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Review of Child and Adolescent Mental Health (CAMH) Policy in Mainland China

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Abstract
Although Child and Adolescent Mental Health (CAMH) poses a global challenge, there is a dearth of rigorous and systematic reviews of related policies in China. This study critically examines CAMH policies in mainland China to pinpoint existing challenges and gaps in different domains. Employing a mixed-method policy review, research findings uncover an increasing trend in CAMH policy development between 1991 and 2023, with the Ministry of Education (MOE) and the National Health Commission (NHC) serving as leading drivers in policy formulation and dissemination, in collaboration with other key stakeholders. However, amongst 52 relevant national-level policies identified, only seven exclusively target child and adolescent mental health, and none of which are laws but regulations, opinions, circulars, and plans, occupying lower positions within the authoritative policy hierarchy. This highlights gaps in specialized mental health policies for young people in mainland China, which mirror global trends and contribute to the exacerbated youth mental health challenges and sustained stigma. To bridge the twelve major gaps identified, we propose integrating the Positive Youth Development (PYD) programs as a promising tool within CAMH policy frameworks.

Keywords Mental health policy · Child and Adolescent Mental Health (CAMH) · Positive youth development · Policy review

Introduction

CAMH is Challenging in Mainland China

Based on the statistics of the United Nations International Children's Emergency Fund (UNICEF), approximately 1.3 billion teenagers fall into the age range of 10

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and 19 constituting one-sixth of the world's population (UNICEF, n.d.-a), with 14% of this cohort showing mental problems, accounting for a substantial 15% burden of disease in this demographic as of 2021 as the World Health Organization (WHO)'s statistics indicates (WHO, 2024). A meta-analysis of over 40 studies across 27 countries indicates that 6.5%, 5.7%, 3.4%, and 2.6% of adolescents showed symptoms of "anxiety disorders," "disruptive disorders," "attention deficit hyperactivity disorder (ADHD)," and "depressive disorders," respectively (Polanczyk et al., 2015). However, children's and adolescents' mental health rights remain largely marginalized, particularly in low- and middle-income countries, where nearly 90% of them reside (WHO, n.d.-a).

In mainland China, the population aged 15 and below, encompassing children and adolescents, reached 239.08 million in 2022, which is 16.9% of the total population (National Bureau of Statistics of China, 2023), and studies have consistently indicated that psychological issues are prevalent. Notably, as early as the 1990s, a collaborative study by the WHO revealed a 7% prevalence of emotional and behavioral disorders among the 6–12-year-old student population in mainland China (Matsuura et al., 1993). A subsequent meta-analysis encompassing eighteen studies published between 1987 and 2011 reported a prevalence rate of 11.8 per 10,000 population for autism among children in China (Sun et al., 2013). Furthermore, in the first national-scale psychiatric epidemiological survey targeted at children and adolescents aged 6–16 years during 2014–2015 and issued in 2021, an overall prevalence rate of 17.5% for any psychiatric disorder was reported. Among the most prevalent psychological disorders in this population were "ADHD" (prevalence = 6.4%), "Oppositional Defiant Disorder" (prevalence = 3.6%), and "Major Depressive Disorder" (prevalence = 2%). Additionally, the survey demonstrated a higher incidence of psychological problems affecting children and teenagers residing in developed cities compared to those residing in less economically disadvantaged areas (Li et al., 2022a).

Moreover, evidence indicates that mental health problems in youngsters in mainland China have experienced an upward trend. Xin et al. (2012) reviewed four studies between 1992 and 2005 using an inter-temporal meta-analysis that demonstrated Chinese adolescents' psychological well-being has declined across birth cohorts from the early 1990s onwards, with elevated anxiety symptoms and depression disorder, and a decline in self-esteem as a positive trait. Similarly, a three-round longitudinal survey using the "Mental Health Inventory of Middle School Students (MMHI-60)" found that adolescents surveyed between 2016 and 2020 had significantly increased levels of anxiety, emotional distress, academic stress, interpersonal sensitivity, obsessive–compulsive behaviors, and depression (Wu et al., 2022). A recent meta-analysis encompassing 191 studies during the COVID-19 pandemic involving more than one million underage students revealed the prevalence of anxiety, depressive symptoms, and sleep difficulties reached 31%, 31%, and 42%, respectively (Deng et al., 2023), these rates indicate an increase compared to the pre-pandemic period.

In summary, psychological challenges concerning children and adolescents in mainland China are not only pervasive but also display an upward trajectory. Extensive research consistently underscores that almost half of adult mental disorders

arise and manifest for the first time during youth or earlier, before age 14 (Belfer & Saxena, 2006; Patel et al., 2007). Failure to address mental health issues during this critical developmental stage engenders enduring consequences that persist into adulthood and severely attenuate global well-being (Remschmidt & Belfer, 2005). Therefore, prioritizing Child and Adolescent Mental Health (CAMH) interventions has critical significance.

Sociocultural and Structural Context of CAMH in Mainland China

CAMH in mainland China is shaped by an interplay of sociocultural, economic, and policy-specific factors, posing unique contextualized challenges. Since China's Reform and Opening-Up Policy in 1978, which catalyzed a shift toward a market-oriented economy and introduced Western values, particularly in urban regions, a hybrid cultural environment has been created with both traditional collectivist norms and globalization influences (Liu, 2003). Concerning it, two critical dimensions—urban–rural disparities and the examination-oriented education system—profoundly influence the design and implementation of mental health policies. First, China's rapid urbanization has exacerbated inequalities in mental health service access, particularly for rural left-behind children (LBC). Studies show that LBC are more prone to suffer from mental health problems, such as anxiety and depression, compared with Non-LBC, compounded by fragmented familial support and limited access to mental health resources (Sun et al., 2021), with mental health professionals clustered in major cities in Eastern and Northeastern provinces, while limited in rural communities in Central and Western provinces (Sun et al., 2024). This urban–rural divide emphasizes the urgency of policies targeting equitable resource allocation, and the "National Mental Health Work Plan (2015–2020)" emphasizes grassroots service expansion (General Office of the State Council, 2015), but faces challenges in implementation due to workforce shortages.

Second, academic achievement, deeply rooted in Confucian values of endurance and diligence (Li, 2001), remains a cornerstone of familial and societal expectations. Mainland China's education system shapes the school-based approaches to mental health policy. However, Gaokao (National College Entrance Examination) perpetuates intense academic competition, contributing to rising rates of stress, burnout, and suicidal ideation among adolescents (Fu, 2024). The PISA 2018 report highlighted that China scored significantly higher in reading than all other countries/economies and performed well in mathematics and science (OECD, 2019), while it comes at a cost of the cultural valorization of academic perseverance (Shek et al., 2013; Tan et al., 2025). Schools, often prioritizing performance over well-being, have been slow to adopt mental health interventions (Zhang, 2016).

Emerging policies, such as the "Double Reduction Policy" in 2021, exemplify efforts to reorient educational priorities toward student well-being, though challenges persist in ensuring schools relocate adequate resources to mental health-promoting activities (Jin & Zhang, 2022). The "Mental Health Action Plan for Children and Adolescents (2019–2022)" (National Health Commission of the PRC et al., 2019) signals a paradigm shift toward integrating CAMH into broader social and

educational reforms. By situating CAMH within these dynamic socio-cultural and policy contexts, this study highlights the necessity of culturally informed, asset-based, and evidence-based approaches to support youth development.

CAMH Concept and Its Evolution

CAMH has increasingly evolved as a holistic construct that encompasses not only the absence of mental disorders but also the presence of cognitive, emotional, and social competencies. UN General Assembly (1989) emphasizes that mental health integrates developmental, educational, and social dimensions. Similarly, the WHO broadly defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2005, p. XVIII). Positive psychology (Seligman & Csikszentmihalyi, 2000) further validates the shift of conceptualizations from behavioral problems and diagnosable illnesses to a strengths-based framework that prioritizes positive youth development (PYD), early intervention, and ecological supports (Shum et al., 2025). Researchers identify CAMH as holistic psychosocial functioning and the dynamic capacity to achieve cognitive, emotional, and social development while maintaining adaptive resilience to stressors (Patel et al., 2008).

In mainland China, CAMH definitions have historically been defined from a narrow perspective, focusing on behavioral deviations and clinically defined mental illnesses (Kuo & Kavanagh, 1994). For instance, the purpose of the enactment of the "Mental Health Law of the People's Republic of China" (issued in 2012, revised in 2018) is to safeguard the legitimate rights and interests of persons with mental disorders (National People's Congress, 2012). However, with advances in cross-cultural health, policy discourse has increasingly incorporated holistic principles from international frameworks, such as the WHO's "Healthy Life Course Approach" (Pan American Health Organization, 2020) and PYD models. For instance, the "Mental Health Action Plan for Children and Adolescents (2019–2022)" aims to promote the mental health and overall quality development of children and adolescents (National Health Commission of the PRC et al., 2019), thereby incorporating the treatment, prevention and developmental well-being across health, educational and social domains (Li et al., 2022b). In this study, CAMH is defined as beyond clinical well-being and encompassing positive developmental attributes, including the acquisition of age-appropriate cognitive, emotional, and social skills in harmony with sociocultural expectations such as collective responsibility.

