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REVIEW PAPER

# REFORM OF CHILD AND ADOLESCENT PSYCHIATRY IN POLAND: CHALLENGES IN DIAGNOSIS AND SYSTEM TRANSFORMATION

**Aleksandra Lewandowska**[1(A,B,C,D,E,F)], **Andrzej Silczuk**[2(A,D,E,F)], **Mateusz Jankowski**[3(A,E)], **Mariusz Gujski**[4(E)], **Paulina Mularczyk-Tomczewska**[4(E)], **Małgorzata Honorata Janas-Kozik**[5,6(E,F)]

[1]Children Psychiatry Unit, Specialized Psychiatric Health Care Centre in Łódź, Poland

[2]Department of Community Psychiatry, Faculty of Life Sciences, Medical University of Warsaw, Poland

[3]Department of Population Health, Center of Postgraduate Medical Education, Warsaw, Poland

[4]Department of Public Health, Faculty of Life Sciences, Medical University of Warsaw, Poland

[5]Department and Clinical Ward of Child and Adolescent Psychiatry and Psychotherapy, Medical University of Silesia in Katowice, Poland

[6]John Paul II Child and Family Health Center in Sosnowiec, Poland

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**Address for correspondence:** Andrzej Silczuk, Department of Community Psychiatry, Faculty of Life Sciences, Medical University of Warsaw, Żwirki i Wigury 61, 02-091 Warsaw, Poland, e-mail: andrzej.silczuk@wum.edu.pl, phone: +48 22 57 20 599

ORCID: Aleksandra Lewandowska https://orcid.org/0009-0000-5216-2165, Andrzej Silczuk https://orcid.org/0000-0002-7048-8094, Mateusz Jankowski https://orcid.org/0000-0002-7142-5167, Mariusz Gujski https://orcid.org/0000-0002-2938-4795, Paulina Mularczyk-Tomczewska https://orcid.org/0000-0001-8006-3818, Małgorzata Honorata Janas-Kozik https://orcid.org/0000-0003-3555-2019





## Summary

This narrative review was undertaken in response to the need for systematizing the current state of knowledge regarding the organization of child and adolescent psychiatric care in Poland. Its primary objective was to provide a comprehensive analysis of the reform of this sector of health care, taking into account both the epidemiological context and systemic determinants. The first part presents an analysis of the initial conditions, highlighting key structural, organizational, and staffing deficits that formed the basis for the necessity of reform. Subsequently, the principles and implementation of the reform process initiated in 2018 are examined, with particular focus on the shift away from an institutional model toward a community-based model, as well as the implementation of a tiered system of mental health services. The following section evaluates the outcomes of the reforms to date, including increased availability of outpatient services, reduced waiting times for intervention, and the expansion of specialist training pathways. The study concludes by identifying key challenges and areas requiring

further intervention, such as limited intersectional coordination, uneven service standardization, workforce shortages, and financial sustainability of the psychiatric care system for minors.

**Keywords:** child psychiatry, healthcare reform, community health services, Poland, mental health services

## Introduction

Mental health disorders in children and adolescents constitute one of the most serious public health challenges of the 21st century. The COVID-19 pandemic, the refugee crisis resulting from the war in Ukraine, and the accelerating pace of digitalization and social isolation have only intensified existing problems [1,2]. Epidemiological data indicates that approximately 25.6% of children and adolescents in Poland suffer from various mental health disorders [3]. Despite the scale of the issue, for many years, the mental healthcare system in Poland failed to respond adequately to these needs. Limited access to services, staff shortages, the dominance of an inpatient care model, and the marginalization of psychotherapeutic support further exacerbated the crisis [4]. In 2018, a comprehensive reform was initiated, with the primary goal of deinstitutionalizing the provision of child and adolescent psychiatric services [3].

According to the World Health Organization (WHO), health is not merely the absence of disease or infirmity, but rather a dynamic state of physical, mental, and social well-being. It is a crucial resource enabling individuals to fully participate in family, social, and professional life, both individually and collectively, and contributes to community and national development [5]. This perspective emphasizes the importance of mental health as an integral part of overall well-being and as a factor influencing not only individual functioning but also social cohesion and public safety.

