Child and Adolescent Mental Health

Renata Szredzińska – Empowering Children Foundation

List of issues

Photo: Victoria Watercolor (Pixabay.com).

In recent years children and adolescents' mental health has been given much attention in public debate. Journalists, decision makers, health care professionals, and parents are alarmed by the growing number of suicide attempts among children and adolescents, poor conditions and insufficient care on in-patient psychiatric wards, long wait times for mental health services, and a lack of broad prevention programmes. In 2018, the assumptions for the reform of child and adolescent psychiatry started being developed, and since 2020 the reform has been implemented in Poland. It is hoped to improve mental health care for children, even though it addresses just one aspect of the problem, i.e., medical care for children who have already developed mental health issues. The reform, at least in its current form, does not place emphasis on the prevention of mental health problems.

This chapter tries to capture the current situation and key trends that may demonstrate the present mental health status of Polish children and adolescents. Since detailed discussion of the whole range of topics related to child and adolescent mental health goes beyond the scope of this chapter, it will largely focus on the indicators of disorders and existing problems, and only briefly mention the positive aspects that build resilience. Thus, it is important to remember that the current discussion covers just a part of the complex problem of Polish children's mental health and the mental health care system.

Definition of mental health

The World Health Organization (WHO) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (WHO, 2001). The Polish National Health Fund (Narodowy Fundusz Zdrowia, NFZ) has adopted the following definition: "Mental health is a state of psychological, physical, and social wellbeing, as well as the ability to develop and achieve self-actualisation" (NFZ, 2021).

Thus, mental health is not defined as mere absence of illness or disorders, but rather as full well-being and the ability to realize one's potential. As already mentioned, this chapter focuses on factors related to negative aspects of the subject, i.e., illnesses and disorders. This results both from limited space and from a lack of systematically collected reliable research data on the positive factors.

Legal framework

Although there are numerous EU and national provisions regulating the protection of mental health, only selected national regulations will be cited here.

The key legal act regulating mental health protection in Poland is the **Act** of the 19th of September 1994, **on the Protection of Mental Health** (Dz.U. [Journal of Laws] 2017, item 882), which describes the general model and principles of care for individuals with mental disorders, specifies the authorities and institutions responsible for providing care for the mentally ill, and ensures the protection of their rights, especially during hospitalisation.

Important provisions were also included in the **National Health Programmes** (NHPs) for 2016–2020 (Dz.U. 2016, item 1492) and 2021–2025 (Dz.U. 2021, item 642). In the current Programme, mental health is addressed by Operational Goal 3, which defines tasks related to the promotion of mental health and the prevention of suicidal behaviour. Notably, the NHP covers both child and adolescent populations, and adults.

Another important legal instrument is the **National Mental Health Protection Programme**, enforced by the regulation of the Council of Ministers of the 8th of February 2017 regarding the National Mental Health Protection Programme for the years 2017–2022 (Dz.U. 2017, item 458). It defines the strategy aimed at providing people suffering from mental disorders with comprehensive, wide-ranging and commonly accessible health care and other forms of care and assistance necessary for living in the family environment and in the community. The Programme also addresses the topic of developing proper social attitudes towards people with mental disorders, in particular understanding, tolerance, kindness, as well as preventing their discrimination.

Finally, a new model of child and adolescent psychiatric care, described further in this chapter, was introduced by the Minister of Health regulation of the 14th of August 2019, amending the regulation on **guaranteed benefits for psychiatric care and addiction treatment** (Dz.U. 2019, item 1640, with amendments).

> *I am afraid to tell my mother about my suicidal thoughts. I fear that she would be angry with me or upset that I told the school counsellor about them. What I'm most afraid of is that she'll take my phone away because she'll think it's all because of using it.*
>
> *15-year-old girl*
> *A quote from phone calls and emails to 116 111 Helpline for Children and Young People*

Mental health risk and protective factors

Mental health depends on multiple inter-related factors: genetic, biological, family-related, and societal. These are summarised in Table 1.

Many of these factors are described in other chapters of the current report. Here it is worth discussing two of them, not addressed elsewhere in the report: excessive stress, especially school stress, and maltreatment.

In recent years, there has been a significant increase in the number of children and adolescents who experience strong school-related stress. According to the latest *Health Behaviour in School-age Children* (HBSC) survey of 2018, more than two fifths of the students participating in the survey experience high or very high levels of school stress, which constitutes a rise of 9 percentage points (pp) in comparison to the 2014 survey, and of 19 pp

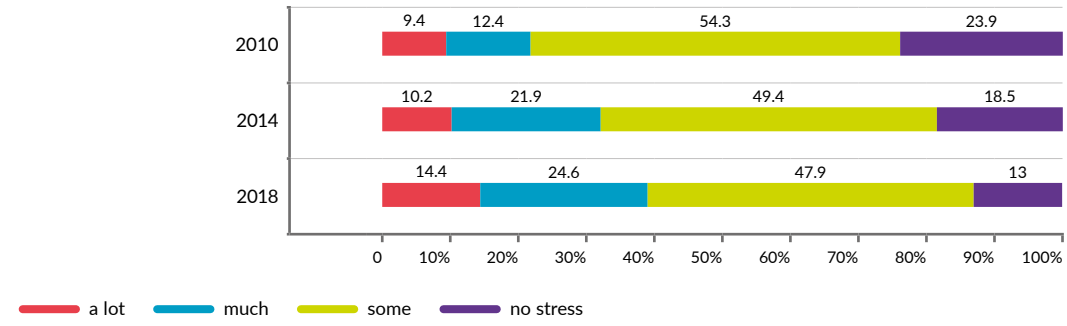
Table 1. Risk factors for mental disorders in children

	From conception to birth	Early childhood	Puberty adolescence	Late teens
Genetic	– Family history of mental disorders – Clinically significant single nucleotide variants (SNV) or copy number variations (CNV), such as 22.q.11.2 deletion			
Biological	– Maternal infection – Preterm birth and obstetric complications – Poor nutrition – Exposure to drugs and some medications	– Brain trauma – Physical health – Epigenetic changes in serotonin and glucocorticoid transporters, changes in brain structure and function	– Brain and hormonal changes – Substance abuse – Physical health	
Family-related	– Perinatal depression	– Parental neglect – Child abuse – Parental mental illness		
Society		– Bullying and other forms of abuse – Lack of proper stimulation	– Bullying and other forms of abuse	
	– Social adversity: socio-economic disadvantage, stressful urban environments, immigration, social isolation – Stigma			

Source: Based on: Arango et al., 2018.

in comparison to the 2010 edition. Only 13% of the children surveyed do not experience any school stress (a decline of 5.5 pp in comparison to 2014 and of nearly 11 pp in comparison to 2010; Figure 1).

Figure 1. The amount of school stress reported by children and adolescents aged 11–15 in Poland in 2010, 2014, and 2018



Source: Mazur, 2015; Mazur and Małkowska-Szkutnik, 2018.

As shown in Table 1, childhood abuse or other adverse experiences significantly increase the risk of mental health problems. Studies of Polish university students, exploring the negative consequences of adverse childhood experiences (ACEs), demonstrated that later self-harming behaviours were the most strongly related with emotional abuse and emotional neglect (e.g., lack of emotional support, insulting, humiliating, and feeling unwanted or unloved). Individuals who had experienced those behaviours from their loved ones, were 7 and 10 times (respectively) more likely to attempt suicide, and

those who had experienced four or more ACEs were 17 times more likely to attempt suicide and 11 times more likely to engage in self-harming behaviours (Makaruk et al., 2018).

Just as there are multiple inter-related risk factors that may have a negative effect on young people's mental health, there are many protective factors, too, which can be enhanced to lower the risk of mental health issues.

A model of protective factors and preventive interventions is presented in Table 2.

