

## *Growing Pains: Mental Health Care in a Developing China*

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Around the world, in high- and low-income countries alike, mental illness and high-risk behaviors contribute to profound suffering and loss at the level of the individual and the state. In the case of China as in other developing countries, gains made in the areas of economics, technology, education, and overall standard of living are being offset by a rise in mental and behavioral problems that suggest the human costs of economic development and rapid social change. Although most Chinese would agree that there has never been more opportunity or freedom to pursue one's capitalistic dreams, the process of adjusting to life in the new economy and its shifting demands and possibilities is adversely affecting the Chinese social world. Such social transformations include (1) an increase in numbers of individuals and families who suffer from major economic losses due to risky ventures or pathological gambling, (2) higher rates of extra-marital affairs, family violence, and divorce, (3) rising rates of substance use and abuse, (4) rapidly increasing costs of health care, which may lead to an inability to pay for necessary care and exacerbate chronic conditions, (5) weakening of traditional family/communal relationships resulting in a degradation of one's social support network, (6) increasing numbers of rural migrants seeking employment in urban areas, (7) the widening economic and social gap between the rich and the poor, which may produce feelings of dissatisfaction and social unrest, (8) increasing work-related stress due to more competition, and (9) in general, a "faster pace of life" (Phillips, Liu, and Zhang, 1999).

Within this social context, recently available statistics suggest that the country's disease burden due to mental and behavioral disorders is substantial and will likely escalate over time. For example, the increased longevity of Chinese citizens

(71.4 years in 2000 versus 40.8 years in 1950) due to improved public health programs is contributing to higher numbers of neuropsychiatric problems such as depression and dementia among the elderly. There is also renewed attention being paid to childhood problems such as attention-deficit-hyperactivity-disorder (ADHD) among China's first generation of only-children. Available data document a twenty-fold increase in alcohol-related problems since 1982 (Hao, Young, and He 1995; Hao, Young, Xiao, Li, and Zhang 1998). Perhaps most disturbing, the World Bank's Global Burden of Disease and Injury Series estimated that in 1990 there were 342,700 reported suicides in China, about three times the world average (Murray and Lopez 1996). Even a conservative estimate would indicate that China has the world's largest number of reported suicides by virtue of its large population (21.5% of the world's total), with 600–800 individuals killing themselves each day (Lee and Kleinman 2000). This figure accounts for somewhere between 25% and 33% of all suicides worldwide.

The story of China's efforts to meet the needs of her most vulnerable citizens mirrors, in a sense, the story of China's journey towards the modern age. Her enormous population, spread throughout a vast and geographically diverse space, presents specific challenges for both governance and economic development. For the estimated 16 million individuals impaired by psychological problems, significant geographic and economic disparities in availability and access to mental health services mean that many receive little or no care at all. For example, it is estimated that one-third of China's 7.8 million persons with schizophrenia and 95% of those with affective disorders have never received formal psychiatric diagnosis or treatment (Murray and Lopez 1996).

This article examines the current system of mental health care in China from its prosperous and cosmopolitan cities along the coast to its most remote, impoverished areas. We present some of the ways in which the state is attempting to meet the mental health needs of the populace and outline some of the challenges that confront China in this era of social and economic change.

### **Brief History of the Development of Mental Health Services**

Unlike the situation in the West, where large proportions of persons with mental illness live on their own or in various institutional settings (e.g., hospitals, nursing homes, board-and-care facilities, shelters), over 90% of Chinese persons with major mental illness live with their families (Phillips 1993). In contrast, the same is true of only 40% of individuals in the United States (Torrey 1998). What is lacking in most regions of China however is affordable and accessible psychiatric treatment.

Efforts to develop a modern system of mental health care in China as elsewhere have been influenced by philosophical traditions as well as political and economic factors. Traditional Chinese theories of medicine did not consider

mental disorders separately from physical disorders, as their origins were also thought to be due to an imbalance of the internal organs. Thus, treatment of mental illness was largely somato-psychic in approach with the restoration of physiological function and balance as the primary goal. The designation of mental illness as a separate field of study and treatment did not occur until the late 1800s, when foreign missionaries began establishing asylums for the insane in China. However, widespread social disruption and war in the first part of the twentieth century halted further developments in mental health care.

