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(No)justification for the stay of children and adolescents with psychiatric problems in educational centres in Poland – a case study

(Nie)zasadność pobytu dzieci i młodzieży z problemami psychiatrycznymi w ośrodkach wychowawczych w Polsce – studium przypadku

Abstract

Aim. Child and adolescent psychiatric care is a complex process because it involves not only the young patient but also his wider environment, including the family. The fact that a patient may behave aggressively is not necessarily related to social maladjustment *per se* but may be a symptom of a psychiatric disorder that, if properly treated, may improve the patient's condition. The aim of this study is to highlight the problematic place-

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ment of adolescents with affective and psychotic mental disorders in Youth Educational Centres (MOW).

Materials and methods. This article presents a case report of a 16-year-old female resident of a MOW. The girl was hospitalized several times in psychiatric wards because of affective, psychotic, and conduct disorders. During her stay in the MOW, a clinical interview and a semi-structured questionnaire K-SADS (Kiddie Schedule for Affective Disorders and Schizophrenia) in the Polish version were conducted with her to identify psychopathological symptoms and enable early diagnosis of mental disorders. Available medical documentation was also reviewed.

Results and conclusion. There might be pupils in MOW with mental disorders that require appropriate treatment or even hospitalization. Access to specialized psychiatric care in MOW institutions is difficult and psychiatric consultations do not always take place, which has a significant impact on the mental condition. It is also worth noting the nationwide character of problems related to the psychiatric care of children and adolescents, which concerns not only the residents of such institutions but is a problem very often occurring among children and adolescents brought up in the so-called "normal family environments".

Keywords: bipolar disorder, schizophrenia, social maladjustment, psychotic disorders, Youth Educational Centre.

Abstrakt

Cel. Opieka psychiatryczna dzieci i młodzieży jest procesem złożonym, ponieważ obejmuje nie tylko młodego pacjenta, lecz także jego środowisko, w tym rodzinę. To, że pacjent może zachowywać się agresywnie, nie musi być koniecznie związane z jego niedostosowaniem społecznym *per se*, ale może stanowić objaw zaburzenia psychicznego, który odpowiednio leczony, jest w stanie poprawić stan pacjenta. Celem pracy jest zwrócenie uwagi na problematykę umieszczania w ramach Młodzieżowych Ośrodków Wychowawczych (MOW) młodzieży z zaburzeniami psychicznymi afektywnymi i psychotycznymi.

Materiały i metody. Niniejszy artykuł stanowi opis przypadku 16-letniej wychowanki MOW. Dziewczynka była kilkakrotnie hospitalizowana na Oddziałach Psychiatrycznych z powodu zaburzeń afektywnych, psychotycznych, a także zaburzeń zachowania. Podczas pobytu w MOW przeprowadzono z nią wywiad kliniczny oraz częściowo ustrukturyzowany kwestionariusz K-SADS (Kiddie Schedule for Affective Disorders and Schizophrenia) w wersji polskiej, mający na celu określenie objawów psychopatologicznych oraz wczesną diagnozę zaburzeń psychotycznych, lękowych, zachowania i zaburzeń afektywnych, takich jak depresja i choroba afektywna dwubiegunowa. Skorzystano także z dostępnej dokumentacji medycznej.

Wyniki i wnioski. W MOW mogą znajdować się wychowankowie z zaburzeniami psy-

chicznymi wymagającymi odpowiedniego leczenia farmakologicznego, terapeutycznego, a nawet hospitalizacji na Oddziałach Psychiatrycznych dla dzieci i młodzieży. Dostęp do specjalistycznej opieki psychiatrycznej w placówkach MOW jest trudny, a konsultacje psychiatryczne nie zawsze się odbywają, co ma niebagatelny wpływ na kondycję psychiczną młodzieży tam skierowanej. Warto zwrócić także uwagę na ogólnopolski charakter problemów związanych z diagnozowaniem oraz opieką psychiatryczną wśród dzieci i młodzieży, który dotyczy nie tylko podopiecznych takich placówek, lecz także dzieci i młodzieży wychowujących się w tzw. normalnych środowiskach rodzinnych.

Słowa kluczowe: choroba afektywna dwubiegunowa, schizofrenia, zaburzenia psychotyczne, niedostosowanie społeczne, Młodzieżowy Ośrodek Wychowawczy.