Table 2. Protective factors for mental disorders in children

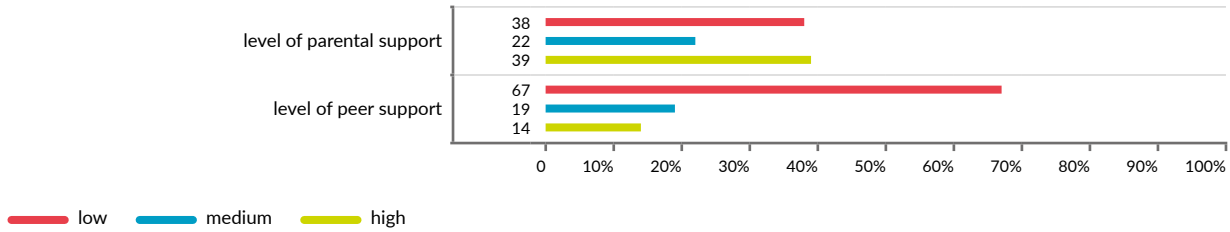
	From conception to birth	Early childhood	Puberty adolescence	Late teens
General population	– Reducing income inequality and unemployment – Improving education and child care (24, 115) – Reducing social stigma – Increasing societal and professional awareness (among different professional groups) about factors determining mental health			
	– Pregnancy care – Appropriate nutrition – Promotion of bonding with parents/caregivers – Informative counselling	– Proper stimulation for developmental stage – Family dinners – School academic achievement, social climate, resilience skills – Anti-bullying interventions in schools – Nutrition and physical exercise	– Having dinner with minors – School academic achievement, social climate, resilience skills – Anti-bullying interventions in schools – Nutrition and physical exercise – Prevention of substance use	
At-risk groups	– Improving support for disadvantaged adolescents pregnant for the first time – Maternal mental illness: close monitoring of physical and mental state, substance and medication use	– Improving parental mental state – Early intensive interventions for ASD – Parent training on externalizing and internalizing problems – Secondary (selective) prevention of ADHD complications	– Psychological interventions for indicated prevention in young people with subclinical symptoms – Cognitive remediation and improving social skills for selective prevention in some high-risk groups	

Source: Arango et al., 2018.

Since some of these protective factors are discussed in other chapters of the current report, here we will only focus on some of them: parental support and good family relationships (Colarossi and Eccles, 2003), and peer support (Pachucki et al., 2015). According to the most recent HSBC survey, in 2018 high parental support was reported by 39% of the adolescent respondents, and a high level of peer support – by 14% (Figure 2). A huge decline was found for peer support, compared to the previous edition of the study, when 23% of the respondents reported a high level of support from their peers.

The proportion of young persons who perceive the level of parental support as high, declines with age. The difference between 11-year-olds and 15-year-olds was 29 pp and was clearly visible both among boys and among girls. Although the percentage of adolescents reporting high levels of peer support also decreases with age, the decline is much smaller, i.e., 5 percentage points.

Figure 2. Perceived levels of support from parents and peers among adolescents aged 11–15 in Poland in 2018 (%)



Source: Mazur and Małkowska-Szkutnik, 2018.

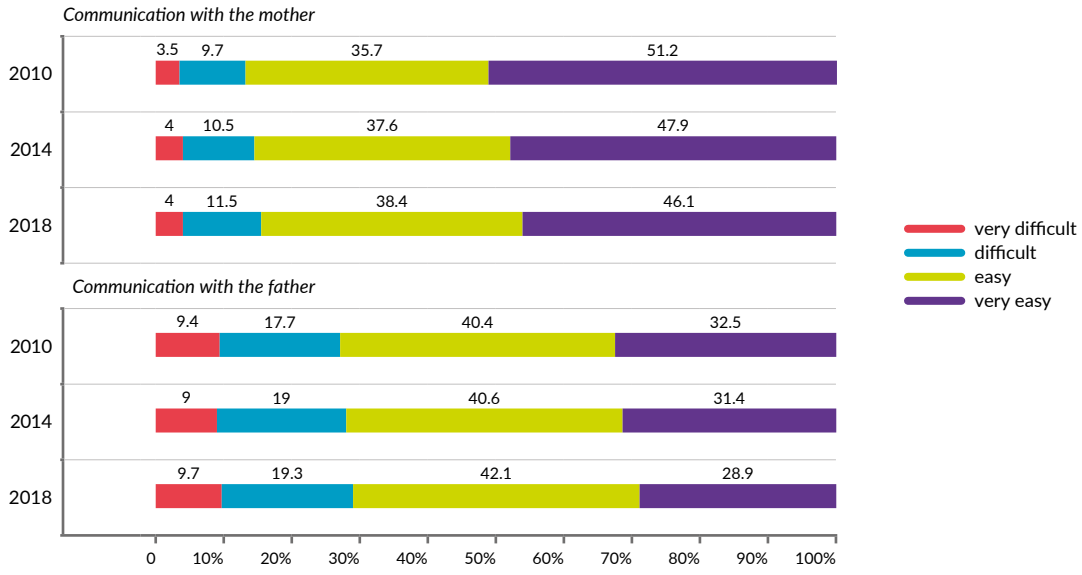
Everything overwhelms me, in particular other people's expectations of me. I'm about to turn 18, but I totally don't feel ready to be an adult. It terrifies me. I have problems at home, I'm stressed about exams, I'm not doing well in heart affairs. Sometimes I want to be done with myself already.

18-year-old boy
A quote from phone calls and emails to 116 111 Helpline for Children and Young People

Research conducted by the Empowering Children Foundation (ECF) among adolescents aged 11–17 found that the vast majority of the respondents (89%) had at least one person they could turn to in times of difficulty. More than half of the respondents (52%) said they had a few such persons, one fourth (23%) had one, and 13% had many such people in their environment. When asked about who exactly they could turn to, the respondents were the most likely to point to their mother (66%), followed by a friend (59%), and the father (39%; Włodarczyk et al., 2018). Similar results were obtained by a survey of children's experiences during the COVID-19 pandemic (Makaruk et al., 2020). At the same time, 7% of the respondents reported they had no one at all to turn to for support in times of difficulty. It is quite alarming, given the fact that a good relationship with at least one parent, especially with the father, is considered to be a protective factor for attempting suicide (Kuramoto-Crawford et al., 2017). Children deprived of such support have a higher risk of developing mental disorders and engaging in self-harming behaviours.

One factor regarded as a good indicator of family relationships and, at the same time, a protective factor for risky behaviours and mental disorders, one that increases young people's life satisfaction, is easy communication within the family (Demidenko et al., 2015). The HBSC surveys suggest that conversations with parents, which were assessed increasingly positively by Polish adolescents until 2002 (and extremely positively compared to other European countries), since 2006 have received more and more negative ratings (Figure 3). In most countries the percentage of adolescents having difficulty talking to their parents increased in the 1990s, and then the situation began to gradually improve. Comparing to this positive trend, the ongoing negative changes in Poland may seem disturbing.

Figure 3. Ease of communication with mother and father among adolescents aged 11–15 in Poland in 2014 and 2018



Source: Mazur, 2015; Mazur and Małkowska-Szkutnik, 2018.

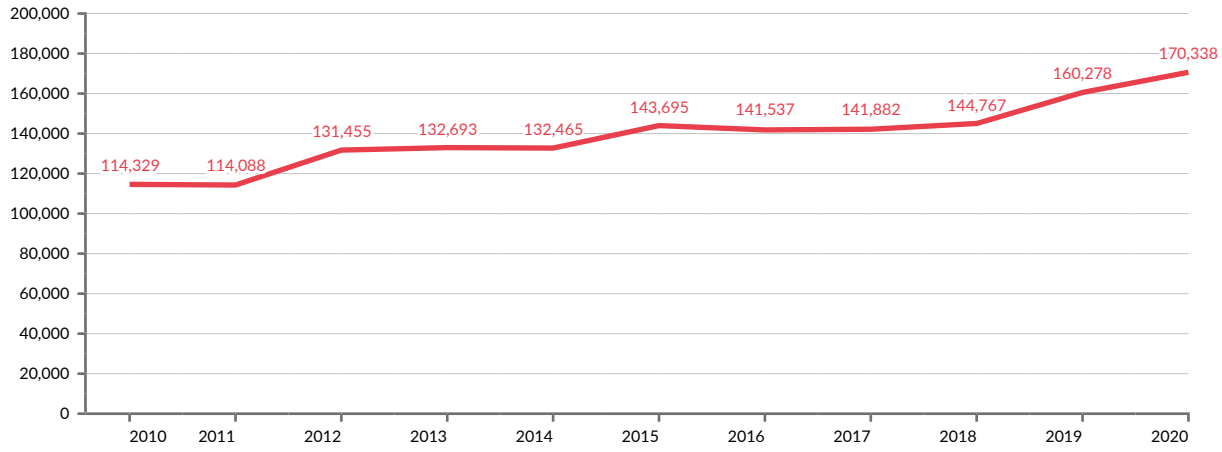
The ease of communication with the parents decreases with age, and talking to the father is markedly more difficult for girls. Furthermore, gender-based differences in the ease of communication with the mother increase over time, and become significant by the age of 15. Talking to their parents is the most difficult for adolescents raised by single parents and those living in big cities.