By 1948, China had only around 60 psychiatrists and five psychiatric hospitals with a total of 1,100 beds for a population of nearly 500 million people. The founding of the People's Republic of China ushered in a period of growth and advancements in health services, as part of the official plan to transform the social system. By the end of 1959, the number of psychiatric beds throughout the country grew to 19 times that of the pre-liberation period. However, severe shortages in trained staff, inadequate medical facilities especially in the rural and mountainous regions, and limited financial resources demanded stop-gap measures that could be widely and inexpensively implemented. In fact, the bulk of treatment during these years was provided via wide-scale mobilization of non-professional treatment teams with minimal education and training.

In the 1950s, Russian neuropsychiatric models dominated professional discourse, and political priorities focused on maintaining public order. During the Cultural Revolution, the biological orientation of Chinese psychiatry provided some protection from political accusations. Nevertheless, psychiatry was disrupted more than any other medical specialty, in that mental illness and other forms of deviance were cast as problems of wrong political thinking to be addressed through re-education, rather than psychiatric care (Pearson 1995).

### **Recent Developments in Mental Health Care**

The end of the Cultural Revolution in 1976 led to a revitalization of psychiatry and the extension of state-run services for the mentally ill. Currently, there are less than 1,000 psychiatric institutions, 150,000 psychiatric beds and 13,000 mental health professionals (of whom perhaps 2,000 are fully trained psychiatrists), with most resources still concentrated in urban areas under the jurisdiction of the Ministries of Public Health, Civil Affairs, Defense, Industry and Mining, Public Security, and the People's Liberation Army (Cohen 2001; Zhang, Yan, and Phillips 1994). While these figures represent a substantial increase since 1948, there is still only one bed per 10,000 population and less than one mental health professional per 100,000. Despite this low bed/population ratio, it is striking to note that an estimated 30% of inpatient hospital beds remain empty because families simply cannot afford treatment under the fee-for-service conditions of today.

The concentration of mental health facilities in urban areas alongside the decline of rural social welfare services in the 1980s have produced a situation of alarming disparity in access and quality of care along the urban-rural divide. For example, 80% of the country's total health budget goes to funding hospital-based treatment in the urban areas, despite the fact that urban residents account for just 30% of the country's population (Zhang 2001). In addition, novel experiments in community-based rehabilitation have yielded favorable results in urban areas, while such models have not been implemented in rural areas or more remote areas of the country (Phillips and Pearson 1994). In recognition of the diversity represented in these different "Chinas", we now turn to a more detailed description of the current state of mental health care within each geographic and economic locale.

### ***Urban Mental Health Care***

Discussions of urban mental health typically refer to China's prosperous coastal edge and its 250 million inhabitants. The enormous economic growth of cities such as Shanghai, Guangzhou, and Shenzhen, has made them laboratories of social and cultural development. Shanghai, the largest city in China, is recognized as having the most comprehensive mental health system in the country.

The so-called Shanghai Model, developed during the 1970s and 80s, was designed as a sophisticated three-tiered scheme that focused limited resources on the three main disability concerns of the state, psychosis, epilepsy, and mental retardation. Increasing levels of care were provided through grass-roots services at the community level, the district level (primary care hospitals), and the municipal level (provincial mental health hospitals). As reviewed elsewhere in greater detail (see Tian, Pearson, Wang, and Phillips 1994), this model of psychiatric rehabilitation was largely successful through the 1980s and 1990s. Innovations in family-based skills training programs, the creation of home "sick beds", and the development of guardianship networks for the maintenance of public security relieved some of the burden of care from the hospitals and allowed patients to return to their communities and families. The development of welfare factories and occupational therapy programs provided culturally relevant opportunities for rehabilitation, improved functioning and quality of life, and provided a source of income for the mentally disabled. Basic maintenance and follow-up treatment was provided by primary care workers who received basic psychiatric training and supervision, reserving the small number of inpatient hospital beds for the most acute cases.