Introduction

Youth Education Centres (MOWs – in polish: *Młodzieżowy ośrodki wychowawcze*) are institutions aimed at counteracting social maladjustment in the child and adolescent population, understood as truancy, theft, hooliganism, taking valuables out of the home, use of cigarettes, alcohol or psychoactive substances. In many cases, however, these centres become – due to system deficiencies and emerging needs – specific care and educational institutions where children and young people stay for many years. In this situation, the centres function as a kind of institution that meets some of the family's needs, even though they are supposed not to be their essence.

According to data from the *Ośrodek Rozwoju Edukacji* [Centre for Education Development], which mediates the process of placing minors in MOWs, there were 91 such institutions in Poland in 2023. The basic task of these institutions is the renewed, corrected socialisation of juveniles. It is carried out under the influence of purposeful interactions of educators with the use of specially selected methods and means, appropriate to the given environment. The tasks of the MOW are primarily the elimination of all manifestations of social maladjustment, which are harmful both to the environment and to the person concerned, preparation of the juvenile for social readjustment, taking up employment and living according to social and legal norms and rules. The inmates are provided with the opportunity to fulfil their compulsory education (there are schools within the MOW), participation in extracurricular activities, assistance in learning, participation in rehabilitation, socio-therapeutic and revalidation activities, preparation for independent functioning in society and round-the-clock care (Dobijański, Kamiński, 2020).

An important problem concerning the functioning of institutions of the MOW character is the issue of the prevalence of undiagnosed psychiatric disorders among its wards

(alumni). In 2021, a survey was conducted on the prevalence of mental disorders among MOW wards in Poland. The questions were answered by the directors of the institutions. It was shown that only 2 out of 94 establishments operating at that time did not have mental health problems. The data presented indicated that 33 % of the young people required specialised psychiatric care due to diagnosed mental disorders, e.g., behavioural disorders, mood disorders, anxiety disorders, and schizophrenia, and 40 % were wards with a diagnosis of addiction to psychoactive substances. Depressive symptoms were reported by as many as 76% of the wards. In almost all establishments, psychiatric counselling takes place (98%), but there is no information on how frequent the counselling is and how effective it is. In almost every MOW, individual psychological and pedagogical support is available (94%), although as many as 83% of the directors of these centres described the access of alumni to specialised psychiatric care as difficult or very difficult (Paluch, 2021). However, from this survey, it is possible to discover that the problem was present in the centre in 2020, although the extent of its severity among young people is not known. It is therefore worth conducting further research in this area, especially using validated questionnaires among wards.

Is the structure of childcare centres a suitable place for people with diagnosed mental disorders such as schizophrenia or bipolar affective disorder? People with the aforementioned disorders require continuous psychiatric care on an ambulatory system (the basis of treatment is appropriate pharmacotherapy selected by a specialist in child and adolescent psychiatry), and it is not uncommon for them to need hospitalisation in a psychiatric ward. Furthermore, taking into account the environmental aspect of such places, it is apparent that educational centres geared towards helping socially maladjusted young people may not be a suitable place for people with a psychiatric diagnosis, because of, for example, the constant presence of other wards that may stigmatise mentally disturbed people. An additional negative element in working with such children is the lack of (or a great limitation of) their contact with their family environment, resulting from the pathological nature of these environments, frequent family conflicts, the distance between the centres, and their family homes or the lack of "proper willingness" on the part of foster families and children's homes to cooperate with minors staying in youth education centres. The environmental aspect, meanwhile, is an important element in the psychiatric rehabilitation of mentally disturbed persons of any age range (Pawłowska, Fijałkowska-Kiecka, Potembska, Domański, & Lewczuk, 2015).

A slightly different course may characterise bipolar disorder (BPAD) in the child and adolescent population than in adults. The classic adult pattern is characterised by episodes of depression and mania or hypomania. BPAD in adolescence, meanwhile, is characterised by a greater propensity for mixed episodes, relapses, shorter intervals between episodes, a course of rapid cycling, associated with substance abuse, which