Prevalence of mental health disorders

The number of children and adolescents using professional services for mental health disorders, has been growing in recent years. In 2020 such services were used by more than 170 thousand persons under 18, with boys constituting more than 57% of that group (Figure 4). Nearly three fourths of young people in that age group lived in towns and cities. It does not necessarily mean that mental health problems are more prevalent in urban than in rural areas. Those differences may also result from poorer access to professional mental health support and from stronger social stigma (or the fear of social stigma) in rural areas.

The most common diagnosis in 2020 was developmental disorders, including developmental speech and language disorders, developmental disorder of scholastic skills, developmental disorder of motor function, pervasive developmental disorder, including ASD, hyperkinetic disorders, including

Figure 4. The number of children and adolescents under 18 using outpatient treatment for mental disorders



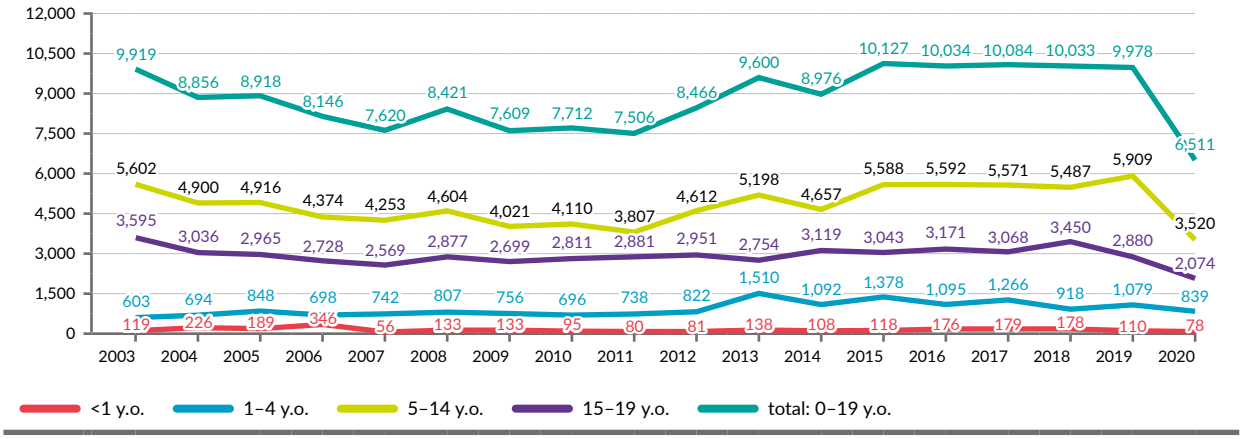
Source: Own analysis, based on the MZ-15 form of the Public Health Department of the Psychiatry and Neurology Institute.

ADHD, behavioural disorders, and others (65%; 108,546 individuals), followed by neurotic disorders (15%; 25,245), affective disorders (7%; 12,088), and intellectual disabilities (5%; 8,676).

Every year several thousand children and adolescents in Poland are hospitalised due to mental and behavioural disorders. In 2020 the number of hospitalisations of persons under 19 was 6,511, and was the lowest in more than 10 years. The decline, however, does not reflect actual improvement in child and adolescent mental health, but was most likely associated with restricted hospital admissions caused by the COVID-19 pandemic and the difficult situation of child and adolescent psychiatry (Figure 5).

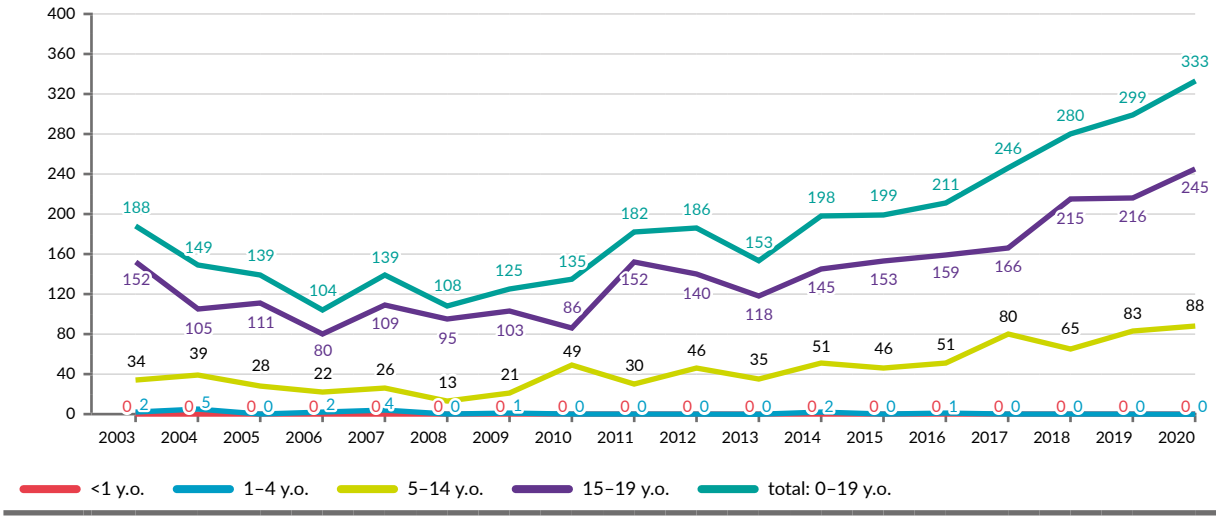
In 2020, mood disorders, including depression, led to hospitalisation of 333 children, including 88 children under 14. The number of hospitalisations due to mood disorders has been growing in recent years, both among children aged 5–14, and among older adolescents (aged 15–19; Figure 6).

Figure 5. The number of hospitalisations of children and adolescents under 19 due to mental and behavioural disorders



Source: Own analysis, based on data from the National Institute of Public Health: National Institute of Hygiene (NIZP–PZH; http://www.statystyka.medstat.waw.pl).

Figure 6. The number of children hospitalised due to the F30–39 diagnoses (mood–affective disorders) in 2003–2020



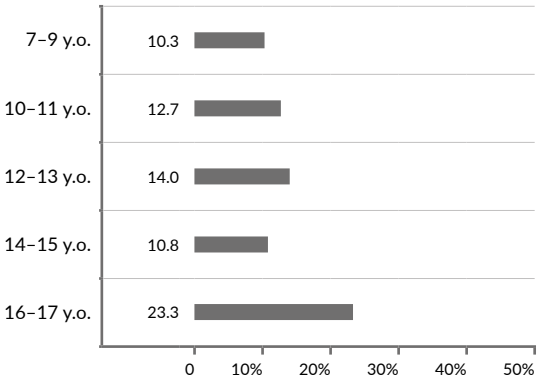
Source: Own analysis, based on data from NIZP–PZH (http://www.statystyka.medstat.waw.pl).

Given the inefficiency of the child and adolescent mental health care system in Poland, official statistics may not reflect the actual prevalence of mental health problems in this population. The picture is completed by data from social surveys.

The results of a comprehensive study into the Polish society's mental health and its determinants, EZOP II, suggest that among children and adolescents (aged 7–17) internalising disorders (such as anxieties and phobias) may occur in 7.3% of the population, affective disorders (e.g., depression, mania) – in 1.7%, and externalising disorders (e.g., behavioural disorders, ODD, ADHD) – in 4%. Eating disorders were found in 2.6% of that group, and substance use disorder – in 4.2%. 5.7% of the adolescent respondents aged 12–17 manifested suicidal tendencies (ideation, attempts) at least once in their lifetime. Generally, internalising disorders prevailed among younger children, whereas adolescents were more likely do show externalising disorders, which were the most prevalent in the 16–17 age group (Figure 7).