Experts underscore that the mental health of children and adolescents significantly affects their ability to learn, build relationships, develop a sense of agency, and adapt to changing life circumstances [6]. In recent years, a steady increase has been observed in the number of diagnosed mental disorders among this population. According to the WHO data, approximately one in five children and adolescents experiences a mental or behavioral disorder, and suicide is the fourth leading cause of death in this age group [5]. One of the latest epidemiological studies by Kieling et al. (2024) reports that 6.80% of children aged 5-9 years, 12.40% aged 10-14, 13.96% aged 15-19, and 13.63% aged 20-24 are affected by mental health disorders [6]. The incidence of specific disorders varied by age group, and gender-related patterns change with age [6]. More than one-third of mental health problems manifest before the age of 14, yet many cases remain undiagnosed and untreated, leading to significant negative consequences not only for the child and their family but also for society at large, including the civic, educational, and economic sectors [7].

In recent years, this phenomenon has intensified, particularly due to the COVID-19 pandemic, which triggered a dramatic rise in depressive, anxiety, and adjustment disorders, as well as suicide attempts among young people [8]. In Poland, one of the most comprehensive epidemiological assessments was the EZOP II study, conducted by the Institute of Psychiatry and Neurology between 2017 and 2020. The study included a large population sample of children aged 0-6, 7-17, and adults. Among the youngest children (0-6 years), the most common disorders were affective, adjustment, and social interaction disorders, affecting approximately 16% of the population, translating to over 420,000 children potentially requiring specialist support. In the 7-17 age group, the study found that over half a million minors struggled with various mental disorders. Anxiety disorders and externalizing disorders (e.g. oppositional defiant behaviors) were the most commonly diagnosed. More than 100,000 cases were related

to substance use disorders. Furthermore, EZOP II data showed that 37% of young people reported an unmet need for psychological support, primarily due to barriers in accessibility [3].

Despite growing awareness of the importance of mental health among children and adolescents, the psychiatric care system in Poland has long struggled with profound structural barriers. Numerous expert reports and public institutions have identified critical systemic deficiencies that undermined the healthcare system's ability to provide timely and effective support to patients. These included inadequate funding, insufficient coordination between the health, education, and social welfare sectors, a chronic shortage of trained professionals, and an outdated, hospital-centric model of care. Moreover, patient care pathways often failed to align with the developmental needs of children and adolescents, as well as the expectations of their families. This systemic diagnosis ultimately formed the foundation for the 2018 reform and the formulation of its strategic objectives [9].

**Aim of the work**

The primary aim of this review is to provide a comprehensive synthesis of the reform of child and adolescent psychiatric care in Poland initiated in 2018, situating it within the broader epidemiological, systemic, and international context. The paper seeks to systematically examine the key determinants that led to the implementation of the reform, describe its conceptual foundations and operational components, and evaluate its initial outcomes. In doing so, it highlights the transition from a hospital-based model to a tiered, community-oriented system of care.

In addition, the review aims to identify persisting structural challenges and gaps that hinder full implementation and sustainability of the reform. Particular attention is given to intersectoral coordination, workforce development, service accessibility, and the integration of

educational and healthcare systems. The paper also draws on comparative perspectives from other European countries to contextualize the Polish experience and to outline best practices that may inform future strategic directions in child and adolescent mental health policy.

## Methods

This review adopts a narrative approach aimed at integrating scientific evidence, national epidemiological data, and strategic policy documents relevant to the reform of child and adolescent psychiatric care in Poland. The choice of literature was guided by both thematic relevance and temporal proximity to the initiation of the reform process in 2018. Accordingly, the primary body of literature reviewed spans the period from January 2010 to May 2025, with particular emphasis on the years 2017-2024, during which key strategic decisions, implementation frameworks, and early evaluations of the reform were formulated.

The literature search was conducted using the PubMed, Scopus, and Google Scholar databases for international peer-reviewed publications, supplemented by searches in the Polish Medical Bibliography and official websites of the Ministry of Health, the National Health Fund, and other governmental institutions. In addition to scientific articles, national policy documents, parliamentary reports, the WHO and European Union (EU) communications, and institutional evaluations (such as the EZOP II study) were reviewed. The inclusion of grey literature and policy texts was deliberate, as these sources offer unique insights into the practical and legal determinants of systemic transformation, which are not always captured in scientific databases. Keywords used in the search included combinations of terms such as “child and adolescent psychiatry”, “mental health reform”, “community-based mental health care”, “Poland”, “tiered services”, “intersectoral collaboration”, “National Mental Health Program”, “WHO mhGAP”, and “EU4Health”.