can certainly arouse aggression, irritability and mood swings in the young person, which are responsible for socially unacceptable and/or legally illegal behaviour (Janiri et al., 2021). One study demonstrated the validity of these considerations, as results reported that the prevalence of lifetime contact with the police was significantly higher among adolescents with BPAD compared to healthy controls (36% vs. 3%) (Barton et al., 2021), and a lifetime diagnosis of depression and/or bipolar disorder may be a predictor of later adjudicated delinquency among adolescents (Mallett, Stoddard Dare, & Seck, 2009). Psychotic symptoms may occur during any of the phases of BPAD. The most common are delusions, such as grandiose, persecutory delusions and ideas of reference. Pseudohallucinations may also occur, e.g., auditory hallucinations, i.e., voice sensations heard from an inadequate space and commenting on the actions of the patient (Galecki, Szulc, 2018). Because of the non-specific presentation of BPAD in adolescents, it can therefore pose a serious diagnostic problem for clinicians, and delaying diagnosis worsens patients' psychosocial prognosis (Joslyn, Hawes, Hunt, & Mitchell, 2016). This research paper aims to highlight the problematic placement of adolescents with affective and psychotic psychiatric disorders within MOW. Based on the case study of one of the MOW ward (young woman), we will consider whether a juvenile correctional centre is an appropriate place for such individuals, putting at stake the process of their eventual rehabilitation and the rehabilitation they should receive.

Case study

The case analysed concerns a 16-year-old girl who was referred to the MOW based on article 26 of the *Ustawa o wspieraniu i resocjalizacji nieletnich* [Act on the support and rehabilitation of juveniles] (*Ustawa* [Act], 2022) due to abuse of psychoactive substances – alcohol and drugs, failure to fulfil her compulsory education, and absconding from educational and therapeutic institutions.

Her family history indicates that one of her older sisters has bipolar disorder and the other has depressive disorder. In her early childhood, she was exposed to domestic violence by her alcohol-dependent father. Her parents divorced and from then on the girl lived once with her mother and once with her father. From kindergarten she had already problems with social adaptation, at the age of six she had bedwetting, but only since the age of eight has she been under the care of the educational counselling service due to emotional difficulties. In 2019, she was the victim of sexual violence by an elderly neighbour. She had been self-harming regularly for several years, there was an apparent mood sway and rebellious and oppositional behaviour, particularly a tendency to aggression. According to her account, she had received psychiatric counselling and psychotherapy during that time. Attempts at treatment with lamotrigine,

risperidone, and aripiprazole (she could not remember the doses) did not result in improvement, according to her, and she therefore discontinued the medication.

The psychopathological symptoms gradually increased until there was an incident of aggression at home – in response to her mother's instruction to clean up a spill on the floor, she threatened her with a knife, for which, assisted by the police, she was taken to hospital in the psychiatric ward for children and adolescents. After leaving the hospital, she was referred for a stay at an anxiety and depressive disorders treatment centre. At that time, she was described as having a grandiose attitude, a lack of self-criticism, and several aggressive behaviours towards peers. It was decided to introduce pharmacotherapy consisting of quetiapine (25 mg) and aripiprazole (7.5 mg). After five weeks, she was disciplinarily discharged for a second escape, which was tantamount to a breach of her behavioural contract, non-cooperation with the treatment team and aggression towards others. Due to the lack of improvement, quetiapine treatment was discontinued and aripiprazole was left at the same dose. During that time, the girl denied hallucinations and delusions. When she returned home, the probation officer requested that she be referred to the MOW as an intervention-type preventive centre. She was placed there.

Five months later, during an outpatient psychiatric consultation, she reported severely increased suicidal thoughts and the doctor recommended taking aripiprazole (15 mg), perazine (75 mg), and mitrazapine (30 mg). Shortly thereafter, on leave from the MOW, she cut her right forearm under the influence of suicidal thoughts, which resulted in another hospitalisation. On admission, sharp objects were found in the patient's vagina and mouth, and, according to her mother's account, the girl had recently tried to choke herself with headphones and had swallowed a large dose of accumulated medication (no information on which and how much) on one occasion. During her stay in the psychiatric ward, CT and EEG examinations were performed, which showed no abnormalities. Features of post-traumatic stress disorder, complicated by behavioural disorders, strongly related to environmental influences and features of an abnormally formed personality, were found. It was decided to discontinue perazine, leaving aripiprazole (15 mg) and mirtazapine (30 mg) in treatment. Just one month later, another hospitalisation occurred. The patient reported persecutory delusions at the same time as denying hallucinations. Impulsive behaviour was evident in her behaviour, and she vividly addressed the topic of firearms and the realisation of suicidal thoughts during meetings. At the time, she frequently provoked unconsciousness by hyperventilating, including once on the ward. Due to her violence towards animals, lack of respect for the emotions of others, disregard for norms, low frustration tolerance and blaming others for being a source of conflict, she was diagnosed with mixed behavioural and emotional disorders – personality development towards dissocial personality. She was taking psychoactive substances on the ward, for which she was discharged. In 2021