One of the tools used within the EZOP II study was the *Ages and Stages: Social-Emotional* (ASQ:SE-2) questionnaire, which assesses seven areas of development in young children (0–6): self-regulation, compliance, adaptive

Figure 7. Prevalence of any kind of mental disorders by age (%)

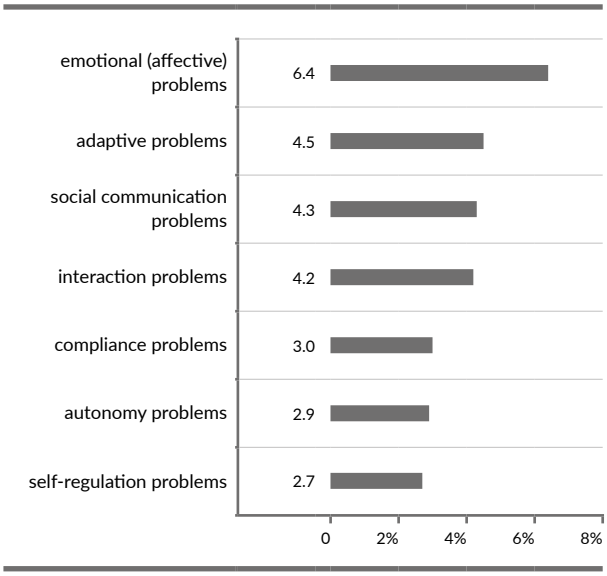


Source: Ostaszewski et al., 2021.

functioning, autonomy, affect, social communication, and interaction (Figure 8).

Among children under 6 living in rural areas, problems in all seven domains were considerably (two or even three times) more prevalent than among those living in urban areas. This may result from a number of factors, such as poorer access to support services, but also lower availability of preschool education and early education for children under 3 (see chapter: Children in the family).

Figure 8. Prevalence of social-emotional problems among children aged 0–6



Source: Biechowska et al., 2021.

The authors of the EZOP II study estimate that among children in need of mental health services, only 20% are provided with them free of charge, within the public health care system (National Health Fund). Although no data is available about private mental health services, the fact that a significant correlation was found between social status and the prevalence of mental disorders (which were more likely to affect children from families using social services), may suggest that many families cannot afford private mental health care. Thus, there is a substantial gap between needs and the ability to satisfy them (Ostaszewski et al., 2021).

Children and adolescents' psychological wellbeing

A study commissioned by the Ombudsman for Children, carried out on a sample of children and adolescents in 2021, found that about 14% of primary and secondary school students in Poland require intervention to improve their psychological wellbeing. Poor psychological wellbeing and low life satisfaction were found in 15% of 2nd grade students, 13% of 6th grade students, and 13% of students of secondary schools (10th grade). There were significant differences related to gender and place of residence. In the 2nd grade of primary school, boys were more likely than girls to report feeling bad, while among 6th graders and secondary school students it was girls who were more likely to report such symptoms. Second-graders an secondary school students (10th grade) living in towns and cities were more likely to report feeling bad than those living in rural areas, whereas among sixth-graders psychological wellbeing was the poorest among those living in villages. In all age groups, reported psychological wellbeing was the poorest among single children and respondents from families with five or more children, and those living in low SES families. The survey was conducted in June 2021 (RPD, 2021).

An earlier survey conducted by the ECF in the summer of 2020, focusing on the initial phase of the COVID-19 lockdown (March-June 2020), found that one third of the respondents aged 11–17 reported low life satisfaction in that period. The main self-reported reasons for those negative ratings included a lack of contact with peers, having to stay at home, and distance learning (Makaruk et al., 2020). A lack of in-person peer interactions may lead to feelings of loneliness and isolation, which cannot be fully mitigated by connecting to friends virtually (Ellis et al., 2020).

Similarly, a survey conducted on a sample of parents and children by a research company Difference at the request of Radio Zet in May 2021, found that the pandemic had a significant effect on children's psychological wellbeing. Three out of four children showed worse emotional regulation than before the pandemic – they were more likely to get angry, rebel, and take offence. One in four children (28%) reported they felt angry often or all the time, and about one in five reported feeling depressed (21%), lonely (21%), and sad (18%; Difference, 2021). Children and adolescents' situation during the COVID-16 pandemic is discussed in more detail in chapter: Children and Adolescents' Experiences of COVID-19 Pandemics. It should be emphasised, however, that the studies cited above are preliminary and reflect just a part of the picture, since they were conducted during the pandemic. Comprehensive examination of the effects

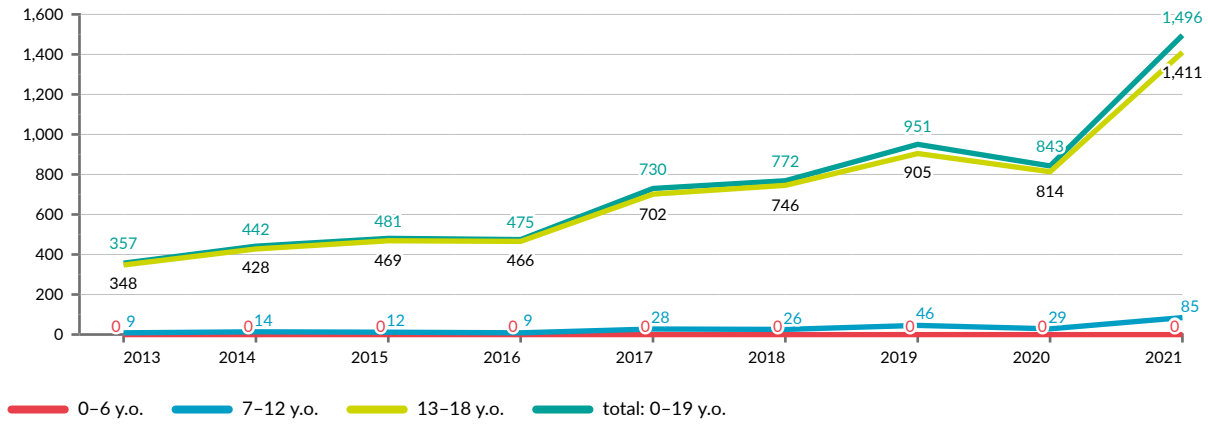
of the pandemic – both positive and negative – on children's lives and health, would require extensive long-term studies using scientifically sound methodology.

One group of young people who find themselves in a unique situation, also in terms of mental health, is the LGBT+ population. A report titled *Situation of LGBTA Persons in Poland 2019–2020* suggests that three fourths of non-heteronormative adolescents feel lonely, 41% have suicidal thoughts – quite often or very often – and 55% show moderate or strong symptoms of depression. Only 22% of the adolescent respondents feel that their non-heteronormative orientation is accepted by their mothers, and only 12% experience such acceptance from their fathers (Winiewski and Świder, 2021).

Suicide

Another indicator of children and adolescents' mental health is the number of suicide attempts, which remains high in Poland. In 2021 it was the highest in many years: 1,496 attempts, including 85 made by children under 12 (Figure 9).

Figure 9. The number of suicide attempts among children and adolescents in Poland between 2013 and 2021



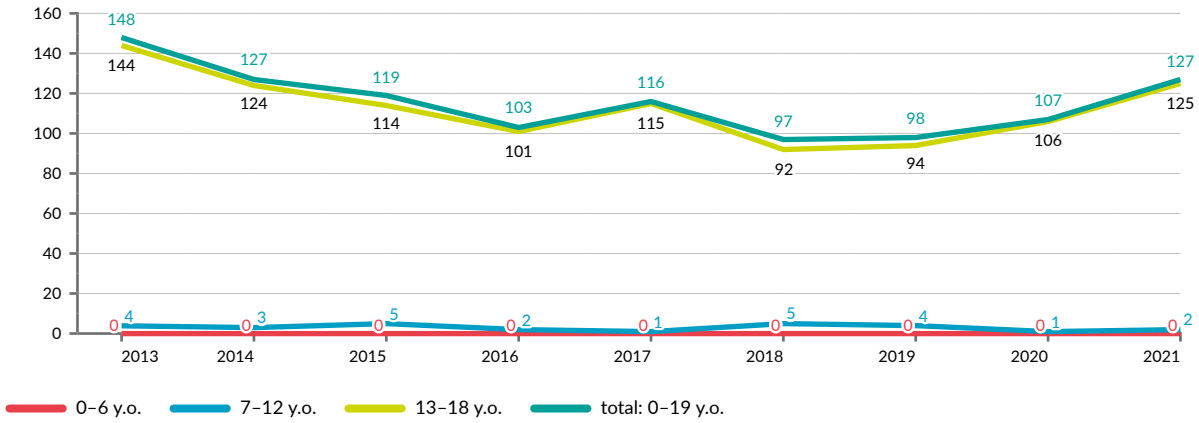
Source: National Police Headquarters.

