

## **Are Rights-Based Child and Adolescent Mental Health Services and Policy Evident in the Hong Kong Chinese Context?**

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### **Abstract**

*In spite of the pervasive proclamation of children's rights in child policy and services worldwide, these rights are hardly witnessed in child and adolescent mental health policies and services in Chinese societies. While western counterparts like the United States and the United Kingdom are progressing towards upholding the rights of children in the area of mental health by developing child-focused, family-centered and community-based mental health services, there is a dearth of studies on this subject in Hong Kong. In this paper, a critical examination of children's rights in the international development of child and adolescent mental health policy and services is conducted. Implications that Chinese societies like Hong Kong need to similarly strive for a rights-based child and adolescent mental health policy and services are discussed.*

**Keywords:** Children's rights, child and adolescent mental health, Chinese, Hong Kong

### **Introduction**

While children's rights are witnessed in different areas like child labor and child protection policies, there is scanty concern for it in child mental health policies and services in Chinese societies like Hong Kong. Advocacy for children's rights has already been formally achieved and explicated in the United Nations Convention on the Rights of the Child (United Nations, 1989). Yet, its realization in child and adolescent mental health policy and services in Hong Kong is still in question. In this paper, a critical examination of the execution of rights-based child and adolescent mental health policy and services in Hong Kong is conducted with regard to two western examples in the United States and United Kingdom. The implication that Chinese societies like Hong Kong should also strive for a rights-based child and adolescent mental health policy and services will be discussed.

### **Child and Adolescent Mental Health**

Child and adolescent mental disorders are receiving growing attention worldwide and about 10% to 20% of the children and adolescents in developing and developed countries are suffering from mental health problems or disorders (WHO, 2005). The prevention and treatment of these mental disorders can lead to improvements in the current state of the suffering of these children and adolescents, improved adult functioning and reduced cross-generational distress (Ford, Goodman & Meltzer, 2003). Concern for child and adolescent mental health also serves the welfare of children and their families, as well as the community and society at large (WHO, 2005).

### **The Value of Children**

In contemporary society, the value of a child as a person worthy of a satisfactory life is increasingly being recognized. Children's needs for survival, development, protection and participation are addressed in the Convention on the Rights of the Child (United Nations, 1989). The dignity of children is respected and their holistic development is advocated. From a developmental perspective, childhood is a critical stage for the development of healthy adulthood, and children need to achieve growth and develop their potentials in a secure and nurturing environment (Erikson, 1964). Their age-appropriate cognitive and moral development needs to be fostered (Piaget & Inhelder, 1969; Kohlberg, 1984).

### ***Children's Rights in Child and Adolescent Mental Health Policy and Services***

Advocacy for children's rights in different areas originated from a recognition of the value of children. As previously mentioned, children's rights have been formally and comprehensively advanced in an international treaty named the Convention on the Rights of the Child (United Nations, 1989). China ratified the convention in 1990. Hong Kong is now a special administrative region of China, and therefore has an obligation to execute the convention. Article 19 has delineated that a child has the right to a non-violent developmental environment and children's rights have become the basis of the advocacy for child protection (Hart, Lee & Wernham, 2011). In a similar vein, a most recent paradigm in perceiving child and adolescent mental health is the rights perspective (Harper & Çetin, 2008; WHO, 2013, p.3). The rights of children are therefore used as the basic grounds for the advocacy of child and adolescent mental health policy and services. Based on the framework of the Convention, a child rights-based service should accentuate the importance of family as a natural environment for the healthy growth of children. The accessibility of child services to working parents is underscored in Article 18. Apart from being family-centered, as indicated in Article 23, it is suggested that child rights-based mental health service be community-based in order for children to achieve individual development and social integration within the community.

Within the World Health Organization (WHO), the human rights of children with mental health needs are gaining increasing significance. This is laid out in the vision of the comprehensive mental health action plan for 2013-2020, specifying that children with mental health needs should be able to 'exercise the full range of human rights' (WHO, 2013, p.7). It is also articulated in this plan that by 2020, it is expected that '80% of member countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments' (p.9).