she was hospitalised again after taking 30 dextromethorphan tablets, and 30 codeine tablets and having 0.23 per mil of alcohol in her blood. She was willing to talk to a psychologist, talking about self-harm and suicidal thoughts. Aripiprazole (15 mg) was still maintained in pharmacotherapy. She subsequently visited the Hospital Emergency Department (ED) twice for substance abuse.

Subsequent hospitalisation in the Department of Child and Adolescent Psychiatry for suicidal thoughts and self-harm was accompanied by delusions of thought-amplification, xobic-persecutory delusions, delusions of guilt, visual and auditory hallucinations, visual pseudo-hallucinations, reversal of circadian rhythm, racing thoughts, mood swings, and increased anxiety symptoms. The girl was also neglecting her hygiene at the same time. The family reports that in recent times she often sat in her room with the windows closed, talking to herself, and shouting vulgarities to the window. She claimed that someone was in the house looking for her while moving around the house with a knife. She created drawings with macabre content and poured red paint on the wall. In contact with a psychologist, her affect was inadequate, she showed cheerfulness, shortened her distance and talked about fantasies of using aggression on other people. The patient was diagnosed with bipolar disorder – a mixed episode with associated psychotic symptoms. Pharmacotherapy included aripiprazole (15 mg), olanzapine (20 mg), and risperidone in syrup form (4 ml), achieving mood equalisation and activation of the patient in the treatment group. She was then recommended to change the educational centre to an inpatient psychiatric treatment centre, but she remained in the MOW.

The K-SADS questionnaire ("The Kiddie Schedule for Affective Disorders and Schizophrenia") was administered to the patient in 2023, during a study to assess bipolar traits in alumnae of upbringing centres in Poland. At that time, the researchers' attention was particularly drawn to the fact that the patient was different in terms of the severity of her psychiatric symptoms – other female wards reported mainly symptoms of oppositional defiant disorder, while she scored high in terms of depressive symptoms (more often in the past), mania (especially grandiosity) and psychotic symptoms. She reported that 2–3 years ago she had auditory hallucinations (especially imperative hallucinations), visual hallucinations, tactile hallucinations, overt thoughts, and persecutory delusions and exposure and that currently she still sometimes has non-verbal auditory hallucinations, mostly coming "from outside" her head and persecutory delusions. The patient reported "the presence of three figures in herself" that correspond to her emotions. During the interview, she showed a shallow affect. She answered within the question line – short and unclear. She avoided eye contact. She made a lot of nervous movements and had difficulty concentrating. At one point in the interview, when it became apparent that there was another female ward in the room next door, she suddenly broke out crying and ran away. It turned out that she had a lot of trouble

relating to other girls at the centre, saying she was ridiculed and called "mentally ill." She recounted that she did not feel comfortable there. The centre gave the girl access to psychiatric consultations, which take place on average every three months. Psychotherapy was also tried, but she did not want to continue it.

For her most recent three-month hospitalisation at the beginning of 2023, the patient was referred from the Youth Educational Centre due to a sudden attack of aggression towards the educators. She also expressed thoughts of self-harm. On admission, she was intermittently tearful, verbal contact could not be established with her at first, her mood was volatile and her affect was pale. She denied suicidal thoughts, delusions and hallucinations. Neuroimaging (normal) and Diagnostic Personality Questionnaire (experimental version) was conducted on the ward, in which she scored very high on the schizophrenia scale, and her distinguishing features were eccentricity and isolation from other people. The patient adapted well to the ward, interacted with her peers, participated in activities and listened to instructions. No psychotic process or depressive/maniacal episode was observed in her. It was decided to discontinue the medications (aripiprazole and olanzapine) and no deterioration in the child's condition was observed. Further treatment in the Mental Health Outpatient Clinic and individual psychotherapy were recommended.