Sources were selected based on their relevance to several interrelated domains: the epidemiological burden of mental health disorders in children and adolescents, the structure and limitations of the pre-reform psychiatric care system in Poland, the rationale and assumptions underlying the 2018 reform, the stages and mechanisms of its implementation, and the preliminary outcomes observed to date. Comparative analyses involving mental health system reforms in selected European countries (Finland, Norway, and the United Kingdom) were also included to provide international context and identify best practices. Special attention was given to documents that addressed the specific characteristics of child and adolescent populations, including developmental needs, family involvement, and the role of schools in mental health promotion and early intervention.

All sources were critically analyzed with regard to their methodological transparency, source credibility, and congruence with existing epidemiological and organizational data. While no formal scoring systems or systematic review tools (e.g. PRISMA or AMSTAR) were applied due to the integrative nature of the review, the consistency of findings across different types of sources and institutions was emphasized as a form of triangulation to ensure analytical robustness. The resulting synthesis seeks to provide not only a descriptive account of the reform process but also a critical perspective on its systemic coherence, operational feasibility, and alignment with international standards of youth mental health care.



## Literature review results

### *Assumptions and objectives of the reform*

The reform of child and adolescent psychiatric care in Poland has been embedded within a broader framework of national and international strategic documents. A key role was played

by the National Mental Health Protection Program for 2017-2022, a governmental policy outlining the country's priorities in mental health promotion, prevention of psychiatric disorders, and the development of a balanced, accessible system of care [10]. Among its principal objectives were the establishment of community-based mental healthcare as the dominant organizational model, the reduction of psychiatric hospitalizations in favor of outpatient services, and the integration of psychiatric care with educational and social welfare systems. Furthermore, the Program called for expanding the mental health workforce specializing in child and adolescent populations, as well as for implementing nationwide public education campaigns aimed at destigmatizing mental illness in youth.

Simultaneously, the reform was aligned with global policy directions promoted by the WHO. In particular, the WHO's Mental Health Gap Action Program (mhGAP) advocates for accessible care at the primary level, early diagnosis, and cross-sector integration of services [11]. The WHO has consistently emphasized a systemic transition away from institutional care toward comprehensive, community-based services that account for the psychosocial and developmental needs of children and their families. In parallel, the EU, through its EU4Health Program (2021-2027), identified mental health as a strategic priority. This EU initiative stresses prevention, the reduction of inequalities in care, workforce development, and systemic resilience, while calling on Member States to adopt integrated care models and intersectoral coordination as prerequisites for effective reform [12-14].

In designing reforms for child and adolescent populations, it is essential to consider the specific developmental context of minors. These include the legal and practical presence of third-party involvement, such as parents or legal guardians, and the role of the school system as both a potential stressor and site of intervention. Consequently, mental health services for children and adolescents must be embedded within the child's everyday environment and prioritize outpatient care. In this population, psychological and psychotherapeutic interventions

are often more appropriate than pharmacological treatments, as many conditions can be effectively managed through psychosocial support alone [12].

Against this backdrop, the primary objective of the reform was to shift from a hospital-centered model to a decentralized, community-based system that facilitates early intervention near the child's place of residence [9,14,15]. Specifically, the reform aimed to expand outpatient and community-based services with improved accessibility and continuity of care; restructure the financing model to move away from fee-for-service mechanisms in favor of integrated, value-based funding solutions; and increase the number of first- and second-tier service centers to address regional inequalities and workforce shortages, ensuring the availability of services in each county. Additionally, it sought to implement care pathways tailored to individual clinical needs and based on standardized diagnostic and risk assessment protocols. Another essential component involved strengthening intersectoral cooperation, especially between schools and mental health services, by promoting the development of local interdisciplinary teams and investing in targeted training for professionals. The reform also prioritized the creation of quality monitoring systems and the development of digital tools to support real-time data analysis and service adaptation. Finally, the plan included measures to reduce regional disparities by equitably distributing resources and facilities, with special attention paid to underserved populations [9,10].