In the "Child and adolescent mental health policies and plans" that is promulgated for the global development of child and adolescent mental health policies and services, the WHO (2005) suggests the dual goals of child and adolescent mental health policy. While addressing the problem of mental disorders, the policy should also promote the healthy development of children and adolescents (p.22). It is asserted that the vision for a child and adolescent mental health policy could be defined as "creating an environment which meets the psychosocial needs of children to enable their optimal development" (p.23). To achieve this, any policy developed should reduce the risk factors and enhance the protective factors of mental disorders in biological, psychological, family, school and community domains (p.2 and p.12). In particular, the significance of the family environment in the development of pre-pubertal children is emphasized. It is advisable to involve parents and communities in making plans for child and adolescent mental health services as it is believed that these people can make suggestions for improving the existing services or can help identify any service gaps (p.28). It is further highlighted in WHO (2013, p.11) that families and teachers should be regarded as informal mental health care providers that deserve to be treated as equal partners in service delivery. Also, a multidisciplinary approach from both public and private sectors and coordinated government efforts that involve the education system, welfare system, health system, and other social systems in offering child and adolescent mental health services is consistently emphasized (WHO, 2005, p.15; WHO, 2013, p. 2,7).

Despite the assertions of children's rights in the Convention on the Rights of the Child and the vision and values underscored by the WHO, the WHO Child Atlas Project revealed that there was a gap between the assertions and the implementation of the convention in children's mental health services worldwide (Belfer & Saxena, 2006). 30 out of 66 countries had a policy on children's rights that focuses on abuse and other matters instead of child mental health needs (Belfer & Saxena, 2006). Are children's rights being recognized in child mental health services and policy in Chinese societies like Hong Kong?

Hong Kong is a society in which both traditional Chinese Confucian values and western individualism and rationalism have fused together. Yet, the traditional Confucian values of harmony and order still exert their subtle influence on the conceptions of mental illness among Chinese (Tseng, Lin & Yeh, 1995) and the somatization of mental illness is reported to reduce the stigma that equates mental illness to "dian" (insanity) or "kuang" (craziness) (Lam et al., 2010; Wong et al., 2012). The position of children in Chinese society is culturally imprinted to be subordinate to the authority of adults through the core Confucian concepts of filial piety and obedience (Chan, Lam & Shae, 2011). Children are rarely seen as separate entities having dignity and being worthy of respect.

In Hong Kong, there have been few studies about children's rights and those studies that have been done are mainly centered on the residency rights of children (Ng, 2007), child labor (Samuels, 2007) and child protection (Chan, Lam & Shae, 2011). Hitherto, there has been no paper written in Hong Kong to examine child and adolescent mental health policy and services from a children's rights perspective. In order to fill this knowledge void, this paper attempts to examine how far rights-based child and adolescent mental health policy and services are evident in the Hong Kong Chinese context. Through a review of examples in the United States and the United Kingdom, both developed countries that have had a longer history of development in this area, insight can be gained for the future development of rights-based child and adolescent mental health policy and services in Hong Kong.

### ***Child and Adolescent Mental Health Policy and Services in the United States***

In the United States, the prevalence of children and adolescents having one or more mental disorder ranges from about 14% to 20% (Merikangas, He, Brody, Fisher, Bourdon & Koretz, 2010; Kataoka, Zhang & Wells, 2002). The National Institute of Mental Health (NIMH) as a federal organization is responsible for the mental health of the nation (Meyers, 1985). The government's commitment to child and adolescent mental health has evolved over time. The first child mental health service in the United States was developed after the social and political movements that formed the first juvenile courts to cater for adolescents in deprived social conditions (Richmond & Harper, 1996; Lourie & Hernandez, 2003).

In 1983 Congress launched the Child and Adolescent Service System Program (CASSP), which was the first federal program that specifically targeted children and youths with mental health problems (Meyers, 1985). The concept behind the CASSP was a "system of care" (Lourie & Hernandez, 2003). It promotes a systemic approach to service delivery that is community-based, child-focused and family-centered (Furman & Jackson, 2002). These principles resonate strictly with the proclamation of children's rights in mental health services by promoting interagency cooperation across different sectors offering various services and by recognizing the key role of the family in defining service needs and benefiting from the services. The family is the main support system for child and the family should be bolstered to be able to take care of its child in need (Lourie & Hernandez, 2003; Furman & Jackson, 2002).