It is important to bear in mind that official statistics are limited to reported suicide attempts. A survey by the ECF suggests that only during the first COVID-19 lockdown (March–June 2020) nearly 3% of the respondents aged 15–17 tried to take their lives (Makaruk et al., 2020).

Deliberate self-harm is a significant predictor of suicide attempts (Duarte et al., 2020). In the above mentioned ECF survey, 9.2% of the adolescent respondents reported to have engaged in deliberate self-harm.

In 2021, 127 suicide attempts resulted in the child's death (Figure 10).

Figure 10. The number of lethal suicide attempts among children and adolescents between 2013 and 2021

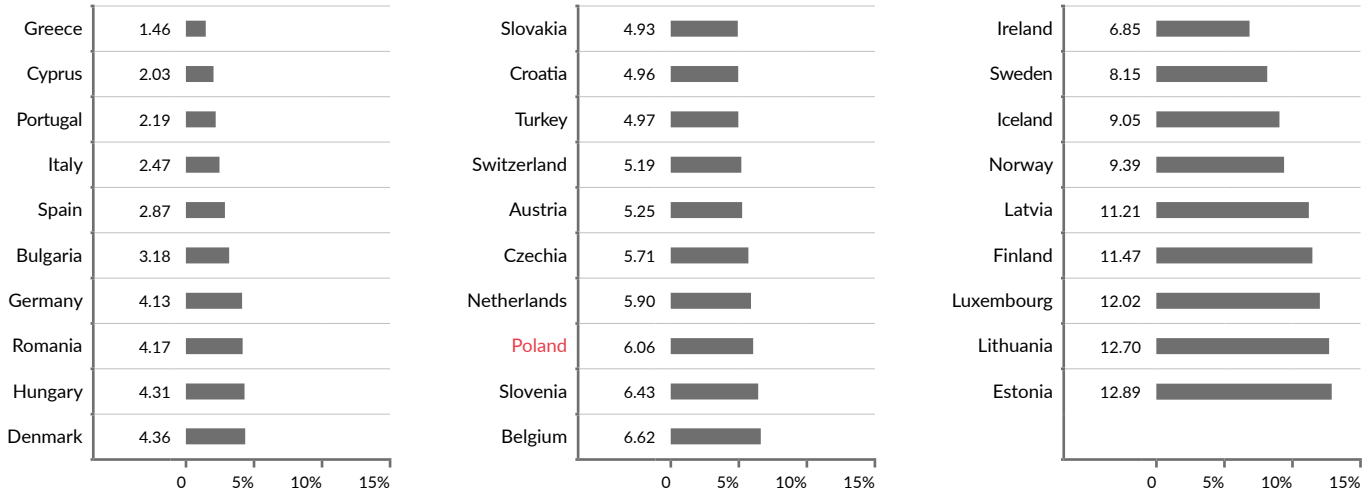


Source: National Police Headquarters.

According to Statistics Poland, in 2021 suicide was the second leading cause of death among adolescents aged 15–19: nearly one in five deaths in this age group resulted from suicide. Boys were almost three times more likely than girls to make lethal suicide attempts.

In 2019, Poland ranked second in Europe (behind Germany) in terms of lethal suicide attempts among children and young people under 19. When the population size was taken into account, Poland ranked 12th among the European states included in Eurostat (Figure 11).

Figure 11. Rates of lethal suicide attempts per 100,000 persons, made by children and young people under 19 in selected European states



Source: Eurostat.

Availability of psychiatric care

A 2019 inspection by the Supreme Audit Office found that in five Polish voivodeships (or provinces): Lubuskie, Opolskie, Świętokrzyskie, Warmińsko-Mazurskie, and Zachodniopomorskie, there was not a single day-care psychiatric unit for children and adolescents, and in Podlaskie Voivodeship there was not a single inpatient ward (NIK, 2020). It should be noted, however, that the inspection took place before the implementation of the community-based model of care for children with mental health problems.

According to a report published by The Citizens Network Watchdog Poland, inpatient psychiatric wards offered one bed per 2,155 to 13,537 children, depending on the voivodeship (Maślankiewicz and Bójko, 2019; Table 3).

The Citizen Network Watchdog's report also shows that the number of psychiatry specialists on inpatient wards has declined (Maślankiewicz and Bójko, 2019; Table 4). Although each ward employed the number of psychiatrists required by law, the question is whether it is really sufficient on inpatient wards.

No voivodeship reached the recommended psychiatrists to population ratio, which should be at least 1:10,000, according to the WHO. The geographical distribution of child and adolescent psychiatrists is shown in the figure below. It suggests that the situation was relatively the most favourable in Łódzkie and Mazowieckie Voivodeships, and the worst in Lubuskie and Podkarpackie Voivodeships.

However, the number of specialists and 1st degree specialists in child and adolescent psychiatry has gradually increased in the past several years (Table 5).

Table 3. The number of beds on inpatient psychiatric wards, and the number of children per one bed, by voivodeship

Voivodeship	Number of beds on inpatient psychiatric wards, according to National Health Fund in 2019	Number of children per one bed
dolnośląskie	135	3,818
kujawsko-pomorskie	43	9,257
lubelskie	52	7,700
lubuskie	90	2,155
łódzkie	106	4,162
małopolskie	50	13,537
mazowieckie	186	5,706
opolskie	18	9,310
podkarpackie	24	13,018
podlaskie	0	–
pomorskie	76	6,267
śląskie	95	8,536
świętokrzyskie	18	12,286
warmińsko-mazurskie	60	4,655
wielkopolskie	50	14,118
zachodniopomorskie	36	8,659

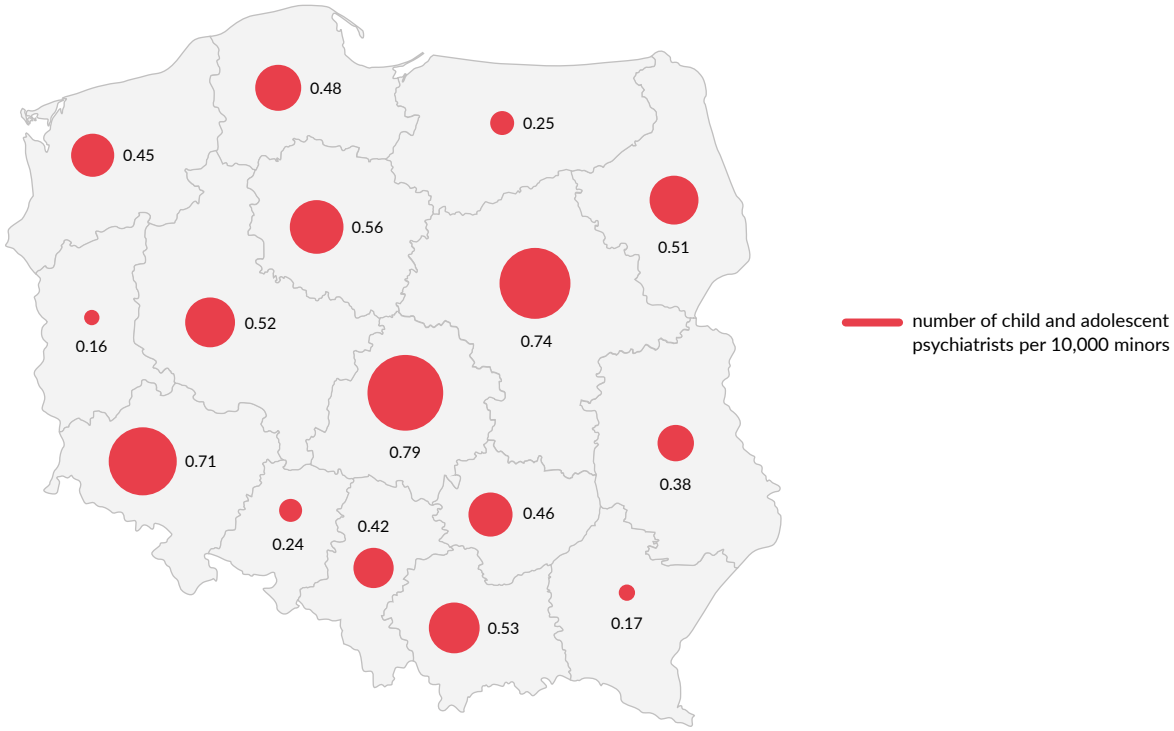
Source: Maślankiewicz and Bójko, 2019.