Regarding the age range of CAMH, we define children and adolescents as individuals 18 years of age and younger, including kindergarten and primary to senior high school students, while excluding college students, aligning with international and domestic policy comparability, developmental science frameworks, and China's legal and service systems. Firstly, international and domestic policy support defining childhood as extending until 18. While the National Bureau of Statistics of China (2002) classifies individuals aged 0–14 as juveniles and children for demographic reporting, China's ratification of the "United Nations Convention on the Rights of

the Child" (UNCRC) states that "child" refers to any person aged under 18 years (UN General Assembly, 1989), and the WHO (n.d.-b) defines "adolescence" as the period of life between childhood and maturity, spanning from ages 10 to 19. Domestically, the "Law of the People's Republic of China on Protection of Minors" (issued in 1991, revised in 2024) states that "minors mean citizens under the age of 18" (Article 2) (National People's Congress, 1991). Secondly, psychological developmental science demonstrates that pubertal development and psychosocial transitions remain salient until age 18 (Vijayakumar et al., 2018), and brain maturation, particularly in the prefrontal cortex and limbic system, persists into late adolescence (Crone & Dahl, 2012). Thirdly, pediatric services typically serve patients until age 18, after which transition to adult care begins (Castillo & Kitsos, 2017). Fourthly, sociocultural factors in mainland China reinforce the appropriateness of the 0–18 classification. China's secondary education completion timeline (usually age 18) marks a crucial shift from familial supervision to independent living for college-bound youth, and physical separation and increased autonomy in decision-making would change mental health risk profiles (Fan et al., 2024; Yang et al., 2023). Besides, social expectations frame adolescence as a period of "preparation" for societal roles, extending protective oversight until emerging adulthood starting from age 18 (Fan et al., 2024). In summary, adopting the 0–18 range captures critical developmental junctures and aligns with both international frameworks and China's legal and cultural contexts.

CAMH Policy as Government Commitment to Improving Mental Health

Numerous factors pose obstacles to the nourishment of CAMH, including limited financial and professional resources, difficulties in accessing psychological services, inadequate mental health education within schools, and societal misconceptions associating mental issues with stigma (Belfer, 2016). Among these factors, the absence of mental health policies tailored to youngsters stands out as particularly crucial (Belfer, 2016; Belfer & Saxena, 2006).

Public policy, as defined by Salisbury (1968), "consists in authoritative or sanctioned decisions by governmental actors. It refers to the 'substance' of what the government does and is to be distinguished from the processes by which decisions are made. Policy here means the outcomes or outputs of governmental processes" (p. 152). Consequently, CAMH policies serve as a guiding framework for government action (Shatkin et al., 2008), reflecting the government's commitment and roadmap to address mental problems and enhance the well-being of young people as a collective. The policy outlines the goals, principles, vision, and values underlying mental health development. Its implementation has proven catalytic in increasing community interest in youth mental health, engaging stakeholders, ensuring oversight and accountability, mobilizing financial and resource support, and promptly addressing gaps in care.

Recognizing the crucial significance of policies concerning mental health, the WHO issued a recommendation in 1977 urging all countries worldwide to establish national plans covering mental health needs for children and adolescents. In line with this, the WHO released "The Mental Health Policy and Service Guidance

Package: Child and Adolescent Mental Health Policies and Plans" in 2004, providing assistance to countries in developing CAMH policies. Furthermore, during "the 8th Global Conference on Health Promotion," co-hosted by the WHO in 2013, the "Helsinki Statement on Health in All Policies" was endorsed. This statement prioritizes health and equity as fundamental responsibilities of governments towards their populations (WHO, 2014).

Moreover, the United Nations (UN) adopted the UNCRC in 1989, which outlines the fundamental right of children to receive mental health care. As of 2024, this convention has been endorsed by 197 economies (United Nations, n.d.). Additionally, The 2002 UN resolution on "A world fit for children: Resolution/adopted by the General Assembly" emphasizes the commitment to "care for every child: nurture children in a safe environment that enables them to be physically healthy, mentally alert, emotionally secure, socially competent and able to learn" (UN General Assembly, 2002, p. 2).

Many countries, particularly low-income and middle-income economies, often consider their ratification of the UNCRC as evidence of dedication to CAMH services. However, research indicates that mere endorsement of the UNCRC does not guarantee the construction of particular policies or program initiatives promoting the provision and support of mental health care for kids and youngsters (Belfer & Saxena, 2006). Therefore, there is a pressing need for a systematic policy review to address this gap.

The Fundamental Need for CAMH Policy Review

As highlighted by Shatkin and Belfer (2004), "no systematic study of the current status of international child and adolescent mental health policy exists" (p. 104). Recognizing this gap as well, the WHO took the "Atlas: Child and Adolescent Mental Health Resources" initiative in 2005 (updated in 2018 and 2021) to address the lack of comprehensive review and evaluation of CAMH policies at the global level (Belfer & Saxena, 2006; WHO, 2018, 2021). Notably, prior to the publication of the Atlas, there was no systematic research linking policy availability to identifiable planning initiatives.

Several policy reviews on CAMH have emerged in different countries and regions after the release of the Atlas. For instance, Kutcher et al. (2010) analyzed the availability and content of CAMH policies in all provinces in Canada, demonstrating that only four provinces have CAMH plans or policies, while the other provinces had no attempt to incorporate these elements into existing mental health strategies. Mokitimi et al. (2018) employed the Walt and Gilson policy triangle framework (1994) to search and identify all provincial CAMH policies across South Africa, showing that none of the provinces had a CAMH policy or plan to support the national CAMH policy, and CAMH professionals were not included in the policy development process, which aligns with concerning findings from other low- or middle-income countries, reinforcing the global neglect of CAMH at the policy level. While research interest in CAMH policy review has grown, systematic reviews of CAMH policies remain fundamentally deficient, particularly in developing countries.

The current lack of a systematic and critical review of CAMH policies in mainland China (Liang et al., 2017; Zhou et al., 2019) has left the Chinese government's actual efforts, commitments, and effectiveness of the initiatives to improve CAMH largely unknown. This knowledge gap poses challenges in providing robust evidence and responding convincingly to the criticisms raised by various stakeholders. Furthermore, it hinders the identification of existing gaps and the implementation of timely remedies. By critically reviewing existing CAMH policies, this study acknowledges the efforts while identifying gaps, providing a reference for policymakers in making firm commitments and policy adjustments to nurture children and adolescents, as a vulnerable population with limited political representation or a "political voice" (Shatkin et al., 2008).

Methods

Epistemological Foundations of the Policy Review

Policy documents, as official records of government actions, provide a factual basis for analysis (Yang et al., 2020). Policy review examines the issuing body of the policy, its objectives, strategy scope, and implementation mechanisms, providing a qualitative, accessible, and cost-effective methodology (Stoffelen, 2019).

The study adopts a pragmatic, mixed-methods approach (Barnow et al., 2024; Brannen & Moss, 2012) to review CAMH policy in mainland China. Grounded in the pragmatic paradigm, which transcends rigid constructivist/realist binaries, we prioritize methodological pluralism and problem-solving utility over adherence to a single epistemological tradition (Patton, 2002). This stance aligns with contemporary shifts in evidence synthesis, where the "paradigms debate" has largely given way to a consensus among serious methodologists and practitioners for practical purposes on methodological flexibility and appropriateness (Bogna et al., 2020; Patton, 2002). As Patton (2002) argued, "A variety of methodological approaches are needed and credible … and that the challenge is appropriately matching methods to questions rather than adhering to some narrow methodological orthodoxy" (p. 264). Joint Committee on Standards for Educational Evaluation (1994) also reinforces this shift, advocating for methodological choices driven by research questions rather than paradigmatic orthodoxy. Demanding methodological purity risks oversimplifying the complexity and dynamic of real-world problems, which often demand adaptive, multidimensional approaches. Methodological openness, far from compromising validity, reflects the nuanced reality of knowledge creation (Bogna et al., 2020; Patton, 2002). By rejecting methodological tribalism, our pragmatic approach exemplifies the "end of the paradigms debate" (Patton, 2002, p. 264), providing a replicable model for policy review.

With respect to the mixed-methods approach, consistent with contemporary studies (Bogna et al., 2020; Patton, 2002; Shek, 2024; Tan et al., 2025), we employ "paradigm triangulation" (Barnow et al., 2024) of combining document analysis with social network analysis of the bibliometric method to balance interpretive depth with systematic pattern recognition. It is theoretically grounded in

complementary strengths (Plano Clark, 2017) and is consistent with the trend of criticizing a single paradigm for its limitation, thus "strengthens the argument for marrying pluralistic theorizing to methodology, resulting in a research strategy based on paradigm triangulation" (Bogna et al., 2020, p. 465). While there are critiques of mixed methods, such as those by Guba and Lincoln (1988), caution against blending epistemologically incompatible approaches. However, as Patton (2002) argues, the practical imperative to address complex questions often outweighs concerns about paradigmatic purity. Human reasoning, in practice, is sufficiently nuanced to reconcile deductive hypothesis testing with inductive exploration.

Our policy review adopts a mixed-methods approach. We conducted a qualitative analysis of the themes derived from the existing policies, official figures, and scientific statistics, with semantic techniques employed to identify relevance to CAMH, the policy objectives, and target populations (Yang et al., 2020). Besides, to address the complexity of large-scale policy networks that traditional document analysis struggles with (Li et al., 2023; Yang et al., 2020), we employed social network analysis of the bibliometric method to reveal structural patterns (Donthu et al., 2021) (e.g., quantifying the dominance of the authority in policy networks), while qualitative analysis of examining available policy information enables us to interpret meaning-making in policy language, which contextualizes quantitative findings and exposes contradictions (e.g., interpreting the CAMH policy gaps). Our paradigm triangulation aligns with pragmatic methodology, where "what works" supersedes paradigmatic purity (Patton, 2002) to produce actionable policy implications.

Scoping Review Strategy

The scoping review is "a type of knowledge synthesis, follow a systematic approach to map evidence on a topic and identify main concepts, theories, sources, and knowledge gaps" (Tricco et al., 2018, p. 467), which applies to clinical guideline development and policy analysis. Policy texts were analyzed as dynamic artifacts shaping and shaped by sociocultural realities, consistent with the scoping review's aims to "inform future research priorities, policy and on occasions influence practice" (Pollock et al., 2024, p. 5). Regarding the scoping review strategy, we follow and adapt the "Arksey and O'Malley framework" (Arksey & O'Malley, 2005) to ensure transparency and rigor, including six stages.

Stage 1: Identifying the Research Question

This policy review addresses two research questions.

Research Question 1: What is the development of CAMH policies in mainland China?
Research Question 2: What gaps exist in CAMH policies in mainland China?