***Tiered mental health services***

Responding to the urgent need for systemic change, the Polish Ministry of Health launched a tiered model designed to create a nationwide, integrated network of support for children and adolescents with mental health disorders and their families. Consistent with national policy directives and the EU recommendations [10-15], the model rests on several

interlocking principles. First, it advances full deinstitutionalization by redirecting care from hospital wards to outpatient and community-based settings [11-15]. Second, it establishes flexible patient pathways that match intervention intensity to clinical severity and adhere to standardized diagnostic and risk-assessment protocols, thereby optimizing the use of limited human resources. Integral to this approach is the provision of rapid, low-threshold services delivered by non-psychiatrist professionals, including psychologists, psychotherapists and community therapists, who can intervene early and prevent clinical deterioration. The architecture of the system also prioritizes geographical equity: services are to be available at the county level, with mandatory collaboration between mental-health teams, families, and school environments to ensure continuity of support across daily contexts. Finally, the reform seeks to narrow regional disparities by strategically allocating resources and by expanding and retraining the workforce so that staffing profiles align with the needs and operational logic of the new three-tier structure.

***Formal establishment of the team***

The formal institutionalization of the reform process occurred with the establishment of the Team for Child and Adolescent Mental Health, hereinafter referred to as “the Team”, by the Ordinance of the Minister of Health on February 20, 2018 [15]. The Team was conceived as a central coordinating and advisory body responsible for overseeing the systemic transformation of psychiatric care for minors. Its composition reflected a broad, interinstitutional mandate, including representatives from the Ministry of Health, the National Health Fund, and external experts drawn from the professional communities engaged in child and adolescent mental health. Notably, the Team incorporated national consultants in key disciplines, most prominently the National Consultant in Child and Adolescent Psychiatry and

the National Consultant in Clinical Psychology, thereby ensuring clinical and scientific expertise in strategic deliberations. Additionally, it included the Plenipotentiary of the Minister of Health for the Reform of Child and Adolescent Psychiatry and the Plenipotentiary for Forensic Psychiatry, indicating a deliberate emphasis on integrative governance and cross-sector alignment.

Although the Team's membership has evolved over time in response to emerging needs and the expanding scope of reform, its organizational leadership has remained stable. The Chair of the Team has consistently been the Secretary of State at the Ministry of Health, while the role of Deputy Chair has been held by another senior official within the Ministry. The Plenipotentiary for the Reform has played a pivotal role in maintaining continuous collaboration between the Team and the Department of Public Health, facilitating policy coherence and operational coordination. The work of the Team has been instrumental in shaping and implementing the new model of care, which is structured around three reference levels of mental health services [14].

*Level I of reference*

The first level of the reference model consists of Community Centers or Teams for Psychological and Psychotherapeutic Care for Children and Adolescents, which are designed to provide easily accessible, non-stigmatizing support without requiring a physician's referral. These centers are staffed by psychologists, psychotherapists, and community therapists and are intended for patients who do not require psychiatric diagnosis or pharmacological treatment. Their principal function is to deliver early interventions in response to emerging emotional, behavioral, or developmental difficulties. By providing support at the initial stage of symptom

presentation, these services aim to prevent clinical deterioration, reduce the risk of psychiatric hospitalization, and promote mental health resilience.

An essential feature of Level I care is its emphasis on proximity and integration with the child's immediate environment. These centers are strategically distributed to ensure availability in each county or group of counties, thereby maximizing territorial accessibility and minimizing systemic delays. Cooperation with local institutions, especially schools, is a foundational element of their operation, facilitating multidimensional support that aligns with the developmental and social context of the child.

The operationalization of Level I services began in 2020 as part of the initial implementation phase of the reform. As of May 7, 2025, there were 498 active Community-Based Psychological and Psychotherapeutic Care Centers or Teams for Children functioning across Poland, marking a substantial increase in the availability of early, non-institutionalized mental health interventions for minors [9].

*Level II of reference*

At the second level of reference operate the Mental Health Centers for Children and Adolescents, which offer services to patients requiring more intensive psychiatric care than is available at the community level. These centers are staffed by multidisciplinary teams that include psychiatrists, enabling the diagnosis and treatment of more complex clinical presentations. In many cases, they also provide structured day treatment programs for individuals who require regular therapeutic contact without necessitating full hospitalization. Each Level II center is designed to cover the needs of several neighboring counties, thus expanding access to specialized care beyond the local level. As of May 7, 2025, a total of 177

Level II centers were operational in Poland, 83 offering outpatient services exclusively, and 94 combining outpatient care with day treatment units [9].