In line with the philosophy of a system-of-care that reflects children's rights, individual states in the United States developed services in a variety of ways. Among them a wrap-around service is currently a vital element of mental health services for children and adolescents that exhibit children's rights through child-focused and family-centered services. It is estimated that about 200,000 children have received wrap-around services every year and 88% of the states in the United States offer various forms of wraparound services (Walter, & Petr, 2011). Some states also offer community-based services for children and adolescents in their homes and in schools. In addition, the wrap-around service is supposed to be team-based. It stresses collaboration among the different formal and informal parties concerned. The child, the family and their advocates are members of the team. The family-centered practice represents a significant embodiment of children's rights in child and adolescent mental health service. A family-centered approach that honors and respects family values, emphasizes families' informed choices, treasures the partnership between family and professionals, recognizes family strengths, empowers the family, and is culturally responsive to the unique needs of a particular family (Dunst, Trivette & Hamby, 2007; Madsen, 2009) is widely recognized as being favorable to children with special health care needs (CSHCN) and their families (Bellin *et al.*, 2011).

Likewise, in an effort to actualize children's rights in child and adolescent mental health policy and services, in 2003 the President's New Commission on Mental Health (NFC) issued a report named *Achieving the Promise: Transforming Mental Health Care in America* that delineated six goals and sixteen recommendations for mental health service development in the United States (Gould, Roberts & Beals, 2009). The report has significant implications for implementing school-based child and adolescent mental health services in such a way that these services would reduce the stigma of mental illnesses, help prevent suicide, improve school mental health prevention and treatment, be more accessible to the socially-disadvantaged population, and increase the chance to cooperate with teachers and parents (Mills *et al.*, 2006).

### ***Child and Adolescent Mental Health Policy and Services in the United Kingdom***

To realize children's rights through multidisciplinary collaboration has been the focal concern of the British government since the lesson learned from the death of Victoria Climbié and other children that highlighted the failure of service coordination (DfES, 2003, p.5). The British government has demonstrated its commitment to respect for the dignity and value of the child that forms the basis of children's rights-based mental health service (Hart, Lee & Wernham, 2011).

Based on two samples taken in 1999 and 2004, the average prevalence of mental disorders for British children and adolescents aged between 5 and 15 is 9.5% (Meltzer, 2007). Children's mental health is endorsed as having a priority equal to physical health by the Deputy Prime Minister in a document named *Children and teenagers to benefit from successful adult mental health therapy* (DoH, 2011).

The British child and adolescent mental health services (CAMHS) used to be commented on as being patchy and piecemeal without having good coordination and cooperation among different agencies (Joughin & Kelly, 1998). Yet, the government issued a Green Paper in 2003 named *Every Child Matters* to reform service delivery for children, young people and families through the integration of services and multi-agency cooperation (DfES, 2003, p.1-2, p.8).

Subsequently, the *National Service Framework for Children, Young People and Maternity Services* which was jointly published by the Department for Education and Skills and the Department of Health in 2004 laid out national standards for health and social services for children (Salmon, 2004). Specifically, Standard 9 has elucidated the government vision for the development of CAMHS (DoH/ DfES, 2004a). It is advocated that all people under the age of 18 with mental disorders and their families be able to receive timely, integrated and multi-disciplinary mental health services (DoH/ DfES, 2004a, p.4).

In addition, partnerships with children, young people and their families are also emphasized in CAMHS. It has embodied children's rights through child-focused and family-centered services. Standard 3 of the *National Service Framework for Children, Young People and Maternity Services* highlights the importance of the participation of children and young people and parents in mental health service development (DoH/ DfES, 2004b, p.86). It stresses that professionals need to see through the eyes of young people and listen to their voices. The views of children, young people and families are valued and they are being incorporated in the planning, delivery and evaluation of services.