Stage 2: Identifying Relevant Policies (Data Source)

The study reviewed policies at the national level, including laws, administrative regulations, legislation, guidelines, plans, programs, official opinions, circulars, and other normative documents. Data were sourced from three main databases: "The Chinese Central Government's Official Web Portal" (http://www.gov.cn), "iPOLICY" (a database by Tsinghua University), and "PKULAW" (formerly LawinfoChina). Academic journals and online news reports were also included to ensure a comprehensive review. Search terms included "children," "youth," "students," "primary and secondary school students," "mental health," "physical and mental health," "moral education," "school health services," "CAMH Policy," and "Health Policy."

Data collection and analysis were conducted by four research assistants between April 2024 and July 2024, and the search covers policies issued since the establishment of the People's Republic of China in 1949 (Table 1). To ensure accuracy and reliability, a rigorous protocol of repeated website visits was implemented for cross-checking and verification. A Research Assistant Professor (first author) reviewed the collected data, verifying key information, policy topic identification, and keyword summaries to minimize potential errors and inconsistencies.

Stage 3: Policy Selection (Inclusion Criteria & Screening Process)

According to three inclusion criteria of "CAMH Relevance" (i.e., related to CAMH), "National-Level" (i.e., excluded regional/local policies, and only include national-level policies), and "Active Status" (i.e., only include "in force" policies), 52 CAMH-relevant policies that were still in force were ultimately selected for analysis (Fig. 1).

1) Policy Theme Screening: Selecting topics explicitly targeting CAMH or implicitly addressing related themes.
2) Policy Level Screening: Focusing on national-level policies issued by the National People's Congress and its Standing Committee, the State Council and relevant ministries and commissions, either individually or jointly.
3) Deletion of repealed policies: Including only policies that are still in force, excluding those that have been repealed.

In addition, we adopted the following criteria to address revised and overlapping policies. For revised policies, only the latest revised version of a policy was included if stated as "in force." For example, the "Mental Health Law of the People's Republic of China" (issued in 2012, revised in 2018) was analyzed in its 2018 iteration; For coexisting Policies, if multiple versions of a policy were active, the latest revised version was included and analyzed.

Table 1 Data Sources of CAMH Policy Searching

Database	Policy issuance	Search period	Purpose
Chinese Central Government Web Portal	1949-July 2024	April 2024-July 2024	Primary repository for active policies
iPOLICY	1949-July 2024	April 2024-July 2024	Cross-referenced with official government notices
PKULAW (formerly LawinfoChina)	1949-July 2024	April 2024-July 2024	Supplementary for the Chinese Central Government Web Portal and iPOLICY
Academic Journals/News Reports	1949-July 2024	April 2024-July 2024	Supplementary sources for policy context and contextual information on policy

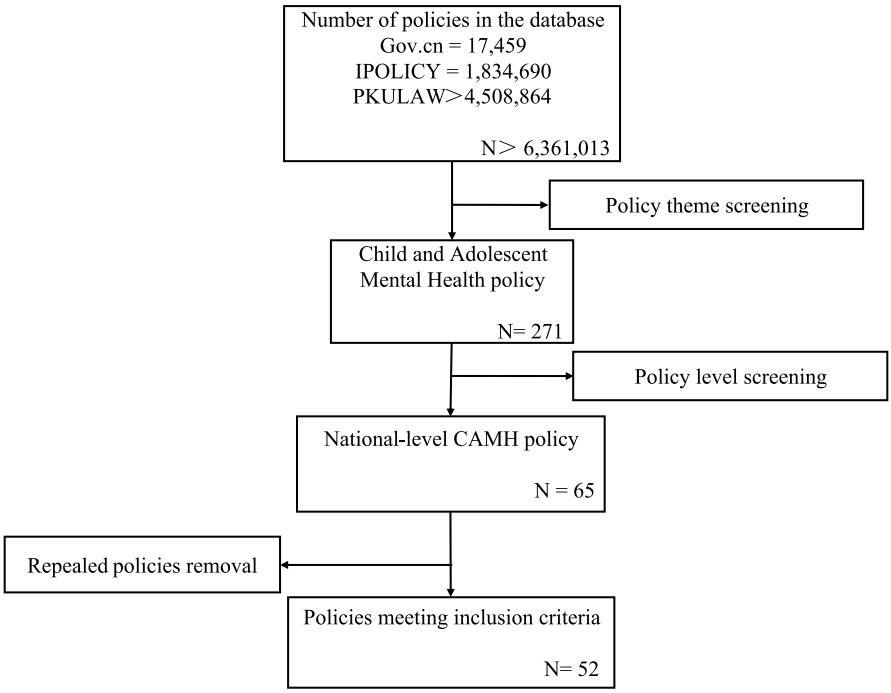

Fig. 1 Policy text screening flowchart

Stage 4: Charting the Data

We employed a mixed-method policy review. Firstly, the thematic analysis focused on five dimensions and sub-codes in the "Thematic Coding Framework" (Fig. 2), including 1) "Policy Relevance": to filter policies explicitly/implicitly addressing child and adolescent mental health; 2) "Target Population": to categorize groups prioritized in policies; 3) "Policy Type": to identify legal authority; 4) Issuing Authority: to map collaboration networks among policymakers; 5) "Policy Theme": to classify policy content.

Secondly, we employed Gephi 0.10.1, which is an open-source tool commonly used for real-time visualization of large networks (Bastian et al., 2009), for the social network analysis to map collaboration networks and identify key policymakers. The basic network statistics include "nodes" and "edges." "Nodes" are the total number of organizations in the network, "edges" are the total number of collaborations (links) between organizations, and "edge weight" is defined as the frequency of collaboration between two agencies. Besides, the centrality measures, including "degree centrality" which is the number of direct collaborations an organization has, with high values that represent hubs of collaboration; "betweenness centrality," which is the fraction of shortest paths passing through a node, with high values that act as bridges between disconnected groups; and "closeness centrality" reflects organizations with short paths to all others can disseminate policies efficiently. In

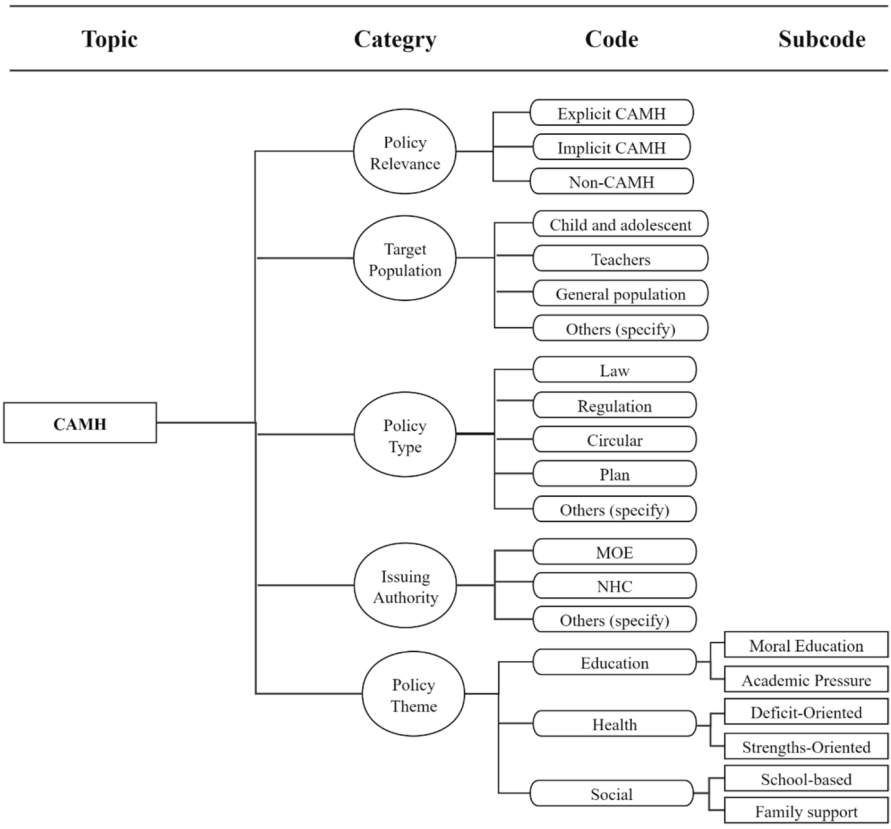

Fig. 2 Thematic Coding Framework

terms of cluster structure, "modularity" measures the strength of division into clusters, with high modularity indicating distinct subgroups (Cherven, 2015).

Stage 5: Collating, Summarizing, and Reporting the Results

In this study, research results include findings of the collaboration network of CAMH policy issuing authorities and findings of policy content review, identified gaps, as well as policy implications proposed.