*Level III of reference and supporting systemic measures*

The third level of reference consists of Highly Specialized Inpatient Psychiatric Care Centers, which provide 24-hour services to children and adolescents presenting with the most severe mental health conditions, including those posing an immediate risk to life or health. These centers serve as the final point in the referral chain, admitting patients either on an emergency or scheduled basis. Their clinical infrastructure is equipped to deliver intensive, multidisciplinary care, and each voivodeship hosts at least one such facility. As of May 2025, 35 Highly Specialized Inpatient Psychiatric Care Centers were in operation nationwide [9].

Complementing the implementation of the tiered model, a parallel support program has been launched to strengthen the structural and human resource foundations of the reformed system. One key priority has been the modernization of infrastructure, including the renovation and expansion of facilities. Financial investment has also targeted the development of digital tools and the prevention of emergent challenges, such as behavioral addictions related to digital media use. Reimbursement rates for child and adolescent psychiatric services have been increased, reflecting a policy shift toward valuing preventive and non-hospital care. Furthermore, child and adolescent psychiatry has been designated as a priority medical specialty, accompanied by financial incentives to attract new trainees and an expansion of residency slots across relevant disciplines [9,15].

An essential aspect of systemic sustainability involves the expansion and formalization of mental health professions beyond psychiatry. In 2019, the Ministry of Health introduced a formal specialization in child and adolescent psychotherapy, with the first certification

examinations taking place in 2020. The competency framework for conducting community-based therapy with children and adolescents was also incorporated into the national Integrated Qualifications System in 2018. Additionally, a new specialization track in clinical psychology focused specifically on children and adolescents was developed in 2018 to meet the growing demand for developmentally tailored diagnostic and therapeutic services. The curriculum for child and adolescent psychiatry itself has undergone modifications to align with the community-centered care model, including the introduction of a dedicated three-year training module for pediatricians transitioning into psychiatry.

To address persistent structural and workforce deficits, the Ministry of Health launched the strategic program "Investments in Psychiatry" in 2024. Scheduled for implementation through 2027, this program encompasses infrastructural, educational, and organizational components. With a total budget exceeding 1 billion PLN, it supports the modernization of existing facilities, the establishment of new Level I and II centers, and the digital transformation of care processes within community psychiatry [15,16]. These measures are designed to ensure the long-term operational viability of the reformed system, while improving equity, quality, and efficiency across all levels of care.

## ***Stages of child and adolescent psychiatry reform in Poland***

### *Systemic diagnosis and policy framing (2017-2018)*

The preparatory phase of the reform began in 2017 as a response to the long-standing structural and functional deficits in child and adolescent psychiatric care in Poland. Building on international frameworks, particularly those of the WHO, UNICEF, and the European Commission, the Ministry of Health initiated conceptual work aimed at replacing the

predominantly hospital-based model with a community-oriented system [4]. In 2018, the establishment of the Team for the Reform of Child and Adolescent Psychiatry, as well as the appointment of the Plenipotentiary of the Minister of Health for the Reform, provided the institutional scaffolding for the development of a coherent national strategy.

*Designing the three-tiered model of care (2018-2019)*

During this phase, the core architecture of the reform was developed. A three-level system of services was proposed: Level I for community-based psychological and psychotherapeutic care; Level II for outpatient clinics and day units supported by psychiatrists; and Level III for highly specialized 24-hour inpatient psychiatric services. The model was designed to decentralize care, facilitate early intervention, and promote the integration of services within the child's natural social environment, particularly in families and schools. The new structure sought to reduce pressure on inpatient units while improving continuity and proximity of care.

*Legal and operational launch (2019-2020)*

The transition from planning to implementation took place between 2019 and 2020. This period saw the introduction of key legislative instruments, including regulations issued by the Minister of Health and the President of the National Health Fund , which enabled the financing and contracting of community-based services. Facilities were allowed to operate in either a full or minimal organizational variant, allowing for regional flexibility. Simultaneously, early revisions to medical specialization curricula were initiated to align postgraduate education with the goals of the reform.