Table 4. The number of psychiatrists on inpatient wards

	2018	2019	Decline in %
The overall number of all child and adolescent psychiatrists employed on psychiatric wards that responded to a public information request	96	87	9.38
The average number of child and adolescent psychiatrists per ward	3.3	3.0	9.09
The average number of full-time child and adolescent psychiatrist jobs per ward	2.7	2.4	11.11

Source: Maślankiewicz and Bójko, 2019.

Figure. Distribution of child and adolescent psychiatrists across voivodeships



Source: NIK, 2020.

Table 5. The number of specialists and 1st degree specialists in child and adolescent psychiatry working in the profession between 2012 and 2022 (as of the 31st of May 2022)

	2012	2017	2022
Specialist	253	362	462
1st degree specialist	43	41	39
Total	296	403	501

Source: Naczelna Izba Lekarska (Supreme Medical Council), 2022.

Data available in the Ministry of Health data base, basiw.mz.gov.pl, shows that wait times for specialised psychiatric services were considerable in 2020 (Table 6).

Table 6. The average wait time for psychiatric services, by facility type, for stable and urgent cases, in November 2020 (in days)

Facility type	Stable cases	Urgent cases
Outpatient clinic for children with ASD	330	213
Day-care psychiatric rehabilitation unit	263	8
Day-care psychiatric unit for children	234	14
Neurotic disorders care unit	74	nd
Mental health clinic for children	66	87
Psychiatric ward for children	66	37

Source: basiw.mz.gov.pl.

Official data available on basiw.mz.gov.pl also suggests that psychiatric care for children and adolescents in 2020 was mostly emergency care. On psychiatric wards, only 22% of all child admissions were planned, and 74% were emergency cases, which means that the mental health care system is not treatment-oriented, but rather focused on interventions in emergency and life-threatening situations.

Reform of child and adolescent psychiatry

In order to improve mental health care for children and adolescents, a reform of child and adolescent psychiatric care is being implemented in Poland. Its main goal is to move medical and therapeutic services as close to the child's environment as possible. As stressed in the introduction, the reform is not going to solve all the problems related to young persons' mental health. It was initiated by appointing a Team for Child and Adolescent Mental Health, in February 2018. Furthermore, the Ministry of Health order of the 28th of October 2019 established the position of Government Plenipotentiary for Child and Adolescent Psychiatry Reform. The new model presumes a three-level system of care:

- Referral level 1: a network of **community mental health care centres for children and adolescents**. Patients can use their services without a doctor's referral. These centres will provide assistance for children who do not need a psychiatric diagnosis or pharmacotherapy, so they will not employ psychiatrists. Ultimately, each district (or *powiat*) is going to have at least one such centre. The centre's staff will consist of:
  - a psychologist,
  - two psychotherapists,
  - a community therapist.

  There is no need to see a psychiatrist before visiting the centre, and the first appointment should be offered within 7 days from (self-)referral. Level 1 facilities are focused on providing services in the patient's immediate environment (at least 15% of the services should be provided at patients' homes).
- Referral level 2: **Mental Health Centres** (MHCs) **for Children and Adolescents** that will employ a psychiatrist, and where patients in need of more intensive care will be able use the services of a day-care unit (at selected MHCs for Children and Adolescents). One such centre will provide support for patients is several neighbouring districts. Similarly to level 1, the first visit at an MHC should take place within 7 days from (self-) referral.
- Referral level 3: **centres providing inpatient psychiatric care** for patients in need of more specialist services, particularly those whose life and health may be threatened, admitted as emergency cases. There should be at least one such facility in each voivodeship. These will be also educational centres for future psychiatrists and other mental health professionals.

The new model was introduced by the Minister of Health regulation of the 14th of August 2019, amending the regulation on guaranteed benefits for psychiatric care and addiction treatment (Dz.U. 2019, item 1640).

The first level 1 centres were launched in April 2020. Until today, 341 such centres have been established all over Poland (as of the 21st of April 2022), but they are unevenly distributed and serve child populations of different sizes: from 12 thousand in Podlaskie Voivodeship to nearly 45.5 thousand in Wielkopolskie Voivodeship (Table 7).

Table 7. The number of level 1 centres and child populations served by them (as of the 21st of April 2022)

Voivodeship	No. of centres	Number of children under 18 per centre
dolnośląskie	20	24,991
kujawsko-pomorskie	12	30,709
lubelskie	29	12,554
lubuskie	8	22,579
łódzkie	23	18,008
małopolskie	30	21,777
mazowieckie	82	12,884
opolskie	7	22,263
podkarpackie	17	22,485
podlaskie	17	12,029
pomorskie	24	19,440
śląskie	32	24,017
świętokrzyskie	7	28,422
warmińsko-mazurskie	11	23,111
wielkopolskie	15	45,481
zachodniopomorskie	7	41,188
Total	341	20,347

Source: Own analysis, based on data from the National Health Fund (NFZ) and Statistics Poland (GUS).

It has been signalled that some of the centres are getting closed due to funding problems (Fundacja Słonie na Balkonie, 2022). The directory of contracts with the National Health Fund (NFZ) shows that on the 18th of July 2022 only 215 service providers had such contracts, which reflected a 37% decline during three months (Table 8).

Table 8. The number of level 1 centres (on 21 Apr 2022 and 18 Jul 2022)

Voivodeship	Number of level 1 centres, as of:	
	21st April 2022	18th July 2022
dolnośląskie	20	20
kujawsko-pomorskie	12	9
lubelskie	29	15
lubuskie	8	6
łódzkie	23	18
małopolskie	30	17
mazowieckie	82	41
opolskie	7	5
podkarpackie	17	13
podlaskie	17	9
pomorskie	24	16
śląskie	32	19
świętokrzyskie	7	6
warmińsko-mazurskie	11	6
wielkopolskie	15	8
zachodniopomorskie	7	7
Total	341	215

Source: NFZ.

According to the National Consultant for Child and Adolescent Psychiatry, in April 2022 information and proposals were forwarded to facilities that could play the role of referral level 2 and 3 centres in the new system (Lewandowska, 2022).

Data on contracts signed with the National Health Fund shows that on the 18th of July 2022 there were 42 level 2 MHCs for children and adolescents in Poland (Table 9).

Table 9. Number of MHCs for children and youth – referral level 2 (as of the 18th of July 2022)

Voivodeship	MHC for children and adolescents – mental health clinic	MHC for children and adolescents
dolnośląskie	2	0
kujawsko-pomorskie	0	0
lubelskie	0	0
lubuskie	1	0
łódzkie	2	1
małopolskie	6	3
mazowieckie	1	0
opolskie	1	0
podkarpackie	4	3
podlaskie	0	3
pomorskie	0	0
śląskie	3	5
świętokrzyskie	0	0
warmińsko-mazurskie	0	0
wielkopolskie	6	1
zachodniopomorskie	0	0
Total	42	

Source: NFZ.

The assumptions of the reform are definitely positive, but there are reasonable doubts about the pace of its implementation, its promotion, funding, and the insufficient quality standards for mental health professionals and their competencies (Frydrych, 2022).