Results and Discussion

Trends in CAMH Policy Issuance

An upward trend in CAMH policy issuance was observed from 1991 to 2023 (Fig. 3), with sporadic policies in the early 1990s gradually increasing towards the

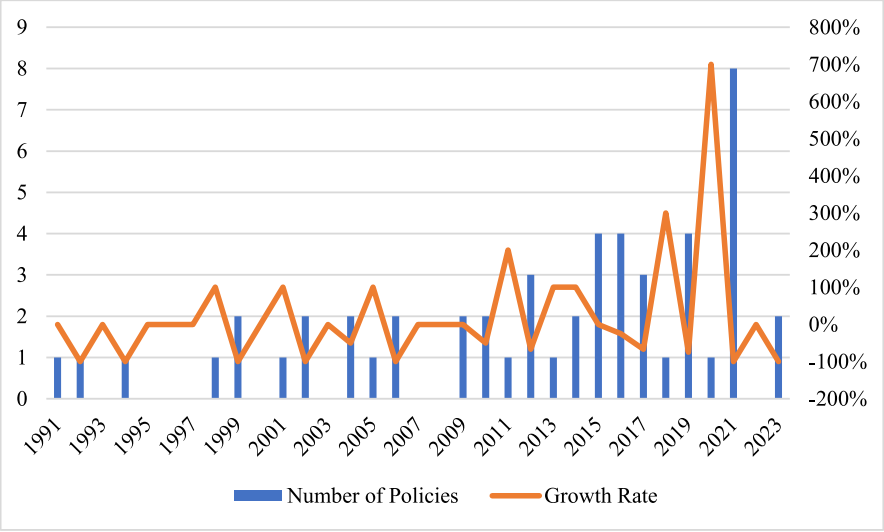

Fig. 3 Number and growth rate of CAMH policies in mainland China

late 1990s. The early 2000s showed gradual growth, intermittent rises, and a notable surge in the 2010s, peaking in 2015 and 2016. A substantial increase in policies was noted in 2021, despite a slight decline in 2022, followed by a resurgence in 2023. With respect to average annual growth rates and key motivating events. From 1991–2000, only 6 policies were issued (0.6/year), spurred by China's ratification of the UNCRC in 1992, which catalyzed its earliest CAMH policies, such as the 1994 issuance of the "Opinions of the Central Committee of the Chinese Communist Party Regarding the Further Strengthening and Improvement of Moral Educational Work in Primary and Secondary Schools" (CPC Central Committee, 1994). However, growth remained slow, with sporadic issuance reflecting limited policy prioritization on CAMH. The 2001–2010 period had doubled output (12 policies, 1.2/year) with a growth rate of 100% compared to the 1990s, driven by the "686 Program" launched in 2004, also known as "The Community Management and Treatment Project for Severe Psychiatric Disorders," as a national initiative to integrate mental health evaluation. Growth accelerated further in 2011–2020 (24 policies, 2.4/year) with a growth rate of 100% compared to the 2000s, following the 2012 "Mental Health Law of the People's Republic of China" was enacted, which institutionalized CAMH priorities such as school-based interventions (National People's Congress, 2012). The 2021–2023 period recorded the highest annual rate (3.3 policies/year, 10 total) with a growth rate of 38% compared to the 2010s, reflecting urgent COVID-19 responses (Shek, 2021). Overall, policy issuance escalated alongside major sociopolitical and public health milestones, while fluctuating growth rates underscore uneven development challenges over time.

When compared to other countries, China's trend in CAMH policy issuance aligns with global patterns of slow development, observed in both developed and developing economies. Shatkin and Belfer (2004) conducted an investigation

collecting policy data from the WHO international databases and consulted psychiatrists worldwide. Their findings revealed that no country worldwide had developed mental health policies exclusively dedicated to children and adolescents, while only a mere 18% of the 191 member countries examined (35 countries in total) possessed mental health policies that had the potential to benefit this population to some extent. The WHO Child Atlas Project in 2005 further substantiated the lack of CAMH policies. Out of the 66 countries that responded to the survey, with no response from the remaining 126 member states, only 30 countries reported having national policies that encompassed children's rights. However, these policies primarily concentrated on addressing cases of maltreatment, rather than encompassing the wider spectrum of mental health needs and PYD (Belfer & Saxena, 2006). In 2017, among the 78 countries that participated in the WHO Child Atlas Project survey, only 46% had established a CAMH plan or strategy (WHO, 2018). According to the recent 2020 WHO Child Atlas Project, 53% of the 168 respondents indicated the presence of dedicated psychological health plans or policies exclusively tailored for kids and teenagers with either stand-alone or integrated within existing frameworks (WHO, 2021).

In high-income economies such as the United States, Canada, the United Kingdom, and Europe, CAMH policies are relatively established (Zhou et al., 2020a), while they still face persistent challenges in forming a systematic CAMH strategy. The establishment of CAMH policy systems has followed nonlinear trajectories, often spanning decades of incremental reforms from an initial focus on care for severe mental disorders to advocating for school-based services, shifting from treatment to prevention. For instance, while national CAMH frameworks have been established, for example, the United Kingdom's "Future in Mind (2015)" (Department of Health & NHS England, 2015) and Scotland's "Mental Health Strategy 2017–2027" (Scottish Government, 2017) prioritize prevention and accessible services, Australia's "National Children's Mental Health and Wellbeing Strategy (2021)" integrates cross-sector collaboration and digital technology (National Mental Health Commission, 2021), these policies often struggle with inconsistent funding, workforce shortages, and fragmented service integration linked with decentralized systems (Kutcher & McLuckie, 2011). Similarly, Canada's Evergreen Framework, which is the first national CAMH framework, though lauded for its emphasis on early intervention, faces criticism for uneven regional execution, overemphasis on clinical care, and a limited outcome evaluation (Kutcher & McLuckie, 2011). These highlight that even in developed countries, CAMH policies frequently lack robust linkages to actionable planning, monitoring, or equity-focused resource allocation. For developing economies, they face significant challenges in CAMH policy development. Several systematic reviews found that low- and middle-income countries not only lack CAMH policies but also encounter implementation challenges related to feasibility and sustainability, as the majority of them lack a dedicated budget for CAMH, and "out-of-pocket payments for services" are common. Such challenges are prevalent in economies such as South Africa, Ghana, India, Iraq, Uganda, Vietnam, and Zambia, as well as regions including Latin America, sub-Saharan Africa, and the Caribbean (Juengsiragulwit, 2015; Zhou et al., 2020a).

Collaboration Network of CAMH Policy Issuing Authorities

Figure 4 shows a network of interactions among entities involved in CAMH policy formulation. The node is 38 and the edge is 341, a network density of 0.485 shows moderate density, with nearly half of all possible edges present, suggesting moderately frequent collaborations between entities. The participation of various entities such as the "Ministry of Public Security" (MPS), the "All-China Women's

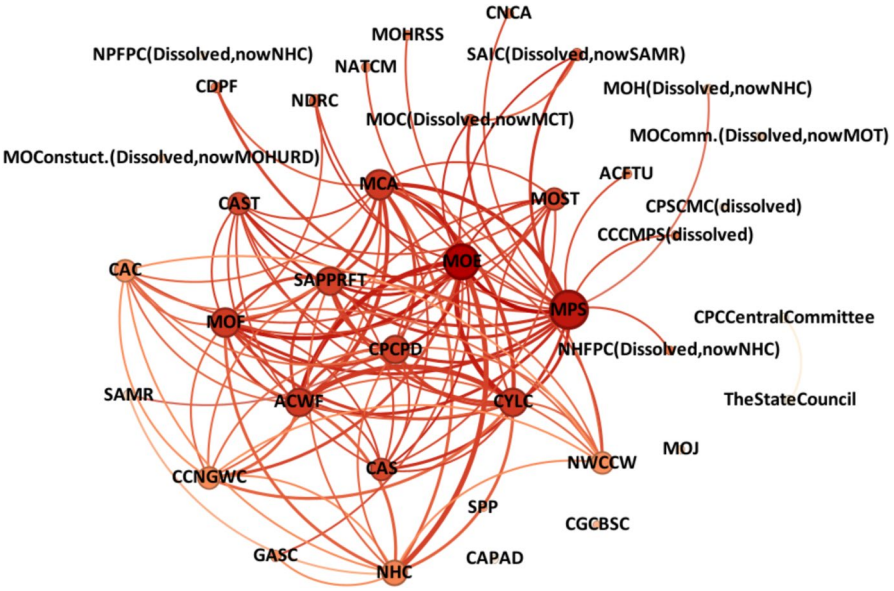

Fig. 4 Collaboration network map of CAMH policy issuing authorities using Gephi 0.10.1 (*Note.* MOH = Ministry of Health; MCA = Ministry of Civil Affairs; MPS = Ministry of Public Security; CDPF = China Disabled Persons' Federation; MOE = Ministry of Education; MOJ = Ministry of Justice; MOConstuct. = Ministry of Construction; MOHURD = Ministry of Housing and Urban–Rural Development; MOComm. = Ministry of Communications; MOT = Ministry of Transport of the PRC; SAIC = State Administration of Industry and Commerce; MOC = Ministry of Culture; MCT = Ministry of Culture and Tourism; CPCCentralCommittee = CPC Central Committee; TheStateCouncil = The State Council; ACWF = All-China Women's Federation; CYLC = Communist Youth League of China; CCNGWC = China Cares for the Next Generation Working Committee; NHFPC = National Health and Family Planning Commission; NHC = National Health Commission; CPCPD = Publicity Department of the Communist Party of China; CCCMPS = Central Committee for Comprehensive Management of Public Security; NDRC = National Development and Reform Commission; MOST = Ministry of Science and Technology; MOF = Ministry of Finance of the PRC; MOHRSS = Ministry of Human Resources and Social Security; SAPPRFT = State Administration of Press, Publication, Radio, Film and Television; CAS = Chinese Academy of Sciences; NATCM = National Administration of Traditional Chinese Medicine; ACFTU = All-China Federation of Trade Unions; CAST = China Association for Science and Technology; CNCA = China National Committee on Ageing; CGCBSC = Central Guidance Commission on Building Spiritual Civilization; CAC = Cyberspace Administration of China; NWCCW = National Working Committee on Children and Women; GASC = General Administration of Sport of China; SPP = The Supreme People's Procuratorate; CPSCMC = Central Public Security Comprehensive Management Commission; NPFPC = National Population and Family Planning Commission; CAPAD = China Association for Poverty Alleviation and Development; SAMR = State Administration for Market Regulation)

Federation" (ACWF), the "Ministry of Finance of the PRC" (MFO), the "National Development and Reform Commission" (NDRC), "State Administration of Press, Publication, Radio, Film and Television" (SAPPRFT), and the "China Association for Science and Technology" (CAST) indicating a broad collective effort to incorporate mental health factors into broader social and educational policies. However, the modularity analysis (Q = 0.159) suggests weak but detectable community division into four groups, reflecting overlapping policy interests rather than strict sectoral divisions.