*Scaling up and local innovation (2021-2022)*

The following phase focused on the broader rollout of the model. New Level I and II centers were opened across the country, and the so-called "Bielany model" of community mental health services was piloted to assess its transferability to other regions. Training capacity was expanded through increased numbers of specialization slots, and specific support was directed toward smaller municipalities. This period also saw the launch of pilot initiatives addressing technology-related behavioral disorders among children and adolescents, signaling the system's growing responsiveness to emerging public mental health threats.

*Infrastructure, workforce, and standard development (2022-2023)*

The 2022-2023 stage marked a consolidation phase in which efforts concentrated on strengthening structural and human resources. Improvements were introduced in the healthcare financing system, notably the adoption of hybrid reimbursement models supportive of long-term and integrated care delivery. National standards for service provision were developed, and significant investments were made in the modernization of 24-hour inpatient units – many of which had suffered underinvestment and structural degradation. Workforce development remained a central priority. Specialization programs in child and adolescent psychotherapy and clinical psychology were expanded, and the profession of community-based therapist was formally recognized and regulated. These measures were designed to increase service capacity, professional diversity, and the overall quality of care across all levels of the system.

*Monitoring, policy adjustment, and strategic coordination (2023-2024)*

The most recent phase focused on system evaluation and refinement. Persistent challenges were identified, including inadequate coordination across the three levels of reference care, barriers to intersectoral data integration, and chronic underfunding. In response, legislative amendments were proposed to increase systemic cohesion. Emphasis was also placed on fostering strategic cooperation between the Ministry of Health and other sectors, particularly education and social services. These adjustments reflect a recognition that sustainable reform requires not only organizational redesign but also governance structures capable of ensuring interministerial integration and long-term policy continuity.

***Outcomes of implementation***

The reform of the child and adolescent psychiatric care system in Poland has resulted in several measurable improvements across service accessibility, system organization, and workforce development. One of the most significant outcomes has been the substantial expansion of psychological and psychotherapeutic services, particularly at the first level of reference. This was achieved through the systematic development of Community-Based Psychological and Psychotherapeutic Care Centers and the targeted recruitment of non-psychiatrist mental health professionals, such as psychologists and psychotherapists [15,18]. The increased availability of early-stage services has contributed to a marked reduction in waiting times for initial consultations, a change facilitated in part by the removal of referral requirements for accessing Level I care [15,17,18].

Another key development since the reform has been the rapid expansion of community-based and outpatient services for minors. The number of children and adolescents receiving

psychiatric and psychological care more than doubled between 2019 and 2023, with the majority supported at the first level of care [19]. Public awareness of where to seek such help has also increased, as shown by recent national surveys [20]. This shift increases the system's capacity to manage cases in ambulatory and day-care settings that previously would have been referred to inpatient wards. While national data up to 2022 indicates that bed occupancy at the third level remained critically high (~110%) [21], the recent decline in suicide deaths among minors in 2023 and 2024 [22-24] may suggest that earlier and more accessible interventions are beginning to translate into improved outcomes. At the same time, persistent public misperceptions about equity and stigma in mental health care [25] underscore the need for continued investment in education and awareness. These changes are consistent with the WHO recommendations on strengthening localized and integrated support systems rather than relying primarily on institutional settings [4,18]. Furthermore, qualitative feedback from families indicates a high level of satisfaction with the reformed system, especially with regard to the accessibility, flexibility, and individualized nature of care provided at Levels I and II [9].

In parallel, the reform has fostered notable growth in the training infrastructure for mental health professionals. The number of specialization slots in child and adolescent psychiatry, clinical psychology, and psychotherapy has increased, and new professional roles, particularly that of community-based therapists, have been formally introduced into the healthcare system. These changes have helped to diversify the workforce and lay the groundwork for long-term sustainability of the tiered model [9,15].

While these outcomes reflect important advances, they also underscore the need for continuous monitoring and adaptive refinement of the system to ensure consistent quality, equitable access, and systemic resilience.

***Reform in Poland in the context of Europe***

The experiences of other European countries provide an important reference point for evaluating both the implementation and the emerging outcomes of the child and adolescent psychiatry reform in Poland [9,14,15]. Among the most influential models are those developed in Scandinavian countries, particularly Finland and Norway, which have long emphasized the importance of integrated, community-based mental health care for young people.