In order to improve access to mental health care, youth organisations such as Nastoletni Azyl (Teenage Asylum) or Fundacja na Rzecz Praw Ucznia (Students' Rights Foundation), have proposed that children over 13 should be able to use psychological counselling without their parents' consent and that each school should provide such services for its students. The latter proposal was included in a draft bill, adopted by the Polish Parliament on the 8th of April 2022, on amending the Act on the Education System and some other laws, with the aim to increase the number of education professionals: guidance counsellors, psychologists, and speech therapists, in Polish schools.

Poland in comparison to other countries

Based on a number of indicators of children and adolescents' wellbeing in rich countries, UNICEF developed a league table of child wellbeing, using two of them: suicide rate and life satisfaction. Poland ranked 30 among 38 countries included in the report (Table 10).

Table 10. A league table of child mental wellbeing in rich countries

Country	Rank in terms of mental wellbeing
Netherlands	1
Cyprus	2
Spain	3
Romania	4
Denmark	5
Portugal	6
France	7
Greece	8
Italy	9
Croatia	10
Norway	11
Finland	12
Switzerland	13
Slovakia	14
Hungary	15
Germany	16
Belgium	17
Bulgaria	18
Luxembourg	19
Iceland	20
Austria	21
Sweden	22
Slovenia	23
Czechia	24
Latvia	25
Ireland	26

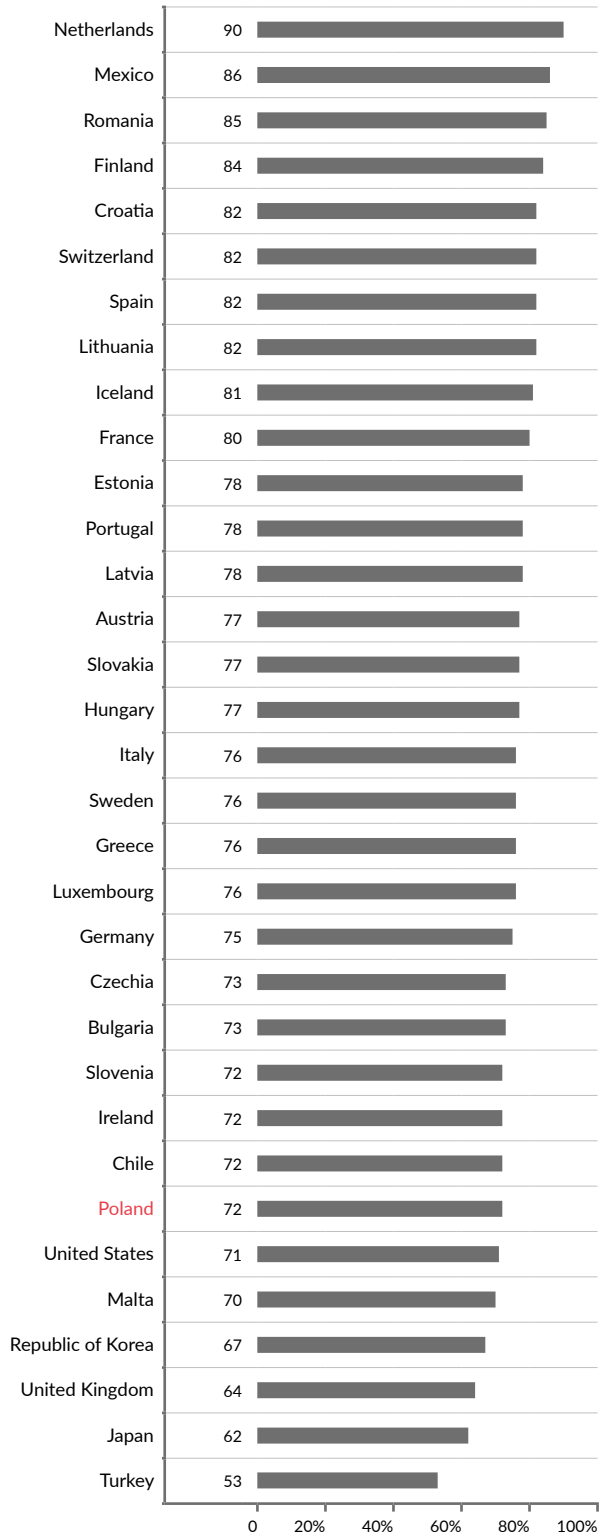
Country	Rank in terms of mental wellbeing
Chile	27
Malta	28
United Kingdom	29
Poland	30
Canada	31
United States	32
Estonia	33
Republic of Korea	34
Australia	35
Lithuania	36
Japan	37
New Zealand	38

Source: UNICEF, 2020.

In terms of life satisfaction itself, Poland was also ranked in the bottom part of the table, with 72% of children and young people under 15 reporting to be satisfied with their lives (Figure 12).

> *Sometimes I wonder if I have an eating disorder. I don't think I need help. Lately I rarely vomit after eating. I count calories very often because I don't want to gain weight again. I'm panicky about it. I feel guilty whenever I eat something. I don't like how I look. I think I have put on weight again.*
>
> *16-year-old boy*
> *A quote from phone calls and emails to 116 111 Helpline for Children and Young People*

Figure 12. Percentages of young people under 15 reporting high levels of life satisfaction



Source: Programme for International Student Assessment (PISA) 2018 (in: UNICEF, 2020).

Summary

In recent years, child and adolescent mental health in Poland has received considerable attention. For a long time, mental health care for children and adolescents was not a priority for the Polish government, which resulted in a situation often referred to as "the collapse of psychiatric care".

The past few years have aroused some hope related to the reform of mental health care for children and adolescents, increased funding, and the restructuring of the system to bring it closer to the child's environment.

Protecting child and adolescent mental health is essential for ensuring young people's good start in life. When identified or diagnosed too late, childhood mental health problems may lead to developing full-blown mental disorders, and become barriers to the child's healthy development and educational, social, and professional opportunities.

At the same time, it should be emphasised that mental health care for children and adolescents should be comprehensive and multifaceted, not limited to psychiatric interventions. One important aspect is the prevention of mental health problems targeted at parents and children, for example through school-based social skill or resilience building programmes. Therefore, it is alarming that the Polish Ministry of Science and Education (MEiN) plans to forgo health education in favour of defence education in the amended school curriculum in safety education (MEiN, 2022), especially that the already disturbing mental health status of children and adolescents has become even more difficult as a result of the COVID-19 pandemic and the inflow of several hundred thousand children from Ukraine, many of whom may manifest mental health problems due to their warfare and refugee experiences. Inclusive schools, providing information about how to take care of one's own mental health, how to react, and where to seek help, could play a significant role in improving child and adolescent mental health in Poland.

Thus, the area of child and adolescent mental health requires a long-term, carefully developed strategy, comprising actions that will contribute to reducing mental health problems. A comprehensive child and family support system should focus on enhancing protective factors and, at the same time, reducing risk factors. Decisions should be based on carefully analysed statistical and research data and broad public consultations, rather than immediate circumstances.

References

Arango, C., Díaz-Caneja, C. M., McGorry, P. D., Rapoport, J., Sommer, I. E., Vorstman, J. A., Carpenter, W. (2018). Preventive strategies for mental health. *The Lancet Psychiatry*, *5*(7), 591–604. https://doi.org/10.1016/S2215-0366(18)30057-9

Biechowska, D., Orłowska, E., Stokwiszewski, J. (2021). *EZOP II. Kompleksowe badanie stanu zdrowia psychicznego społeczeństwa i jego uwarunkowań. Wyniki badania dzieci w wieku 0–6 lat*. Instytut Psychiatrii i Neurologii.