The network exhibits a short average path length (1.461), meaning nodes are closely connected with most pairs reachable within 1–2 steps, which indicates efficient policy dissemination but may also show over-reliance on central hubs. In terms of centrality metrics, "Ministry of Education" (MOE) emerges as the most central actor, with the highest node degree (35) and betweenness centrality (124.62), signifying its hub role as a critical broker and influencer in the formulation and dissemination of CAMH policies. This centrality is evidenced by its numerous connections with other key stakeholders, including the "National Health Commission" (NHC), the "Ministry of Civil Affairs" (MCA), the "Publicity Department of the Communist Party of China" (CPCPD); and the "Communist Youth League of China" (CYLC). Besides, MCA also exhibits high centrality (degree = 28), indicating its strategic positions. The "CPC Central Committee" (CPCCentralCommittee) and the "State Council" (TheStateCouncil) show maximal closeness centrality (1.0) shows direct access to other nodes, suggesting centralized decision-making bodies with shortest paths to all entities.

Edge weight analysis reveals intense collaboration frequency between CYLC and MOE, MOE targets NHC, ACWF targets CYLC, and ACWF targets MOE, with edge weights = 10, which are the thickest edges. The moderate ties exist in MCA-MPS (weight = 8), tied to civil affairs coordination, and weak ties (weights ≤ 3) involve agencies (e.g., CYLC-NDRC), demonstrating marginal roles in cooperation.

Policy Focus, Target Populations, Types, and Themes in CAMH Policies

Among the 52 CAMH-related policies analyzed, two categories were identified. The first category was "Explicit CAMH Focus," which is directly CAMH-targeted policies ($n = 7$) with two criteria: 1) "Primary Recipients": Children and/or adolescents are explicitly designated as the primary target population; 2) "Dedicated Mental Health Focus": The policy's core theme is exclusively centered on mental health, with dedicated provisions for CAMH. For example, the "Mental Health Action Plan for Children and Adolescents (2019–2022)" explicitly addresses CAMH through targeted interventions, fulfilling both criteria (National Health Commission of the PRC et al., 2019).

The second category is "Implicit CAMH Focus," which is indirectly relevant policy but with CAMH components ($n = 45$). These policies fall into two conditions: 1) Secondary CAMH components in non-child and adolescent targeted population policies: Policies that primarily target other populations (e.g., teachers, the general public) but contain secondary provisions and items concerning

CAMH. For instance, "Opinions of the Ministry of Education on Strengthening the Training of Primary and Secondary School Teachers" focuses on teacher training while integrating student mental health support modules (Ministry of Education, 2011); 2) Indirect CAMH relevance in child and adolescent-targeted policies: Policies addressing children and/or adolescent populations but not primarily focused on mental health. For instance, the "Law of the People's Republic of China on Protection of Minors" (issued in 1991, revised 2024) emphasizes safeguarding minors' legal rights (e.g., personal and property rights) but includes provisions relevant to psychological well-being within protective frameworks (National People's Congress, 1991).

Concerning the target population, the 7 explicitly CAMH-focused policies targeted primary/secondary students ($n = 5$), and children/teens ($n = 2$); while 45 implicit policies addressed the general public ($n = 14$), teachers ($n = 2$), children/minors/adolescents ($n = 12$), and kindergarteners/primary/secondary/general students ($n = 17$). In summary, among the 52 analyzed policies, 36 policies target children and adolescents, with varied expressions such as children, minors, primary and secondary students, and kindergarten students, 14 policies target the general public, and 2 policies address teachers (Table 2).

Regarding policy types, only four of the 52 policies are laws. These include the "Law of the People's Republic of China on Protection of Minors" (issued in 1991, revised 2024) (National People's Congress, 1991), the "Law of the People's Republic of China on Prevention of Juvenile Delinquency" (issued in 1999, revised 2020) (National People's Congress, 1999), the "Mental Health Law of the People's Republic of China" (issued in 2012, revised 2018) (National People's Congress, 2012), and the "Law of the People's Republic of China on Family Education Promotion" (2021) (National People's Congress, 2021). Notably, none of these laws are exclusive to CAMH, although they address related issues. The remaining documents consist of departmental regulations and other normative documents, such as official opinions, outlines, plans, and circulars.

In terms of policy themes, only seven policies exclusively address the mental health of children and adolescents. These include "Opinions of the Ministry of Education Regarding the Strengthening of Mental Health Education in Primary and Secondary Schools" issued by the MOE in 1998 (Ministry of Education, 1998); "Guidelines for Mental Health Education in Primary and Secondary Schools, Ministry of Education" by MOE in 2002 (Ministry of Education, 2002) and last revised in 2012; "Circular of the Ministry of Education on the Implementation of the Programme for the Creation of Schools with Characteristics in Mental Health Education in Primary and Secondary Schools" issued by MOE in 2014 (Ministry of Education, 2014); "Mental Health Action Plan for Children and Adolescents (2019–2022)" jointly issued by 12 authorities in 2019 (National Health Commission of the PRC et al., 2019); and "Circular of the Ministry of Education on Strengthening the Management of Students' Mental Health" issued in 2021 by MOE (Ministry of Education, 2021a), among others.

Table 2 CAMH policy at the national level in Mainland China

No	Date issued	Document Number*	Target population	Explicit Focus on CAMH
1	09/04/1991 (revised 2024)	Order No. 50 of the President of the PRC	Minor	N
2	06/03/1992	n.a (Title: Mental Health Work and the Outline of the Eighth Five Year Plan)	General public	N
3	08/31/1994	n.a (Title: Opinions of the Central Committee of the Chinese Communist Party Regarding the Further Strengthening and Improvement of Moral Educational Work in Primary and Secondary Schools)	Students	N
4	08/13/1998	JiaoJi [1999] No. 13	Primary and secondary students	Y
5	01/13/1999	No. 4 [1999], State Council	Students	N
6	06/28/1999 (revised 2020)	Order No. 17 of the President of the PRC	Minor	N
7	05/22/2001	No. 18 [2001], State Council	Children	N
8	04/10/2002	WeiJiKongFa [2002] No. 96	General public	N
9	08/01/2002 (revised 2012)	JiaoJi [2002] No. 14	Primary and secondary students	Y
10	02/26/2004	ZhongFa [2004] No. 8	Minor	N
11	09/20/2004	No.71 [2004] of the General Office of the State Council	General public	N
12	01/04/2005	JiaoZhengFa [2005] No. 1	Students	N
13	02/06/2006	No. 7 [2006], State Council	General public	N
14	06/30/2006	n.a (Title: Safety Management Measures for Primary and Secondary Schools and Kindergartens)	Primary, secondary, and Kindergarteners	N
15	01/07/2009	JiaoZhengFa [2009] No. 2	Students	N
16	12/17/2009	WeiFuSheFa [2009] No. 235	Children	N

Table 2 (continued)

No	Date issued	Document Number*	Target population	Explicit Focus on CAMH
17	02/21/2010	WeiBanJiKongFa [2010] No. 24	General public	N
18	09/26/2010	RenKouXuanJiao [2010] No. 71	Adolescents	N
19	01/04/2011	JiaoShi [2011] No. 1	Primary and secondary school teachers	N
20	05/09/2012	WeiFuSheFa [2012] No. 35	Kindergarteners	N
21	07/24/2012	JiaoBanTingHan [2012] No. 57	General public	N
22	10/26/2012 (revised 2018)	Order No. 62 of the President of the PRC	General public	N
23	01/04/2013	JiaoJiYi [2013] No. 1	Children	N
24	03/18/2014	JiaoJiYiTingHan[2014] No. 14	Primary and secondary students	Y
25	04/01/2014	JiaoJiYi [2014] No. 4	Primary and secondary students	N
26	01/31/2015	JiaoZhengFa [2015] No.3	General public	N
27	06/18/2015	No.44 [2015] of the General Office of the State Council	General public	N
28	07/29/2015	JiaoJiYiTingHan [2015] No.36	Primary and secondary students	N
29	12/15/2015	GuoWeiFuYouBan [2015] No. 59	Children	N
30	01/05/2016	No. 39 Order of the Ministry of Education	Kindergarteners	N
31	06/13/2016	No. 36 [2016], State Council	Children	N
32	07/02/2016	No. 40 [2016], State Council	Primary and secondary students	N
33	12/30/2016	GuoWeiJiKongFa [2016] No. 77	General public	N
34	01/19/2017	No. 4 [2017], State Council	General public	N
35	08/17/2017	JiaoJi [2017] No. 8	Primary and secondary students	N
36	12/04/2017	JiaoJi [2017] No. 9	Primary and secondary students	N
37	11/08/2018	JiaoZhengFa [2018] No. 17	Students	N

Table 2 (continued)

No	Date issued	Document Number*	Target population	Explicit Focus on CAMH
38	06/23/2019	n.a (Title: Opinions of the Central Committee of the Communist Party of China and the State Council on Deepening the comprehensive Education Reform to Improve the Quality of Compulsory Education)	Primary and secondary students	N
39	06/24/2019	No.32 [2019] of the General Office of the State Council	General public	N
40	07/09/2019	n.a (Title: Healthy China Action Plan (2019–2030))	General public	N
41	12/18/2019	WeiJiKongFa [2019] No. 63	Kids and teens	Y
42	06/19/2020	JiaoTiYiHan [2020] No. 3	Students	N
43	01/08/2021	GuoWeiBanJiKongHan [2021] No. 15	General public	N
44	03/23/2021	JiaoTiYiTingHan [2021] No. 9	Teachers and students	N
45	06/01/2021	No. 50 Order of the Ministry of Education	Minor	N
46	06/07/2021	GuoWeiBanShiPingHan [2021] No. 316	Students	N
47	07/07/2021	JiaoSiTingHan [2021] No. 10	Students	Y
48	08/02/2021	JiaoTiYi [2021] No. 7	Students	N
49	10/23/2021	Order No. 98 of the President of the PRC	Minor	N
50	10/29/2021	GuoWeiFuYouFa [2021] No. 33	Children	N
51	04/20/2023	JiaoTiYi [2023] No. 1	Students	Y
52	10/26/2023	No. 61 [2023] of the Ministry of Civil Affairs	Children	Y

Note. *For document numbers, official English names were prioritized. If unavailable, names from academic sources were used. If neither was available, a direct Hanyu Pinyin translation was used

Challenges and Reflections

Policy Commitment

"Policy should not be seen to be dependent on the economic status of a country but rather on the consciousness to provide for some of its most vulnerable citizens" (Belfer, 2016, p. 434). It is pertinent to acknowledge that the Chinese government has implemented several measures to support children and adolescents' mental well-being. China ratified the UNCRC in 1992, demonstrating its commitment to safeguarding children's rights. Historically, mental health education policies in mainland China initially emphasized moral education. This focus is evident in the 1994 issuance of the "Opinions of the Central Committee of the Chinese Communist Party Regarding the Further Strengthening and Improvement of Moral Educational Work in Primary and Secondary Schools" (CPC Central Committee, 1994).