In Finland, the principle of "care close to home" serves as the foundation of child and adolescent psychiatric services. The system comprises an extensive network of mental health clinics, school-based counseling points, and mobile outreach teams, enabling timely and developmentally appropriate interventions. A key strength of the Finnish approach lies in the coordination between municipalities, schools, and healthcare institutions, which facilitates rapid information exchange and seamless continuity of care. Programs such as Nuorisoasema (Youth Station) exemplify this model, offering young people a full spectrum of support ranging from individual and family therapy to educational guidance and preventive initiatives embedded in school environments [26].

Similarly, the Norwegian system prioritizes early, school-linked mental health support. Each educational institution is expected to maintain regular collaboration with a local child and adolescent mental health clinic (Barneog Ungdomspsykiatrisk Poliklinikk, BUP), allowing for direct referrals to psychological services without the need for prior consultation with a physician. Therapeutic interventions are often delivered within the school context by interdisciplinary community teams, emphasizing accessibility and social inclusion. Norway also invests significantly in emotional education for children and parents and conducts large-scale public awareness campaigns aimed at reducing the stigma surrounding mental illness [27,28].

The British model has likewise influenced the Polish reform, particularly in its approach to integrating mental health services within the educational system. In the United Kingdom, Mental Health Support Teams operate directly in schools, providing structured psychological assistance to students, educators, and families. The implementation of Trailblazer Sites has further enabled the piloting of localized innovations in care delivery, focused on enhancing interprofessional collaboration and strengthening community engagement [29].

The Polish reform also aligns with the policy directions set by the WHO, particularly through the Mental Health Gap Action Program (mhGAP). This initiative emphasizes the decentralization of services, early detection of mental health disorders, and the integration of care across sectors such as health, education, and social support [11]. Deinstitutionalization is positioned by the WHO as a cornerstone of mental health system transformation, aimed at reducing patient isolation and enabling social reintegration.

At the EU level, strategic documents such as the EU4Health program advocate for the resilience of mental health systems, improved access to care for children and adolescents, and investment in community-based innovation. The EU encourages Member States to reduce regional inequalities, implement digital solutions, and develop early intervention systems embedded in local infrastructure [12].

Although developed in response to local conditions and systemic deficits, the Polish reform reflects broader European and global trends in the modernization of psychiatric care. Its core components including the three-tiered service structure, emphasis on collaboration with schools, expansion of outpatient and preventive services, and implementation of quality standards closely mirror best practices observed across Western Europe. As such, the reform represents both an adaptation of international models and a contribution to the ongoing European discourse on improving mental health outcomes in youth populations.

***Importance of intersectoral collaboration***

The effectiveness of community-based mental health care for children and adolescents fundamentally depends on the quality of cooperation between key public sectors, particularly education, health care, and social services. Intersectoral collaboration facilitates early detection of psychological difficulties, ensures continuity of care, and enables the creation of a supportive environment that promotes both therapeutic and educational goals [11].

Schools play a particularly critical role in this system, often serving as the first point of contact for children experiencing mental health challenges. Teachers who are adequately trained to recognize early warning signs such as withdrawal, behavioral changes, or declining academic performance can direct students to appropriate support systems, potentially preventing the escalation of symptoms. Research consistently shows that early intervention significantly improves clinical outcomes and reduces the risk of hospitalization, while delays in care increase the likelihood of long-term developmental impairments and engagement in high-risk behaviors during adolescence and adulthood [5,6,30].

The educational environment is uniquely positioned to function as a gatekeeper for mental health surveillance. With the support of mental health professionals, schools can implement individualized educational plans tailored to students diagnosed with conditions such as depression, anxiety disorders, or ADHD. Evidence from countries such as the United Kingdom and Canada indicates that such integrated interventions not only improve students' psychological functioning but also reduce absenteeism and enhance academic performance [31-33].

Family involvement is equally essential. Integrated actions involving parents, teachers, and clinicians allow for consistent messaging, improve parental understanding of their child's condition, and increase family engagement in the therapeutic process. Strengthening these

connections enhances treatment adherence and improves long-term outcomes [34,35]. International good practices demonstrate that coordinated care across sectors reduces the frequency of psychiatric hospitalizations, lowers the incidence of mental health crises, and promotes more efficient allocation of public resources [36]. School-based mental health promotion initiatives such as workshops, psychoeducation campaigns, and classroom-based resilience training have been shown to reduce stigma and enhance emotional coping strategies in children and adolescents [37].

