilitation programmes must treat families as partners in care. The first step is to provide families with basic education about mental illnesses. In China, members of families of the mentally ill, like their Western counterparts, have difficulty understanding and accepting the chronic nature of schizophrenia, which leads to problems of compliance with treatment (Phillips, 1993); and they are keen to have more information to help them manage the patient constructively at home (Pearson & Jin, 1992; Pearson, 1993). It is easy to transmit such information, but clinicians rarely do so. Indeed, many family members of discharged patients are not told the patients' diagnosis or the name of the medication the patient is taking. The reasons for this reside in the authoritarian doctor–client relationship in China; many clinicians do not consider education about the illness part of their responsibility, and some believe that providing information to patients and family members will decrease their willingness to comply with doctors' recommendations. The paper by Zhang, Wang, Li & Phillips convincingly demonstrates the benefits of educating family members. The more difficult task will be to transform Chinese mental health professionals' perception of their role.

With the possible exception of the work by Xiong *et al* (1994), family therapy for the severely mentally ill as it is known in the West (Lam, 1991) has not yet evolved in China. The reasons for this are the aforementioned lack of training in the psychosocial aspects of care and the lack of a culture-specific theory about family relationships and roles. Many aspects of family life are so different in China that the application of unmodified Western approaches is clearly inappropriate. For example, the emphasis found in Western families on the separation and independence of children from parents is not found in China; there is, rather, an acceptance within Chinese families of the desirability of mutual dependence, the balance of caring gradually changing as the parents age. The development of culture-sensitive methods of dealing with these issues in family counselling for persons with chronic mental illnesses will be a complex and time-consuming task, but it is a challenge that must be faced if rehabilitation practitioners in China wish to intervene in their clients' most important social environment.

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