Over time, there has been a significant shift towards recognizing the importance of psychological well-being. In 2001, the first "China National Program for Child Development (2011–2020)" was promulgated and updated in 2011 and 2021, emphasizing the significance of child psychological health and the provision of diverse forms of counseling and corrective services for mental adjustment (The State Council, 2001). The "686 Program" in 2004 allocated a start-up fund of CNY 6.86 million to have a thorough grasp of the state of psychological health in the nation. Furthermore, in 2012, the "Mental Health Law of the People's Republic of China" was enacted, marking the country's first national law on mental health, which includes provisions targeting the mental health of children and adolescents (National People's Congress, 2012). In 2015, the "National Mental Health Work Plan (2015–2020)" set forth a goal to "establish psychological counseling rooms in schools, staffed by full-time or part-time teachers" and aims to achieve an 80% knowledge rate among school students regarding core mental health concepts by the year 2020 (General Office of the State Council, 2015). Moreover, in 2019, the "Healthy China Action Plan—Mental Health Action Plan for Children and Adolescents (2019–2022)" proposed the construction of a mental health service mode that would integrate families, schools, communities, medical and healthcare organizations, and media, amongst others (National Health Commission of the PRC et al., 2019).

In 2023, a significant policy advancement was marked by the Circular of the 17 departments including the MOE jointly issuing "Special Action Plan to Comprehensively Strengthen and Improve Student Mental Health Work in the New Era (2023–2025)" (Ministry of Education et al., 2023), outlining a more comprehensive strategy to enhance student mental health after the COVID-19 pandemic. To facilitate the plan's implementation, the MOE has announced the inauguration of the first "National Mental Health Education Month," scheduled for May 2024. In parallel, "Guidelines on Strengthening Mental Health Care Services for Destitute Children," jointly issued by five authorities in 2023, underscores the critical need to focus on vulnerable populations (Ministry of Civil Affairs et al., 2023). These measures reflect a progressive shift from moral education to a more holistic approach to mental health, demonstrating the Chinese government's evolving commitment to the CAMH.

Policy Gaps and Criticisms

China demonstrates efforts in CAMH policy initiatives, but also faces several policy gaps common to other low- to middle-income economies (Juengsiragulwit, 2015; Zhou et al., 2020a). China has been criticized for deficiencies in mental health services, revolving around the government's low willingness to formulate policies, insufficient financial investment, a fragmented mental health care delivery system centered on hospitals, the failure to integrate mental health education into schools, a shortage of qualified psychological professionals, limited engagement of social workers, and a dearth of psychoeducational teachers in schools (Liang et al., 2017; Patel et al., 2016). Specifically, there are twelve policy gaps concerning the present deficiencies of CAMH policies that require reflection.

Gap 1: Lack of Comprehensive CAMH Policy from a Public Health Perspective

CAMH policies mainly concentrate on tertiary prevention, dealing with mental health issues after they arise, rather than emphasizing primary and secondary prevention strategies. This approach is similar to the situation in economies such as Jordan, Lebanon, Libya, Kuwait, and Saudi Arabia, where there is insufficient integration of mental health services at the primary care level (UNICEF, n.d.-b). For example, the "Mental Health Law of the People's Republic of China" (issued in 2012, revised in 2018) emphasizes tertiary prevention (e.g., Article 2 mandates prevention and treatment of mental disorders) but lacks provisions for universal primary prevention programs on empowering positive psychological attributes (National People's Congress, 2012). The "National Mental Health Work Plan (2015–2020)" focuses on clinical care for severe mental illness (General Office of the State Council, 2015), lacking preventive strategies such as community resilience-building. WHO asserts that effective mental health policies should encompass all levels of prevention to ensure a comprehensive approach (Juengsiragulwit, 2015). Shek (2024) underscores the urgent need for primary prevention programs in China, particularly in the post-epidemic era, to not only treat existing issues (tertiary prevention) and detect problems early (secondary prevention) but also to prevent psychological problems by decreasing risk variables and enhancing protective factors (primary prevention). Furthermore, CAMH Coalition (2023) and Mental Health America (2020) advocate for comprehensive strategies that include prevention, early identification, and early intervention, emphasizing pediatric primary care and the expansion of school-based services.

Gap 2: MOE Takes the Lead – Education Matters or Health Matters?

Figure 4 shows the dominance of the MOE in CAMH initiatives, which raises questions about whether the focus is primarily on educational outcomes rather than broader health considerations. This approach could sideline the mental health requirements of individuals who have transitioned out of the formal schooling system post-junior high school. The "Special Action Plan to Comprehensively Strengthen and Improve Student Mental Health Work in the New Era (2023–2025)"

tasks schools with mental health screenings (Ministry of Education et al., 2023), and policies including the "Guidelines for Mental Health Education in Primary and Secondary Schools, Ministry of Education" in 2002 (Ministry of Education, 2002) and "Regulations for the protection of minors in schools" in 2021 (Ministry of Education, 2021b) reinforces MOE's dominance. UNICEF emphasizes integrating mental health services within both educational and health systems, and enhanced coordination between sectors of education, public health, and child protection to ensure comprehensive care (UNICEF, n.d.-b). Besides, Confucian emphasis on moral cultivation has led to policies blending mental health with moral education (Ministry of Education, 2017). There is a need to reflect on the role of moral education in mental health education and how to integrate these two domains.

Gap 3: Conflicting Policies – Obsessive Academic Achievement Orientation

The conflicting nature of policies that prioritize academic excellence while overlooking student psychological well-being emphasizes the necessity for aligning educational strategies with mental health objectives. For instance, the "Guidelines on Moral Education in Primary and Secondary Schools" (Ministry of Education, 2017) prioritizes school education and ideological conformity. In China, Confucian values of scholarly achievement exacerbate social pressure, which links student success to socialist core values, and policies often prioritize exam outcomes over holistic well-being (Shek & Siu, 2019b; Zhu & Shek, 2020). Since 1985, China's educational reforms have ostensibly aimed to transition from a traditional exam-centric model to a quality-oriented, student-centered framework (Liu & Dunne, 2009). Nevertheless, the entrenched competitive examination system persists as the primary determinant of educational progression. This reliance on examination outcomes not only impacts individual students but also serves as the predominant criterion for assessing school performance by local education authorities and parents (Liu & Dunne, 2009; Zhu & Shek, 2020), leading to institutional practices that diverge from national policy intentions and prioritize academic achievement (Liu & Dunne, 2009). Empirical evidence suggests that this pervasive academic pressure is related to elevated incidences of depression, anxiety, and self-harm among students (Steare et al., 2023).

Gap 4: Lack of Cultural Emphasis on "No Health Without Mental Health"

Stigma is a major cultural barrier to mental health care, and anti-stigma efforts have been far from adequate. Policies imply that one of the purposes of concern for mental health issues is to improve social stability and harmony, thus indirectly discouraging open discourse on youth mental health and perpetuating public stigma unconsciously. Comparative studies have shown that Chinese people exhibit a stronger stigma towards mental illnesses than Western individuals (Chang et al., 2017). This highlights a lack of emphasis on the concept of "no health without mental health" in Chinese culture. Stigma is a significant deterrent that prevents people, particularly vulnerable young children and adolescents, from seeking services and support (Shatkin & Belfer, 2004; Zhou et al., 2020a). Parents also often avoid discussing their children's mental health concerns for fear of societal judgment and the risk

of being labeled or treated differently (Zhang et al., 2024), or "losing face" under the collectivist values (Leung & Shek, 2014). This fear often leads parents to seek private support and solutions, sometimes resorting to non-scientific methods such as superstition, which further suppresses children trying to express their struggles. Moreover, the absence of CAMH policies tailored to young people's needs (Chen et al., 2024) exacerbates the prevalent stigma surrounding mental health. Finally, there is a need to further understand the determinants of child and adolescent mental health (such as gender differences and self-conception, Cheung et al., 1998; Shek, 1995) within the Chinese culture.

Gap 5: Shortage of Professionals and Case-Oriented Intervention Approach

The shortage of qualified professionals, including psychiatrists, psychiatric nurses, counseling and clinical psychologists, school psychology teachers, and social workers, significantly hinders the provision of comprehensive mental health services in China, particularly in CAMH services (Liang et al., 2017; Zhong & Wang, 2021).

By the end of 2021, China had 64,000 psychiatrists, constituting only 1.49% of the country's total physicians (4,287,000) (CCTV NEWS, 2022), equating to 4.53 psychiatrists per 100,000 people. Although this ratio surpasses that of many low- and middle-income economies, it remains below the levels in developed economies. For instance, in 2020, the global average was 1.7 psychiatrists per 100,000 population, 0.1 psychiatrists per 100,000 population in the African Region, and 0.4 psychiatrists per 100,000 population in Southeast Asia regions, compared with the European Region having 9.7 psychiatrists per 100,000 population (WHO, 2021). Additionally, there is a severe shortage of professionals in CAMH services, such as clinical psychologists, with a significant imbalance in resource distribution favoring eastern and urban areas over western and rural regions in China (Sun et al., 2024).