Discussion

Child and adolescent psychiatric care is a complex process because it involves not only the young patient but also his or her environment, including the family. Such care should take place comprehensively at different levels, depending on the state of the severity of the mental disorder. It should aim to maintain the patient in the home environment, the school environment and also among peers. The fact that a patient may behave aggressively is not necessarily related to his or her social maladjustment *per se* but may be a symptom of a mental disorder that, if properly treated, is capable of improving the patient's condition. Therefore, such a patient should not be isolated. Still, distressing features that may be prodromal features, such as schizophrenia or bipolar disorder, should be noted, and such a person could then be allowed to improve his or her mental state under conditions appropriate to the patient. Research indicates that symptoms of aggression and irritability are the most common symptoms of BPAD in the child and adolescent population, whereas in adults it is mainly cognitive impairment (Safer, Zito, & Safer, 2012; Van Meter, Burke, Findling, & Youngstrom, 2016). Schizophrenia is a disorder whose typical symptoms usually manifest at the beginning of the third decade of life. Still, they can already appear in children and adolescents, such as early-onset schizophrenia (EOS, early-onset of schizophrenia), which affects

people between 13 and 18 years of age. The most frequent prodromal symptoms of early-onset schizophrenia are cognitive decline, isolation, problems with peer relationships, problems in family relationships, current symptoms of anxiety or depression, bizarre behaviour, disruption of diurnal rhythms, obsessive-compulsive disorder, and irritability and/or aggressive behaviour (Shioiri, Shinada, Kuwabara, & Someya, 2007). In the patient in question, aggressive behaviour appeared at a very early age and preceded the onset of delusions and hallucinations. It was based on these symptoms that she was referred to MOW. At that time, however, certain symptoms could already draw attention to the fact that the patient might be manifesting early symptoms of BPAD. This girl was then displaying a grandiose attitude and lack of criticism, which is very characteristic of a manic episode, and self-injury may additionally indicate a mixed episode. However, these symptoms were somewhat "masked" by the behavioural and oppositional-rebellion disorders presented by the patient, such as disregard for norms (escapes from the centre), aggression attacks (knife attack on her mother), and – later on – aggression towards animals and substance abuse. At first glance, it may seem that these are just manifestations of the patient's social maladjustment and that the best choice for her would be the MOW. However, despite her stay in the Youth Educational Centre, the patient continued to be aggressive, and her subsequent hospitalisations were accompanied by quite specific self-harm (insertion of sharp objects into the vagina) and suicidal thoughts. The turning point turned out to be the hospitalisation in the psychiatric ward, during which the patient, in addition to suicidal thoughts, reported delusions and hallucinations, which are the basic symptoms of psychosis. In addition to that, she reported an inversion of her circadian rhythm, racing thoughts and mood swings, which led doctors to make a diagnosis of BPAD (mixed episode with psychotic symptoms). A change from MOW to a therapeutic centre was also suggested at that time, but for unknown reasons, the patient remained in MOW.

A diagnosis of bipolar disorder, especially with psychotic symptoms, is a diagnosis that has a not inconsiderable impact on the adolescent's life. In 90 % of people, after a manic episode, an affective episode reappears, and the psychotic symptoms accompanying the first episode make it more likely that the next episode will also occur with psychotic symptoms (Galecki et al., 2018). Bipolar disorder is a risk factor for suicide (Brent et al., 1988), especially in combination with substance use or conduct disorders (Brent, 1995). Many researchers have also shown an association between a poorer clinical course of psychotic disorders with early onset, particularly due to cognitive impairment, which may contribute to stunted child development (Rajewska-Rager, Rajewski, 2010). In addition, the early onset of bipolar disorder is associated with an increased risk of substance abuse, with up to 32% of young people with BPAD studied starting to abuse psychoactive substances (Goldstein et al., 2013). This problem also occurred in the presenting patient at an early age.

The difficulty is in spotting early features that may indicate the development of bipolar disorder or schizophrenia in the child and adolescent population. As many as 80% of paediatric patients with a diagnosis of BPAD in a study by Michal Goetz and colleagues (2015) were initially treated for a reason other than BPAD, such as depressive disorder, acute psychosis, adjustment disorder, intrusive thoughts and actions, BPAD, eating disorders, anxiety disorders, conduct disorders or personality disorders. The patient in question had also been hospitalised for maladaptive personality towards dissocial personality and eating disorders. Additionally, other psychiatric disorders often co-occur in BPAD the most common being ADHD, borderline personality, anxiety disorders, oppositional defiant disorder or conduct disorder, and substance abuse (Goetz et al., 2015). Regarding the last three disorders, the patient met their criteria according to the DSM-5 classification.