Colarossi, L. G, Eccles, J. S. (2003). Differential effects of support providers on adolescents' mental health. *Social Work Research*, *27*(1), 19–30. https://doi.org/10.1093/swr/27.1.19

Demidenko, N., Manion, I., Lee, C. M. (2015). Father–daughter attachment and communication in depressed and nondepressed adolescent girls. *Journal of Child and Family Studies*, *24*(6), 1727–1734. https://doi.org/10.1007/s10826-014-9976-6

Difference. (2021). *Dzieci w pandemii. Raport z badania ilościowego na zlecenie Radia Zet*. https://newsroom.eurozet.pl/141891-dzieci-w-pandemii-raport-radia-zet

Duarte, T. A., Paulino, S., Almeida, C., Gomes, H. S., Santos, N., Gouveia-Pereira, M. (2020). Self-harm as a predisposition for suicide attempts: A study of adolescents' deliberate self-harm, suicidal ideation, and suicide attempts. *Psychiatry Research*, *287*, 112553. https://doi.org/10.1016/j.psychres.2019.112553

Ellis, W. E., Dumas, T. M., Forbes, L. M. (2020). Physically isolated but socially connected: Psychological adjustment and stress among adolescents during the initial COVID-19 crisis. *Canadian Journal of Behavioural Science / Revue canadienne des sciences du comportement*, *52*(3), 177–187. https://doi.org/10.1037/cbs0000215

Fundacja Słonie na Balkonie. (2022). *Apel do Ministra Zdrowia o reakcję na znikanie I poziomów referencyjnych, które obecnie są filarem reformy psychiatrii dzieci i młodzieży*. https://apel.slonienabalkonie.pl/

Frydrych, D. (2022, 23 lutego) Ten system rodzi się w bólach. Oto jak wygląda psychiatria dziecięca. *Interia Kobieta*. https://kobieta.interia.pl/zycie-i-styl/news-ten-system-rodzi-sie-w-bolach-oto-jak-wyglada-psychiatria-dz,nId,5836186

Kuramoto-Crawford, S. J., Ali, M. M., Wilcox, H. C. (2017). Parent–child connectedness and long-term risk for suicidal ideation in a nationally representative sample of US adolescents. *Crisis*, *38*(5), 309–318. https://psycnet.apa.org/doi/10.1027/0227-5910/a000439

Lewandowska, A. (2022). Powolna reforma psychiatrii dzieci i młodzieży. *mzdrowie.pl*. https://www.mzdrowie.pl/medycyna/powolna-reforma-psychiatrii-dzieci-i-mlodziezy/

Makaruk, K., Włodarczyk, J., Sethi, D., Michalski, P., Szredzińska, R., Karwowska, P. (2018). *Survey of adverse childhood experiences and associated health-harming behaviours among Polish students*. Światowa Organizacja Zdrowia.

Makaruk, K., Włodarczyk, J., Szredzińska, R. (2020). *Negatywne doświadczenia młodzieży w trakcie pandemii*. Fundacja Dajemy Dzieciom Siłę.

Maślankiewicz, R., Bójko, M. (2019) *Psychiatria dzieci i młodzieży w Polsce. Raport*. Sieć Obywatelska Watchdog.

Mazur, J. (ed.). (2015). *Zdrowie i zachowania zdrowotne młodzieży szkolnej w Polsce na tle wybranych uwarunkowań socjodemograficznych. Wyniki badań HBSC 2014*. Instytut Matki i Dziecka.

Mazur, J., Małkowska-Szkutnik, A. (ed.). (2018). *Zdrowie uczniów w 2018 roku na tle nowego modelu badań HBSC*. Instytut Matki i Dziecka.

MEiN. (2022). *Zmiany w edukacji dla bezpieczeństwa w szkołach podstawowych i ponadpodstawowych – projekty rozporządzeń skierowane do konsultacji i uzgodnień.* https://www.gov.pl/web/edukacja-i-nauka/zmiany-w-edukacji-dla-bezpieczenstwa-w-szkolach-podstawowych-i-ponadpodstawowych--projekty-rozporzadzen-skierowane-do-konsultacji-i-uzgodnien

Naczelna Izba Lekarska. (2022). Zestawienie liczbowe lekarzy i lekarzy dentystów wg dziedziny i stopnia specjalizacji. https://nil.org.pl/uploaded_files/1664786043_stan-na-30092022-zestawienie-nr-04.pdf

NFZ. (2021). Zdrowie psychiczne dzieci i młodzieży. *Ze Zdrowiem*, *nr 5*. Pobrane z: https://www.nfz.gov.pl/gfx/nfz/userfiles/_public/dla_pacjenta/magazyn_ze_zdrowiem/nfz_nr_5.pdf

NIK. (2020). *Dostępność lecznictwa psychiatrycznego dla dzieci i młodzieży (w latach 2017–2019)*. Naczelna Izba Kontroli. Pobrane z: https://www.nik.gov.pl/plik/id,22730,vp,25429.pdf

Ostaszewski, K., Kucharski, M., Stokwiszewski, J. (2021). *Kompleksowe badanie stanu zdrowia psychicznego społeczeństwa i jego uwarunkowań EZOP II. Wyniki badania dzieci i młodzieży*. Instytut Psychiatrii i Neurologii. Pobrane z: https://ezop.edu.pl/wp-content/uploads/2021/12/EZOPII_Wyniki-badania-dzieci-i-mlodziezy-7-17-lat.pdf

Pachucki, M. C., Ozer, E. J., Barrat, A., Cattuto, C. (2015). Mental health and social networks in early adolescence: A dynamic study of objectively-measured social interaction behaviors, *Social Science & Medicine*, *125*, 40–50.

RPD. (2021). *Ogólnopolskie badanie jakości życia dzieci i młodzieży w Polsce, obszar nr 3: Samopoczucie psychiczne*. Biuro Rzecznika Praw Dziecka. Pobrane z: https://brpd.gov.pl/wp-content/uploads/2021/11/Raport-RPD-samopoczucie-psychiczne-PDF.pdf

UNICEF. (2020). *World of influence. Understanding what shapes child well-being in rich countries. Innocenti Report card 16*. UNICEF Office of Research – Innocenti.

WHO. (2001). *Strengthening mental health promotion. Fact sheet No 220*. https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Winiewski, M., Świder M. (ed.). (2021). *Sytuacja społeczna osób LGBTA w Polsce. Raport za lata 2019–2020*. Kampania przeciwko Homofobii i Stowarzyszenie Lambda Warszawa.

Włodarczyk, J., Makaruk, K., Michalski, P., Sajkowska, M. (2018). *Ogólnopolska diagnoza skali i uwarunkowań krzywdzenia dzieci. Raport z badania*. Fundacja Dajemy Dzieciom Siłę.

Legal references

Rozporządzenie Ministra Zdrowia z dnia 14 sierpnia 2019 r. zmieniającym rozporządzenie w sprawie świadczeń gwarantowanych z zakresu opieki psychiatrycznej i leczenia uzależnień (Dz.U. 2019 poz. 1640 ze zm.). (Regulation of the Minister of Health amending the Regulation on guaranteed services in the field of psychiatric care and addiction treatment)

Rozporządzenie Rady Ministrów z dnia 8 lutego 2017 r. w sprawie Narodowego Programu Ochrony Zdrowia Psychicznego na lata 2017–2022 (Dz.U. 2017 poz. 458). (Regulation of the Council of Ministers on the National Mental Health Protection Programme for 2017–2022)

Rozporządzenie Rady Ministrów z dnia 30 marca 2021 r. w sprawie Narodowego Programu Zdrowia na lata 2021–2025 (Dz.U. 2021 poz. 642). (Regulation of the Council of Ministers on the National Health Programme for 2021–2025)

Ustawa z dnia 19 sierpnia 1994 r. o ochronie zdrowia psychicznego (Dz.U. z 2017 r. poz. 882). (Act on mental health protection)

Online resources

Baza Analiz Systemowych i Wdrożeniowych – https://basiw.mz.gov.pl

Baza Demografia – https://demografia.stat.gov.pl

Eurostat – http://ec.europa.eu/eurostat/data/database

Ministerstwo Edukacji i Nauki – www.gov.pl/web/edukacja-i-nauka

Tabele wynikowe Badania Chorobowości Szpitalnej Ogólnej – http://www.statystyka.medstat.waw.pl

Wyszukiwanie świadczeń – Informator o umowach – nfz.gov.pl

Citation:

Szredzińska, R. (2022). Child and Adolescent Mental Health. In: M. Sajkowska, R. Szredzińska (ed.), *Children Count 2022. Report on risks to children's safety and development in Poland* (pp. 136–157). Empowering Children Foundation.

English edition of the Report prepared in partnership with UNICEF

Polish version of the Report prepared with financial support from the Justice Fund, at disposal of the Ministry of Justice

Sfinansowano ze środków Funduszu Sprawiedliwości, którego dysponentem jest Minister Sprawiedliwości