Moreover, regarding the access and location of services, Standard 9 of the *National Service Framework for Children, Young People and Maternity Services* states that the provision of CAMHS in a variety of settings such as school, clinics, home or community agencies is encouraged (DoH/ DfES, 2004a, p.15). School is viewed as a favorable place for young people to have their first contact with CAMHS as the school environment may be considered less stigmatizing. Yet, a readiness of teachers and schools to cooperate is the key to success (Finney, 2006; Kidger *et al.*, 2010) and more effort need to be paid to narrow the gap between the proposition and the reality of the implementation of CAMHS in schools .

The British government takes an active role in promoting and evaluating child and adolescent mental health policy and services. In 2007, the British government commissioned an independent review of CAMHS to evaluate the provision of the service (DoH/ DfCSF, 2010). The review has endorsed the present vision and contribution of CAMHS while advocating that the government should show how the services could be integrated and how good practice could be promoted (DoH/ DfCSF, 2010, p.12). The child and adolescent mental health field is a complex entity that involves a multiplicity of professionals and disciplines. The role of the government in bringing about rights-based reforms in child and adolescent mental health services is very crucial and the British government has noticeably shown a commitment to it.

### ***Child and Adolescent Mental Health Policy and Services in Hong Kong***

After reviewing the experience of western countries with developing rights-based child and adolescent mental health policy and services, it is appropriate to examine that of Hong Kong. Children's rights as a basis for advocacy has a long history of development in child protection, such as protection from child abuse, and the Hong Kong government has set up a unit called the Family and Child Protective Services Unit (FCPSU) to specialize in handling various types of child abuse (SWD, 2014). This represents progress, but how about the exhibition of children's rights in child and adolescent mental health policy and services in Hong Kong?

Hong Kong has a history of special political development. Before 1997, Hong Kong was under the reign of the British government. After the 1<sup>st</sup> of July, 1997, the sovereignty of Hong Kong returned to China and it was renamed the Hong Kong Special Administrative Region (HKSAR). In Hong Kong, mental health falls under the realm of rehabilitation. Two significant policy papers on rehabilitation were produced under the rule of the British government. In 1976, the then colonial government issued the first Hong Kong Rehabilitation Program Plan. The recommendations made in that plan form the basis of the first white paper on rehabilitation (LWB, 2007, p.1). In 1977, the government issued the first white paper on rehabilitation. It was named *Integrating the Disabled into the Community: A United Effort*. In 1995, the government then in power issued its second white paper on rehabilitation, entitled *Equal Opportunities and Full Participation: A Better Tomorrow for All* (Cheng, 2011, p.7). The main theme is to provide people having different kinds of disabilities, including those with mental health problems, with equal opportunities for full participation in their personal and social development. Comprehensive measures are to be developed to prevent disabilities, to help people with disabilities to develop their physical, mental and social capacities, and to create a barrier-free physical and social environment (Cheng, 2011, p.7). Although there is neither differentiation between mental health and other types of disabilities nor differentiation between adult and child and adolescent mental health in that rehabilitation paper, the overall policy objectives set in 1995 still serve as the major reference for subsequent policy papers.

Based on the aforementioned policy direction, the latest Rehabilitation Program Plan developed by the Labor and Welfare Bureau of the HKSAR in 2007 has laid down directions for development in different areas of rehabilitation services. The same as the white paper issued in 1995, the 2007 Rehabilitation Program Plan is for both adults and children and for all types of rehabilitation including mental health. Conspicuously, the government has not shown special concern with children's rights in mental health matters as it has not issued a specific document guiding its development, and the current direction of development is carried on from that of the white paper of 1995.

In the 2007 Rehabilitation Program Plan, only three categories of childhood mental disorders are classified as disabilities that require special services. They are autism, attention deficit/hyperactivity disorder (AD/HD) and specific learning difficulties (SpLD) (LWB, 2007, p. ii). It reflects the dominant residual model of welfare services in Hong Kong in which only the least able can receive government-subsidized social service, and the responsibility for care resides mainly on individuals themselves and an informal support system.