Although this system was successfully carried out in Shanghai and other select cities through the 1980s and early 1990s, widespread dissemination is practically impossible, given the scarce facilities and lack of well-trained mental health professionals in other parts of the country. Furthermore, massive transfor-

mations in China's economic system have deeply undermined the social and economic conditions that have sustained the Shanghai Model and other innovative programs over the past two decades (Chang, Xu, Kleinman, and Kleinman 2002; Gu and Tang 1995). These transformations include the rising costs of hospitalization and treatment, changes in health insurance coverage, declining community involvement in guardianship networks, weakening of the welfare safety net for the disabled, and fewer economic incentives to employ disabled workers. Furthermore, the introduction of the "contract responsibility system" in the early 1980s has created strong incentives for hospital-based physicians to recommend unnecessary procedures, longer hospitalization, and expensive medications. These added costs to the consumer translate into more take-home pay for the physician, as bonuses are computed on the basis of their income-generating power (Pearson and Phillips 1994). For the poor and chronically ill patients however, these changes mean that many can no longer afford the treatments they need. A recent study found that among those in the lowest income bracket who reported illness, 70% did not obtain treatment because of financial difficulty (Gao, Tang, Tolhurst, and Rao 2001).

At the same time, the demand for mental health services to address psychosocial problems appears to be on the rise among an emerging sector of Chinese urbanites. This demand is evidenced by higher numbers of outpatient psychiatry visits, the growth in popularity of mental health hotlines and radio call-in programs, and the increasing utilization of newly available pharmaceutical agents and psychological consulting services among the educated and wealthy elite. For example, the Shanghai Mental Health Centre provided various forms of psychological consulting and psychotherapy to an average of 120 patients per day in 2001, an increase of 60% from a decade before. The most common reasons for seeking help included education or school-related problems, family and relationship difficulties, mental distress, frustration, and insomnia ("Mental Health Care Widens in China", *China Daily*, May 23, 2001).

This brief discussion of mental health care in urban areas reveals a tension between the development of professional services on the one hand, and growing inequities in the financing and access to those services on the other. Under these current conditions, those in greatest need are the least likely to be able to afford treatment.

### **Rural Mental Health Care**

Individuals living in rural areas comprise 70% of the total population but receive poor mental health care compared to those living in urban areas. The uneven pace of economic development across the country means that rural and other remote areas are significantly disadvantaged with regard to the availability, scope, and quality of services. In the absence of psychiatric services within the local

community, acutely ill persons must frequently travel long distances to the nearest large urban center to obtain expensive inpatient care (Wang et al. 1994). As a result, the majority of rural patients with severe and persistent mental illness receive no professional care at all.

In addition, the collapse of the cooperative medical care scheme in most rural areas has severely impacted patients' ability to pay for the minimal services that are available. By 1989, only 5% of the rural population were covered by the system of cooperative health insurance, compared to 84.5% in 1975 (Gu et al. 1993). For the hundreds of millions of rural Chinese who remain poor despite the economic developments occurring elsewhere in the country, the self-pay system has impacted patients in much the same way as their poor urban counterparts. Even when care is available, it may simply be unaffordable.

Another aspect of economic reform that is impacting the rural areas is that health workers are now able to have some choice in their placements instead of being assigned to a work unit as before. Because larger and better-equipped facilities can generate more profits and thus pay out more bonuses, there is a strong financial incentive for qualified personnel in district hospitals to leave for larger city hospitals, and for trained health workers in rural areas to seek employment to county or city hospitals (Li Ming, personal communication, April 18, 2002). A recent report cited that during the 1980s, more than 80% of qualified doctors sampled from eight Chinese provinces left poor counties for more lucrative positions in urban facilities (Gong, Wilkes, and Bloom 1997). This trend has contributed to an even greater scarcity of trained mental health professionals in the countryside, leaving the responsibility of treatment in the hands of less qualified personnel.