What is the management of such a young patient with a diagnosis of BPAD with psychotic symptoms? Clinical data on the safety of psychotropic drugs in children and adolescents are limited. The treatment of patients with early-onset schizophrenia or BPAD is mainly based on principles known and used in adults, and atypical neuroleptics, such as aripiprazole, which was used in the patient, are considered the safest drugs (Rajewska-Rager, Rajewski, 2010; Cichoń, Janas-Kozik, Siwiec, & Rybakowski, 2020). Regarding psychotherapeutic interactions, no psychotherapy method is considered the most appropriate for the treatment of BPAD, but family-centred therapy for adolescents and multifamily psychoeducational psychotherapy may be of greatest benefit (Fristad, MacPherson, 2014). Family-centred therapy for adolescents consists of 21 50-minute sessions that last for nine months, and aim to provide psychoeducation and strengthen communication skills (Goldstein et al., 2017). Multifamily psychoeducational psychotherapy is a group therapy for children with affective disorders and their parents and aims to provide psychoeducation, gain group support and develop social skills. In a study among children aged 8 to 12 years, even brief supportive psychoeducational multifamily group psychotherapy combined with pharmacotherapy was associated with a better prognosis than in patients without this form of psychotherapy (Fristad, Verducci, Walters, & Young, 2009). The process of psychiatric rehabilitation is an interaction of many factors, in which the appropriate patient environment is fundamental. Despite an appropriate diagnosis and the implementation of appropriate treatment, an unsupportive environment in which the patient resides can hinder improvement in mental status. Psychiatric rehabilitation programmes, which operate at hospitals, among others, help patients reduce their levels of fear and anxiety, cope better with stress and rules, establish interpersonal bonds and increase self-esteem (Pawłowska et al., 2015).

Mental Health Centres are another idea that can help people like the patient in the case described above. Their idea is to relieve the burden of inpatient forms of treatment

through deinstitutionalisation and to channel psychiatric treatment and social support into services organised in the patient's living environment. It is to improve the quality of life of adolescents and children experiencing a mental health crisis and their families through activities close to where they live. It keeps people with mental disorders in their environment, thus avoiding the stigma that is often encountered. However, the reality is not so ideal. In Poland, apart from a few regional initiatives of such centres, e.g., in Sosnowiec, there is a lack of similar interventions to help children and adolescents in mental crisis (Surma-Kuś, Pilawski, Siwiec, & Janas-Kozik, 2018).

Why was the patient still in MOW? Perhaps it was because the mental health care system for children and adolescents was not fully functioning. The fact that during her last hospitalisation, preceded by aggression towards the MOW educators, the patient was able to engage in community group activities, establish contact with others and listen to recommendations, thanks to appropriate environmental support on the ward, may indicate that her mental state may have improved. Her mental state also improved – she denied hallucinations, delusions and symptoms of affective disorder. Before her hospitalisation, she had said outright that she did not feel comfortable in the MOW, mainly due to other female pupils, by whom she was constantly ridiculed and stigmatised. This is not an isolated case. There are often people with mental disorders in such centres. A case in the media was that of a 16-year-old who was unable to adapt to an MOW due to his autism spectrum disorder and hearing impairment. The court placed him in an MOW due to "progressive demoralisation." The boy was ridiculed and even harassed and often did not understand the communication of his peers. Both specialists from the Autism Team Foundation, representatives of the Helsinki Foundation for Human Rights and psychologists from the MOW agreed that the centre where he was placed was not the place for him; as it was not adapted to people with such problems. The case of his referral there proceeded to court.

Conclusion

Unfortunately, in Poland, psychiatric consultations are not obligatory at the time of admission of a minor to an MOW, which means that they do not always take place despite obvious needs. As mentioned, as many as 83% of the directors of MOWs in Poland claim that access to specialised psychiatric care in their institution is difficult, which has an insignificant impact on the psychological condition of the pupils. Perhaps the imposition of such an obligation, e.g., in the first weeks of stay, would capture those who should not be sent there, and thus mentally disturbed young people could receive appropriate psychiatric care in a supportive environment. However, attention should be drawn to the nationwide nature of the problems

associated with the diagnosis and psychiatric care of children and adolescents, not only concerning the wards of educational or rehabilitation institutions but also a problem that is very often present among children and adolescents raised in so-called "normal" family environments.

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