In contrast, the absence of structured intersectoral collaboration can have serious negative consequences. Delayed or missed diagnoses, inappropriate educational placements, fragmented support, and ineffective therapeutic outcomes are among the common failures in systems lacking coordination [38-42]. Teachers, in particular, often report feeling overwhelmed and powerless in the face of growing student mental health needs, especially when they lack access to consultation with mental health professionals. This sense of helplessness contributes to burnout and emotional strain within the educational workforce [43].

Successful intersectoral collaboration requires clear role delineation, systematic communication – often facilitated by interdisciplinary teams or community consultations and continuous training of educational staff to recognize and respond to mental health concerns [27]. In the Polish context, where there is a well-documented shortage of mental health professionals, schools may serve a compensatory function. While not a substitute for therapy, schools can act as a vital support structure, helping to sustain the child's mental health trajectory between clinical encounters and reinforcing therapeutic goals within the educational setting.

## Conclusions

The reform of child and adolescent psychiatry in Poland is both justified and necessary in light of the growing mental health crisis among young people. The introduced model, based on a community-oriented, three-tiered system of care, constitutes a fundamental step toward building a modern, integrated, and accessible mental health service network. To ensure its effectiveness and sustainability, coordinated efforts are required in several key domains.

### *Securing stable and comprehensive financing*

The long-term success of the reform depends on embedding mental health services for children and adolescents into stable public financing structures. This includes not only sustained contracting of services through the National Health Fund but also investments in infrastructure, mobile teams, prevention programs, and educational activities. Funding mechanisms must reflect the multidimensional character of the services and support their territorial accessibility.

### *Human resources development and retention*

Expanding the availability and competency of the workforce is crucial. This includes increasing the number of residency positions in child and adolescent psychiatry, expanding accredited postgraduate training opportunities in psychotherapy and clinical psychology, and introducing financial incentives for professionals working in underserved areas. Long-term professional development programs should incorporate supervision, burnout prevention strategies, and continuing education in line with the demands of integrated care models.

***Implementing outcome monitoring and evaluation tools***

An integrated monitoring system should be established, incorporating both quantitative and qualitative indicators. Digital tools enabling real-time data collection and analysis are essential to guide system improvements. Additionally, internal and external audit mechanisms should be introduced to assess service effectiveness, identify regional disparities, and track longitudinal outcomes.

***Strengthening intersectoral and local-level cooperation***

Effective mental health care for minors requires the coordination of actions across sectors and levels of governance. Cooperation between the ministries of health, education, and social policy should be formalized through interdisciplinary teams, local networks, and jointly implemented programs. A coherent national care pathway should link early identification (often in schools) with diagnosis and long-term support. Clear delineation of roles is required across institutions: the Ministry of Health (psychiatrists, psychologists, psychotherapists, community therapists), the Ministry of Education (teachers, pedagogues, school psychologists), and the Ministry of Family and Social Policy (social workers, family assistants). Such collaboration must be supported by joint training programs, information exchange protocols, and data protection standards.

***Standardization of service quality and development of digital tools***

It is essential to develop and implement nationwide standards for diagnosis, therapeutic interventions, and cooperation with families and educational institutions. E-health tools should

be expanded to include teleconsultation platforms, therapeutic applications, and interoperable information management systems to enhance accessibility and coordination. Moreover, there is an increasing need to integrate addiction treatment into the mental healthcare system and to standardize digital solutions for diagnostics, therapy, and health system management.

The reform has already delivered notable results: the creation of a new care model, the launch of hundreds of community-based centers, an increase in training opportunities, and improved access to services. Nevertheless, significant challenges remain. The system still requires closer integration of intersectoral activities, a more coherent care trajectory for children and adolescents, and nationwide enforcement of quality standards. Crucially, sustained public funding, continuous professional development, and real-time monitoring are essential to preserving the momentum of the reform. If these conditions are met, the Polish model may not only align with international standards of deinstitutionalization but also serve as an innovative and replicable example of systemic transformation in youth mental health care.



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