Without a cadre of committed and knowledgeable mental health professionals, the few successful experiments in rural psychiatric care will not be sustainable in the long-term. For example, the well-documented and highly-praised Yantai model of rural mental health care relies on the enthusiastic efforts of hospital-based psychiatrists who are charged with the training and supervision of community providers (Wang, Gong, and Niu 1994). In addition, the same economic incentives that are drawing physicians into the bonus-system of urban hospitals are also operating at the county- and township-levels. The ability of community-based rehabilitation and primary-care services to be sustained in this climate will depend on the establishment of health care financing schemes that will redistribute government funds back into township hospitals.

Recent years have seen a rebirth of popular religion in rural China. This includes religious healers such as shamans in the folk religions, Buddhist adepts, Taoist priests, and in areas with sizable Christian populations, priests and ministers. Whereas their activities may be useful in handling certain stress-related conditions, family problems and community tensions, there is no evidence that reli-

gious healing of any kind is effective in healing serious mental illnesses like schizophrenia, bipolar disorder, and major depression. Nonetheless, religious healers, itinerant herbalists, and qi gong masters do provide a certain level of support services, which may be all that many mentally ill individuals have available to them.

### **The Challenge of Mental Health Reform**

President Jiang Zemin, Minister of Health Zhang Wenkang and other public officials have recently issued public statements that mental health is now a top public health priority. These endorsements have provided a tremendous boost to the field of Chinese psychiatry and encouraged innovations in mental health service delivery. As has been suggested by many experts in the field, what are likely to be most successful are programs that combine the knowledge and experience of other countries with recognition of the specific conditions in China. The particularities of China's history and developmental trajectory will undoubtedly necessitate creative strategies for mental health reform.

#### ***Political and Ethical Considerations***

Nothing in China under Communism has resisted politicization, and psychiatry is no exception. The fledgling profession in the 1950s was dominated by Russian neuropsychiatric and Pavlovian behavioral paradigms much as the rest of Chinese intellectual and professional life was infused with Russian influence. During the Anti-Rightist Campaign in the late 1950s, psychoanalysis was anathematized as a Western bourgeois science. The staff of Nanjing Psychiatric Hospital were labeled rightists and punished because of their well-known interest in Freudian theories. In the disastrous aftermath of the Great Leap Forward (1958–60), when as many as 30 million Chinese, largely peasants, died of starvation, psychiatrists were, like their colleagues in other fields of medicine, forbidden to investigate or write about this massive trauma. As mentioned, during the Cultural Revolution (1966–76), psychiatrists were coerced into accepting the notion that most mental illness was not disease but wrong political thinking. Those few who resisted (and also those who acquiesced) were beaten and imprisoned or sent to remote villages to practice as general doctors. They were encouraged to hype the usefulness of traditional Chinese medicine's herbal remedies, because of the ideological emphasis the radical Maoists placed on indigenous treatments. In some instances, this policy resulted in the falsification of research data. Psychiatrists also had to hide their Western training and contacts in order to avoid the dangerous label of a foreign problem. And for the most part, as in the rest of biomedicine, these years were terrible ones in which training, research, and, to a considerable degree, even clinical practice were dissipated and curtailed.

The era of economic reforms has been a much better time for psychiatry and psychiatrists. The profession in effect reconstituted itself. New physicians were sent for training (there was no voluntary selection of a specialty). Research started up again. Clinics functioned, and a new diagnostic system was developed to bring Chinese psychiatric practices in line with international standards. The policy of openness to the West greatly benefited psychiatry. Psychiatrists traveled to Europe, Japan and most prominently to the U.S., where they caught up with the huge developments that had taken place in diagnosis, treatment and prevention. Foreign periodicals and textbooks unavailable for 20 years were popularized.

During the 1990s allegations began to appear about the political abuse of psychiatry. Charges have been leveled particularly against the police-run Ankang system of psychiatric hospitals for confining dissidents and members of outlawed groups, such as the Falun Gong. China's fledgling psychiatric profession has vigorously protested some of this international criticism which it has perceived as a witch hunt meant to tar Chinese psychiatry with the same brush that tarred Soviet psychiatry in the 1970s and 80s. While to a certain degree such criticism may appropriately target individual psychiatrists and psychiatric institutions that have been suborned by the public security services, there is little evidence to substantiate claims for widespread abuse (Lee and Kleinman 2002).