In addition, the service nature specified in the Rehabilitation Program Plan is far from the principles of the rights-based frameworks of western counterparts. While family-centered practice is a major direction of the rights-based approach, the major services provided for children with these types of disorders in Hong Kong only include early identification and assessment, pre-school training, education services and medical rehabilitation that are individual-based without regarding the family as a significant stakeholder in child and adolescent mental health (LWB, 2007, p.7,8,12). Involving the family as an equal partner together with the professionals in children's mental health assessment and treatment does not get adequate attention from the Hong Kong government. This omission is clearly against the rights of children as laid down by the World Health Organization in the Convention on the Rights of the Child in that the family, as the natural context within which children develop, deserves respectful involvement and support (United Nations, 1989; WHO, 2013).

In the public sphere of child and adolescent mental health service, early identification of problems and the assessment of pre-school children are conducted by the Department of Health. This department runs 31 Maternal and Child Health Centers (MCHCs) that offer universal integrated child health and development programs for all children from birth to five years old. Immunization and health and developmental surveillance programs are available to monitor the physical and developmental conditions of babies and children (DH, 2012a). Children with suspected delayed development in physical, psychological and social aspects are referred to the Child Assessment Centers (CAC) of the same department for a multi-disciplinary assessment (LWB, 2007, p.20; DH, 2010). Regarding follow up services after the assessment, where necessary, the CAC will refer cases to the Social Welfare Department for the provision of pre-school rehabilitation services. Besides this, suspected cases will also be referred to the Hospital Authority for further diagnosis in a child and adolescent psychiatric clinic. Medical support will be provided whenever necessary.

Likewise, early identification and assessment of school-age children with potential problems is conducted by the Department of Health through the universal Student Health Service (LWB, 2007, p.18; DH, 2012c). The physical and psychological health of school-age children is assessed through a preventive health program.

Children identified as having special needs such as learning difficulties and behavioral problems will be referred to the CAC, which offers assessment services to children from 0 to 12 years old. After assessment, school-age children with mental health service needs will have their needs met mainly by the Education Department through inclusive education or special schools. Suspected cases will also be referred to the Hospital Authority for further diagnosis in a child and adolescent psychiatric clinic. Medical support will be provided whenever necessary.

While the child rights-based approach advocates community-based and especially school-based mental health services for holistic development and the social inclusion of children, the Hong Kong government focuses mainly on the academic functioning of children in school instead of valuing children as whole persons worthy of a quality life. The long waiting time needed for a diagnosis from a psychiatrist from government clinics makes parents worried and anxious about missing helping their children during their child's critical developmental period (Ma and Lai, in press).

Multidisciplinary collaboration is a foundation for child rights-based mental health policy and services. As mentioned before, various different departments and professionals are involved in the provision of child and adolescent mental health services. To achieve a successful multidisciplinary collaboration, a smoothly functioning policy interface and smoothly functioning service interfaces between different departments and disciplines are imperative. How far has the Hong Kong government achieved this goal in child and adolescent mental health?

In Hong Kong, the Food and Health Bureau (FHB) is responsible for the overall coordination of policies and services concerned with mental health. It works with the Labor and Welfare Bureau (LWB) and other related government departments to improve service delivery (Cheng, 2011, p.72). How well does the FHB function in playing the role of the coordinator of mental health services?

There is no formal document reviewing the coordination of mental health services in Hong Kong. However, in the minutes of a meeting held by the Panel on Health Services and the Panel on Welfare Services of the Legislative Council in May 2011, there are concerns about the overall mental health policy lacking coordination among various government departments (LegCo, 2011). Frontline clinicians who work with children with multiple problems also urge for a genuine liaison among the multiple disciplines in Hong Kong (Wong, 1990).

It is obvious that child and adolescent mental health has not adequately reached the political agenda in Hong Kong. The Chief Executive of Hong Kong committed more resources for autistic children only in the Policy Address of 2010-2011, but not in the subsequent Policy Address of 2011-2012 (HKSAR, 2010; HKSAR, 2011). In addition, there is no mission or value statement in all Hong Kong policy papers guiding the provision of child and adolescent mental health services. Unlike the examples of the United States and the United Kingdom, where clear rights-based principles such as child-focused, family-centered, community-based, school-based and multidisciplinary approaches guide the provision of child and adolescent mental health services, all Hong Kong can refer to is just the broad statement laid down in the 1995 white paper. It was written by the then colonial British government and even after about 19 years it has not yet been reviewed by the new HK government (HKSAR) under the sovereignty of China.