The role of social workers is similarly unclear. As of 2022, there were 931,000 licensed social workers in China (Ministry of Civil Affairs, 2023). However, their focus is dispersed across various sectors with limited emphasis on mental health services (Liang et al., 2017). Additionally, holding a professional license does not ensure active participation in social work, as many leave the field due to low wages and professional stigma (Gao, 2017).

The scarcity of school psychology teachers further exacerbates the issue (Wang et al., 2014). The "Special Action Plan to Comprehensively Strengthen and Improve Student Mental Health Work in the New Era (2023–2025)" requires primary and secondary schools to employ at least one psychology teacher (Article 14) and sets a target of 95% of schools with full-time or part-time psychology teachers by 2025 (Ministry of Education et al., 2023). However, in 2022, only 33.2% of primary schools and 58.6% of secondary schools were staffed with full-time psychology teachers (National Bureau of Statistics of China, 2024).

Moreover, the deficiency of a case-oriented approach severely limits psychology educators' capacity to provide tailored support to students based on specific needs (Kemp, 1980). The educational system in mainland China predominantly employs traditional teacher-centered methodologies that emphasize rote learning and position students as passive recipients of knowledge (Gao & Watkins, 2002). This approach

limits the integration of case-oriented and student-centered teaching strategies, which are crucial for fostering critical thinking and problem-solving skills.

Gap 6: Loose Regulation of Mental Health Professionals

The WHO has also emphasized the significance of regulatory frameworks in maintaining high standards of care (Juengsiragulwit, 2015), and the insufficiency of stringent oversight of mental health professionals is a critical concern. For example, the "Circular of the Ministry of Education on issuing the Guidelines for the Construction of Psychological Counselling Rooms in Primary and Secondary Schools" proposes that full-time and part-time teachers should, in principle, have a bachelor's degree in Psychology or a related field and obtain the relevant qualifications (Ministry of Education, 2015). However, the operational guidelines for implementation necessitate further enrichment. Research indicates that low training standards, insufficient ongoing education, and inadequate supervision of mental health service providers not only erode social trust but also diminish the effectiveness of interventions (Gao et al., 2010). Regarding training inadequacies, a significant portion have undergone non-standardized training regimens, devoid of supervised clinical exposure (Chen et al., 2012). Approximately half of the primary and secondary school psychology service providers (SPs) in Beijing were dissatisfied with their roles, primarily stemming from the deficiencies in training and requisite skills (Wang et al., 2014). Concurrently, the absence of an independent accreditation system for school psychologists exacerbates the regulatory vacuum, as there is no effective regulation to ensure the quality of practice. A potential solution could model school psychology practice in the United States, such as evidence-based interventions, professional training, and supervision, involving the formulation of training prerequisites by bodies such as the "Division of School Administration Psychology" under the "China Psychological Association" (CPA), encompassing structured coursework, supervised practical experience, internships, and avenues for continuous professional development (Gao et al., 2010; Wang et al., 2014).

Gap 7: Lack of Multidisciplinary and Interdisciplinary Collaboration

Best practices in mental health care emphasize the importance of interdisciplinary collaboration to deal with the multifaceted nature of mental health challenges (Nancarrow et al., 2013; Shek, 2007). The "Special Action Plan to Comprehensively Strengthen and Improve Student Mental Health Work in the New Era (2023–2025)" advocates for multi-sectoral cooperation (Article 12) but has encountered challenges in practice (Ministry of Education et al., 2023), thus impeding the advancement of holistic mental health services. Effective CAMH policies require collaboration among psychologists, psychiatrists, social workers, policymakers, school teachers, and other stakeholders.

In contrast, the United States provides an example of a diversified mental health care system, where a wide range of specialists, such as social workers, psychologists, and marital family therapists, play diverse roles in the diagnosis, management,

and treatment of psychological issues. While primary care facilities and community mental health are essential in providing mental health services, psychiatrists mostly focus on medication management (Drake & Latimer, 2012). Additionally, psychologists can expand their practice in underprivileged areas by obtaining extra training and licenses (Liang et al., 2017). Such practice is absent in mainland China, highlighting a critical area for potential reform.

Gap 8: Deficiency of Indigenously Developed and Culturally Relevant CAMH Programs

Among CAMH programs in mainland China, there is a scarcity of initiatives that are indigenously developed and culturally relevant. An exception is the PYD program known as the "Tin Ka Ping P.A.T.H.S. Project," adapted from Hong Kong's "Project P.A.T.H.S.," which stands as the only evidence-based PYD initiative recognized in China (Catalano et al., 2012; Shek, 2024; Shek & Dou, 2024).

Globally, PYD programs, one of CAMH initiatives, have gained substantial attention. In the United States, 25 out of 77 PYD programs are classified as "effective" (Catalano et al., 2004), such as "Big Brothers/Big Sisters," "Know Your Body," "Life Skills Training (LST)," "Project ALERT," and the "Valued Youth Partnership Program." Similarly, the United Kingdom has adopted initiatives such as "UK Youth," while Australia has introduced a leadership-focused "Youth Leadership Program." While the expansion of PYD programs across 38 economies (Dimitrova & Wiium, 2021), there remains a significant gap in documenting the impact of PYD interventions in developing economies (Shek et al., 2019a), particularly in China (Shek, 2024). This gap highlights the urgency of developing and implementing culturally relevant and evidence-based CAMH programs in the Chinese context.

Gap 9: Lack of a Rigorous Program Evaluation Culture

The lack of a robust program evaluation culture hampers the assessment of program effectiveness to facilitate evidence-based decision-making. In contrast, many Western countries have developed strong evaluation cultures that integrate evaluation into policy cycles with dedicated funding and institutional support (Rossi et al., 2004).

In mainland China, program evaluation has predominantly focused on economic and infrastructure projects, with limited attention to social initiatives, including those in health and education (Leung & Xu, 2015), which reflects a broader policy tendency to prioritize economic growth over social welfare. Consequently, many social programs lack systematic evaluation frameworks. Culturally, evaluation is often perceived as a critique rather than a constructive process, leading to resistance from program implementers (Yu, 2023) and impeding the integration of evaluation practices into standard program management. Furthermore, institutional support, technology, and resources for assessment activities are also a concern (Chen, 2022). The "Healthy China Action Plan—Mental Health Action Plan for Children and Adolescents (2019–2022)" proposes to improve the monitoring, evaluation, and intervention mechanism, advocating that health and other departments should rely on existing resources to build a CAMH data collection platform, tracking the

changes in the mental health status (Article 3.4), but with limited arrangement for health funding allocation for evaluation (National Health Commission of the PRC et al., 2019).

Gap 10: Lack of Database on Validated Mental Health Programs

China faces a significant gap in the availability of validated mental health program databases compared to Western countries. Historically, mental health services in China were hospital-centric with limited emphasis on prevention (Zhao et al., 2017). Post-2003 SARS outbreak, China introduced the "686 program," the first to focus on severe mental illness management, integrating hospital and community mental health services for severe cases, which modeled on the WHO's approach. However, there is a lack of public databases (Qu et al., 2024).

Despite increased engagement in global health programs like the WHO's "Mental Health Atlas" (WHO, 2021) and the "China–Australia–Hong Kong tripartite community mental health training program" (Ng et al., 2009), China's efforts are limited in comparison to Western countries that boast established databases, such as the "National Mental Health Services Survey" (N-MHSS) and "SAMHSA's Center for Behavioral Health Statistics and Quality" (CBHSQ) in the United States, the "Mental Health Services Data Set" (MHSDS) in the United Kingdom, Australia's "National Community Mental Health Care Database" (NCMHCD) support evidence-based practices and policy formulation. This discrepancy highlights China's early-stage development and validation of mental health programs, lacking the data infrastructure seen in advanced healthcare systems.

Gap 11: Lack of Periodic Epidemiological Studies on Student Mental Health

The WHO emphasizes periodic epidemiological studies to monitor mental health indicators, identify risk factors, and guide interventions (WHO, 2021). China, however, requires more periodic epidemiological studies, especially on CAMH, to inform policy decisions and interventions. The "Healthy China Action Plan—Mental Health Action Plan for Children and Adolescents (2019–2022)" mandates annual student assessments, but lacks verification mechanisms for implementation (National Health Commission of the PRC et al., 2019).

Early epidemiological surveys in China were localized, such as those conducted in Hunan Province in 1990 (Cui et al., 2021). Although national-scale mental health surveys have increased in recent years, they remain sporadic and fragmented. The "China Mental Health Survey" (CMHS), initiated in 2012 with results released in 2019, was the first national survey on mental disorders and mental health service utilization, covering 31 provinces, excluding Hong Kong, Macao, and Taiwan (Lu et al., 2021). In 2019, the Institute of Psychology, Chinese Academy of Sciences, released China's first blue book on mental health, the "China National Mental Health Development Report (2017–2018)," covering the child and adolescent population. Specifically for the CAMH, the Beijing Anding Hospital conducted the first national epidemiologic survey on mental health for children aged 6–16 years in 2014–2015 and released the results in 2021 (Li et al., 2022a). The MOE mandates

annual mental health assessments for students in upper primary, middle, high school, and secondary vocational schools (Ministry of Education et al., 2023), however, the effectiveness of this requirement's implementation remains unverified.

Gap 12: Deficit-Oriented Policy Rather than Strengths-Oriented Policy

The prevailing focus within mental health policy has been predominantly deficit-oriented, concentrating on the remediation of mental health problems. This approach, while addressing immediate issues, often overlooks the nurturing of positive psychological attributes. The "Mental Health Law of the People's Republic of China" (issued in 2012, revised in 2018) states the purpose of the law is "to preserve and promote the mental health of citizens, prevent and treat mental disorders, and promote the rehabilitation of mental disorders" (Article 2), reflecting the deficit-oriented approach of preventing and treating rather than the strengths-oriented approach of empowering (National People's Congress, 2012). Emerging positive psychology offers a paradigm shift in which adolescents are viewed as potential rather than burdens to society (Adams & Abubakar, 2016). This strengths-oriented approach is consistent with the findings of Ryff (2022), who advocates for a holistic understanding of well-being that includes being absence of mental illness and having positive psychological attributes.