A much more widespread problem is the quality of psychiatric care in hospitals and clinics which, while improving year by year, still has serious deficiencies in technical competence and in respect for patient rights. The chief cultural and political influence on psychiatric care is the primacy of concern for public safety and social control over concern for patient rights. This manifests itself in everyday practices in the psychiatric hospital which are often paternalistic if not infantilizing, and in the failure to enact mental health legislation that adequately protects patient rights. Most psychiatric wards remain locked, and their patients confined without a clear policy about how to guard against such abuses as involuntary commitment in the absence of compelling reason, forced use of ECT and medications, and prolonged psychiatric evaluations even when mental illness is not indicated.

In recent years, economic factors have begun to supplant political factors as major influences on the profession, albeit the structural status of the Chinese Psychiatric Association as a dependent of the Ministry of Health makes it clear that psychiatry remains part, even if a distant part, of the state apparatus. Nowadays, psychiatrists are increasingly influenced by the pharmaceutical industry (foreign and local) which actively markets drugs through such means as giving gifts, providing free travel to meetings, sponsoring professional activities, luring outstanding young psychiatrists away from academia and clinical practice with salaries several times greater than what hospitals can offer, and providing

free samples—all practices found in established market economies like the U.S. As a result, as in the West, conflict of interest is a problem, and economic and business issues are coming to be more central to what psychiatry is about.

### ***Economic Constraints***

With the breakdown of both the rural health care systems and health insurance, the situation for rural China is dire. But even the urban setting is beset by a transformation of health policies away from a solidarity based insurance system and toward an individual fee-for-service model. Economic constraints have also weakened research programs and public health psychiatry.

As already described, the major challenge to mental health reform is the development of financing schemes that can contain costs on the supply side and assist the poor and mentally disabled who cannot otherwise afford the services that they need. Recent years have seen a drastic increase in medical expenses. Phillips (1998) estimates that consumer costs for health care have increased two to three times over the past decade as the reduction of subsidies from the government has forced hospitals to rely increasingly on their own income-generating abilities, such as increasing the use of unnecessary drugs and high-tech procedures. A second problem is the inadequacy of resources devoted to health during this period of economic and social transition. Total health expenditures make up only 5% of China's GDP, compared to 13% in the United States, and 7% in Japan and Thailand (Zhang 2001). This translates to 1% of the world's total health expenditures allocated to the care of 21% of the world's population. And as mentioned earlier, 80% of the total health budget in China goes to funding hospital-based treatment in the urban areas, despite the fact that urban residents account for 30% of the country's population.

The limited government budget for health care calls for the development of inexpensive yet effective strategies for meeting the increasing public demand for mental health services. In development are proposals that aim to reduce reliance on specialized psychiatric facilities and develop more cost-effective modes of care that may be implemented in diverse geographical areas. Yet government subsidies will be necessary to sustain such programs in the face of fierce competition from hospitals for patients' fees. The creation of a flexible insurance system will be important to address inequities in access to services in both rural and urban areas.

### ***Education and Training Needs***

Advancements in mental health service delivery and the development of psychiatric knowledge require a broad base of trained mental health practitioners, clinical researchers, and educators. Yet China's reliance on psychiatrists and general medical doctors and nurses for mental health care has yielded a one-sided

approach to the treatment and management of the mentally ill, one focused on symptom reduction, rather than the enhancement of quality of life and functional status. The lack of psychological and sociological perspectives on caring for the mentally ill has severely restricted the development of indigenous models of biopsychosocial care that are grounded in scientific principles and rigorous research (Pearson 1995). Moreover, in the absence of specialized training programs for nurses engaged in psychiatric work, misperceptions and fears about mental illness and the mentally ill are common and may adversely affect treatment and rehabilitation outcomes (Sévigney et al. 1999).