Apart from the invisible leading role of the Hong Kong government, there is also a lack of studies done on Hong Kong child and adolescent mental health policy and services by the academic community. Only three related studies can be found in the database within the 24 years from 1990 to 2014. One of them reveals the lack of multidisciplinary collaboration (Wong, 1990); one of them examines the effect of a triage system in a child and adolescent psychiatric clinic in Hong Kong (Lai, 2006); and one study examines family engagement in child mental health services (Ma and Lai, in press). Researchers could certainly play a more proactive role in realizing children's rights in child and adolescent mental health policy and services in Chinese societies like Hong Kong.

## ***Discussion***

With respect to the global value placed on human rights, the promotion of rights-based child and adolescent mental health policy and services is conceived to be appropriate. Although the Hong Kong government realizes children's rights in mental health through offering universal health surveillance programs, it stills needs to demonstrate a deep commitment through developing a long-term and comprehensive plan for the mental health of children and adolescents.

Even if the Hong Kong government is committed to children's rights, rights-based child and adolescent mental health could not be achieved without a clear vision and values. As can be learned from the United Nations, WHO, and the experience of the United States and the United Kingdom, being child-focused, family-centered, community-based and involving multi-disciplinary collaboration are the common element of a rights-based approach to child and adolescent mental health services.

For child and adolescent mental health policies and services to be child-focused, the child should be viewed as a whole person with his or her developmental needs in their natural contexts. The child should not be viewed only as a disorder-bearer. The voices and views of children and young people should be solicited and valued.

For child and adolescent mental health policies and services to be family-centered, the family should be viewed not only as an information provider but also as a resource person and an agent able to be active in helping the children. In Hong Kong, parents of children with ADHD are not actively engaged by professionals in the decision-making process of assessment and treatment (Ma and Lai, in press). Just like in the wraparound service in the United States, children and family should be viewed as being part of the mental health team. In those wraparound services, family advocates are employed to support and empower the families. All these examples are worthy of further examination by the Hong Kong government to decide on the transferability of these principles to the Hong Kong Chinese context.

For child and adolescent mental health services to be community-based, mental health treatment must be provided in places within the community such as school, family, and welfare agencies. As illustrated by the trends of the United States and the United Kingdom, cooperation with school or school-based mental health programs is becoming prevalent. Although there have been comments that the Education Bureau has offered little information and support to parents of children with mental health needs (Ma and Lai, in press), it can in future strive to have closer cooperation with other departments as is the case in the United Kingdom in which the role of the Education Department is not limited simply to education but involves children's welfare as well. For child and adolescent mental health policy and services to be rights-based, satisfactory interfaces between education, medical and social welfare sectors are vital. Besides the above, an integrated community-based service center for families of children with ADHD is a goal of care-takers in Hong Kong (Ma and Lai, in press). All these points deserve serious consideration by the Hong Kong government for the sake of the welfare of our younger generation.

### ***Conclusion***

This paper presents a ground-breaking endeavor by examining child and adolescent mental health policy and services in Hong Kong through a child rights paradigm. The Hong Kong government faces a sensible challenge to develop an indigenized child and adolescent mental health policy and services within the global context of human rights. Children's rights have been affirmed internationally by the United Nations and the World Health Organization. Western countries like the United States and the United Kingdom have demonstrated their awareness and commitment to children's rights by developing rights-based child-focused, family-centered, community-based and multi-disciplinary child and adolescent mental health policy and services. The Hong Kong government should take concrete steps to lead the promotion of children's rights in child and adolescent mental health in Hong Kong.

The Hong Kong child and adolescent mental health policy and services realize children's rights by providing universal health surveillance programs. Yet, it lacks a long-term mission and values for guiding its development. The concept of children's rights and family involvement in service provision is relatively weak. Services without firm vision and strong values always appear to be piecemeal and fragmented and going nowhere. As stated by Harper & Çetin (2008), policy is not static and is always subject to a dynamic interaction among different stakeholders. The improvement of Hong Kong child and adolescent mental health services requires the concerted partnership of children, young people, their families, different government departments and professionals. If this is done, the goal of a rights-based child and adolescent mental health policy and services will never be out of reach.

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