Empirical research suggests that interventions aimed at improving positive psychological attributes such as optimism, resilience, and life satisfaction can significantly improve mental health outcomes (Catalano et al., 2012; Chai & Shek, 2024; Shek et al., 2023; Zhu & Shek, 2020). A bibliometric analysis of positive psychology research from 1999 to 2021 demonstrates the steady growth, highlighting the significant benefits of focusing on fostering positive attributes (Wang et al., 2023).

Consequences of a Deficient CAMH Policy

Public policy shapes public opinion, societal norms, and priorities (Colebatch, 2006) by serving as an official and authoritative endorsement. The mental health policy deficit has exacerbated youth mental health problems (Shek, 2020; Shek & Siu, 2019a). A study across 30 European countries indicates that effective CAMH policies correlate with reduced adolescent aggressive behavior (Hendriks et al., 2019). Without effective CAMH policies, individuals often lack access to accurate mental health information, hindering parents and teachers from recognizing mental health symptoms in children. For instance, children with ADHD are commonly misidentified as being merely energetic (Sharifi et al., 2016).

Easton (1965) conceptualized politics as the "authoritative distribution of values," which involves the distribution of wealth and resources to create a social "safety net." One consequence of the gap in CAMH policy has been a shift towards personal affordability rather than public support with the commercialization of mental health services (Callaghan et al., 2017). Over decades, extensive research has explored the underlying mechanisms underlying CAMH problems, examining factors ranging from family dynamics and economic conditions to neurobiological and biochemical influences (Buehler, 2020; Vijayakumar et al., 2018). However, translating research

findings into effective policy remains a challenge. Moreover, rather than driving systemic change, policymakers may misinterpret these research findings as endorsing greater individual and familial accountability, inadvertently promoting the notion that mental health care is a personal financial responsibility. It is widely recognized that parents have primary responsibility for their children's well-being, which highlights parental education and training but often overlooks the need for societal support (Callaghan et al., 2017).

This trend also drives the commercialization of mental health services. Currently, self-help literature and digital aids, including mindfulness applications and virtual therapy platforms, are aiding individuals worldwide in coping with mental health challenges. However, the commercialization of mental health services gradually shifts the burden of responsibility from governmental entities to individuals. The absence of CAMH policy and the trend of mental health as a "personal choice" not only obscures the socioeconomic determinants of health disparities but also markedly disregards the intrinsic status of mental health as a fundamental human right (Cosgrove & Shaughnessy, 2020). Moreover, it renders families and individuals with constrained access to mental health literacy more susceptible to psychological distress, thereby amplifying the socioeconomic hardships they endure (Callaghan et al., 2017).

Policy Implications

Research findings indicate the dearth of mental health policies targeted exclusively at children and adolescents in mainland China, mirroring a global trend of insufficient CAMH policies that has been extensively documented (Belfer & Saxena, 2006; Shatkin & Belfer, 2004; WHO, 2018, 2021). Although China has been responding to rising mental health issues with more CAMH-related policy initiatives, particularly in the post-COVID-19 era, significant policy gaps remain, which are similar to those in other low- to middle-income economies (Juengsiragulwit, 2015; Zhou et al., 2020a).

To address the challenge of gaps in CAMH policies, this study suggests integrating the PYD program as a promising tool in CAMH policy. The PYD approach provides ideological guidance and a comprehensive framework for public policy-making. Traditionally, public mental health policies have focused on a deficit-oriented approach to mitigate negative outcomes by identifying and reducing risk factors (Benson et al., 2004). However, in recent decades, there has been a shift towards a PYD perspective, which emphasizes fostering young people's strengths (Benson, 1997; Catalano et al., 2004; Lerner et al., 2005; Shek et al., 2019a). This perspective is increasingly recognized in policy discourse (Benson et al., 2004; Sherrod, 1997) and provides a blueprint for policy formulation. For example, a government document released in 1996 stated that "focusing on young people's strengths rather than their failings is the underlying principle of the youth development construct and has been the driving force behind the U.S. Department of Health and Human Services' youth-related programs for over two decades" (National Clearinghouse on Families & Youth, 1996, p. 13). In addition, the PYD framework is reflected in a policy

paper by the U.S. Agency for International Development (USAID), titled "Youth in Development: Realizing the Demographic Opportunity," which stresses the value of involving youth voices in policy decision-making processes and advocates for strengthening family and community ties to promote social stability (USAID, 2012).

Furthermore, policy recommendations in health should be evidence-based (Hickie, 2011; Shek & Siu, 2019a). From the "policy outcome" perspective, PYD initiatives benefit the achievement of the policy's objective of improving CAMH. Research consistently indicates that PYD programs enhance intrapersonal competence in social, emotional, ethical, and cognitive aspects (Catalano et al., 2019; Taylor et al., 2017). Additionally, PYD programs contribute positively to well-being, fostering positive peer relationships, family harmony, citizenship, achievement motivation, and life satisfaction (Catalano et al., 2019; Shek & Zhu, 2020; Taylor et al., 2017; Zhu & Shek, 2020). Furthermore, PYD programs functioned as protective measures against risks of anxiety, depression, suicidal tendencies, and internet addiction (Zhou et al., 2020b). Acknowledging the significance of PYD programs, the international community has made substantial investments. For instance, USAID allocated over $440 million towards PYD initiatives (USAID, 2013) and established "YouthPower.org," an online learning platform with over 1,000 resources to support the global adoption of the PYD approach. Unfortunately, despite the abundance of PYD programs in the West, there are very few PYD programs in China (Shek & Yu, 2011).

The "Project P.A.T.H.S." in Hong Kong and its mainland China adaptation, the "TKP P.A.T.H.S. Project," were identified as the only evidence-based PYD initiatives in China (Catalano et al., 2012) and recognized as an effective life skills training program by the WHO (2016), warranting broader dissemination. Launched in Hong Kong in 2005 with over HK$750 million fund from the Hong Kong Jockey Club Charities Trust, the "Project P.A.T.H.S." adopts a structured curriculum grounded in 15 PYD constructs (Catalano et al., 2004), such as emotional competence, bonding, resilience, social competence, self-efficacy, and spirituality, benefiting over 360 schools and 357,839 junior high school students through over 120 teaching units. Adapted to mainland China's sociocultural context, the "TKP P.A.T.H.S. Project" integrates localized priorities such as academic stress management, Confucian ethics, and civic responsibility. Following a pilot phase (2011–2014) in four Tin Ka Ping secondary schools in East China (Shanghai, Suzhou, Yangzhou, and Changzhou), the program expanded to over 30 junior and senior secondary schools by 2015–2016. As of July 2024, cumulative participation exceeded 67 schools (262,145 person-times) and 816 schools (772,897 person-times) through both face-to-face and online courses, totaling 1,035,042 student person-times in various regions.

A recent *Lancet* review paper highlighted the significance of the program's innovative integration of multi-strategy interventions to enhance youth well-being, citing Project P.A.T.H.S. as "promising" (Qu et al., 2024). Objective outcome evaluations using quasi-experimental designs (Shek & Zhu, 2020; Shek et al., 2014), subjective outcome evaluation (Shek et al., 2012, 2018), and qualitative evaluation through focus groups and student diaries (Shek, 2024; Shek et al., 2019b; Tan et al., 2025) demonstrate statistically significant improvements in participants' self-efficacy, resilience, peer support, and academic performance. Notably, the project's culturally

tailored strategies, such as family-system collaboration and Confucian value integration (Shek et al., 2013), enhanced program acceptability across urban and rural communities in mainland China (Shek, 2019). Recently, a rural version of the project with adapted curricular content was developed, while international implementation in Sri Lanka, South Korea, Argentina, and Malaysia (Shek & Dou, 2024) demonstrates its cross-cultural applicability. Given its efficacy, systematic promotion of this evidence-based program is critical to extending its benefits to wider youth populations.

Several research limitations should be acknowledged in this study. While document analysis has the advantages of accessibility, stability, and comprehensive coverage (Merriam, 1988; Yin, 1994), it also has drawbacks. Specifically, some documents might be difficult to retrieve or intentionally blocked within institutional firewalls, limiting the scope of the analysis (Yin, 1994). Besides, relying solely on online public policy documents might lead to missing out on hard-copy policies that haven't been digitized or made publicly available (Jaeger et al., 2012), resulting in an incomplete dataset. Furthermore, the exclusive focus on national-level policies might overlook regional dynamics, which could limit our understanding of how CAMH policies develop across different administrative levels in mainland China. Moreover, the study doesn't include perceptions from key stakeholders such as policymakers, healthcare providers, educators, parents, and young people, which are crucial for a holistic understanding of CAMH policy challenges.

Despite the above limitations, this study has academic and practical significance. Firstly, it addresses a major research gap by providing a systematic review of CAMH policies, with a particular focus on mainland China (Kutcher et al., 2010; Mokitimi et al., 2018). Secondly, it aims to draw the attention and involvement of key stakeholders to the growing CAMH problems in mainland China (Li et al., 2022a; Matsuura et al., 1993; Shek et al., 2023). By highlighting the severity of psychological disorders and the associated disease burden, this study aims to alert and mobilize policymakers, non-governmental organizations (NGOs), mental health professionals, educators, and the general public to address these pressing issues. Thirdly, the CAMH policy review contributes to identifying and addressing policy gaps in mainland China. Due to the lack of a systematic and in-depth review of CAMH policies (Liang et al., 2017; Zhou et al., 2019), the actual efforts of the Chinese government's initiatives to improve adolescent mental health are obscured, as well as hindering the policy gaps and associated remedies. By critically reviewing these policies, this study provides a significant reference for policymakers in making firm commitments and policy adjustments to improve the CAMH in mainland China.

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Declarations

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