Whereas the community is becoming increasingly responsible for prevention, public education, maintenance, and rehabilitation, the role of hospitals is being reduced to conducting diagnosis and initial treatment. Because the majority of Chinese with psychological problems resist seeking treatment in psychiatric hospitals (which are few in number anyway), general medical settings act as *de facto* mental health centers. Yet, general medical physicians frequently fail to correctly identify and diagnose mental disorders in their patients. For example, in a study conducted by Xiao (1990, unpublished study), 390 Chinese outpatients from two general hospitals were assessed with the General Health Questionnaire and the Structured Clinical Interview for DSM-III-R disorders. Results showed that 15.7% of the patients suffered from psychological disorders. However, only 46.7% were identified by the physicians and the specificity of identification was 31.5%.

To address this problem, mental health professionals are needed to provide training and supervision to medical school students and current nonpsychiatric health workers in the recognition and treatment of psychiatric disorders from a biopsychosocial rather than a biomedical perspective. In particular, general medical staff in both rural and urban settings should be supervised in the application of psychosocial interventions in their clinical practice, which are associated with improved treatment adherence and outcome over pharmacological treatment alone. In a review of WHO demonstration projects regarding the treatment of mental illness in primary care, Cohen (2001) concluded that the most successful programs were those that provided regular supervision of health workers and continuing education, both of which require a source of ongoing funding and a stable workforce. At present, the feasibility of such a program has yet to be empirically evaluated in China.

Outside of China, mental health specialties such as psychiatric nursing, psychiatric social work, and clinical psychology enhance psychiatric knowledge through research and the provision of services as psychoeducation, skills training, psychotherapy, case management, discharge planning, family support, training, and consultation. As the needs of mentally ill people and their families in China are similar to those elsewhere, the development of training and degree programs

in these specialties (or some alternate form) would increase and diversify the mental health services available to the public.

## Conclusion

China's rush towards a market economy has radically transformed social life over the last two decades. Along with the expansion of economic opportunity, the burden of mental and behavior-related problems appears to be growing due to increasing longevity and a weakening in traditional communal structures, among other factors. The social welfare net which China had constructed during the socialist era is being rapidly dismantled, transforming the health sector into a fee-for-service system. The immense size of the country and the significant regional economic disparities have contributed to marked geographic variations in standard and quality of mental health services. Although there is only minimal psychiatric care available in the poorest regions, China has also developed some of the most innovative and effective treatment models in the world.

The problem of equity is a troubling matter across the health care system, but is particularly pronounced within the mental health sector. Since 1949, political priorities and public security concerns have exercised decisive influence over the medical definition, social perception, and treatment procedures of mental illnesses in China. Only in the last several decades has psychiatry in China re-emerged as an important scientific enterprise. Nevertheless the longstanding stigma of mental illness and the low status of psychiatry within the medical profession have made it especially difficult to recruit and retain well-trained staff in rural areas. Lucrative prospects in the growing pharmaceutical industry as well as a higher earning potential in city hospitals are contributing to staffing problems in rural hospitals and urban-rural disparities in the quality of care that is available.

Criticisms of China's mental health care system however must be tempered by the fact that China is still a poor, developing country overall. Compared to other developing countries, the standard of psychiatric treatment in China is adequate and showing signs of improvement (Lee and Kleinman 2002). In urban areas in particular, diagnostic practices and treatment guidelines are gradually meeting international standards of care. Research publications in both Chinese and international journals are increasingly of a higher standard than in the past. The content and orientation to research reflects Chinese psychiatrists' engagement in a global scientific community as well as a commitment to developing culturally meaningful clinical models (see Zhang et al. 2002). Public education campaigns and exposure to Western cultural values and practices are improving the public's perception of psychiatry in some areas ("Psychiatrist's Couch No Longer Shunned," *Beijing Review*, Nov. 30, 1998; "Psychological Consulting on the Increase," *Beijing Review*, May 8, 1995).

The central government's prioritization of mental health as a key public health issue marks a promising turn of events in the story of psychiatry in China. In the upcoming years, it is hoped that the government's verbal commitment to reform the mental health system will translate into concrete changes that will improve the lives of the millions suffering from mental health problems.

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