

# White Paper: Introducing a Mental Health and Well-being Lens to the Continuum of Care in Europe and Central Asia

## Integrating Mental Health and Psychosocial Support into Family Support, Alternative Care, and Leaving Care Services

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On 24 September 2023, Sidra (10) hugs her grandfather Hassan (75) in her grandparents' garden, where the extended family now lives between three tents and two containers in Antakya, Hatay, Türkiye, after their homes were in February by the devastating earthquakes that struck southern Türkiye and Syria. Sidra spends time at the homes of both her father's parents, Hasan and Semiha, and her mother's parents. Hassan does his best to comfort his grandchildren, calming their fears of more earthquakes happening and telling them that things will improve. He says, "They don't always believe me, and always end up thinking about the earthquake again. The kids are always scared, remembering the quake. They don't sleep properly, or when there's a storm. They're just always asking about the earthquake to everybody on the phone."

## Acronyms and abbreviations

<b>ACEs</b>	Adverse childhood experiences
<b>CHIMES</b>	The Care-experienced children and young people's Interventions to improve Mental health and well-being outcomes Systematic review
<b>CBT</b>	Cognitive behaviour therapy
<b>ECARO</b>	Europe and Central Asia Regional Office
<b>EU</b>	European Union
<b>IASC</b>	Inter-Agency Standing Committee
<b>MHPSS</b>	Mental health and psychosocial support
<b>MHPSS MSP</b>	Inter-Agency Standing Committee <i>Mental Health and Psychosocial Support Minimum Service Package</i>
<b>SDQ</b>	Strengths and difficulties questionnaire
<b>PFA</b>	Psychological first aid
<b>PTSD</b>	Post-traumatic stress disorder
<b>TBRI</b>	Trust-based relational intervention
<b>TFC</b>	Therapeutic foster care
<b>TF-CBT</b>	Trauma-focused cognitive behavioural therapy
<b>TSI</b>	Technical support instrument
<b>UASC</b>	Unaccompanied and separated children
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>WHO</b>	World Health Organization

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## Executive summary

Children across Europe and Central Asia who are at risk of entering, currently in, or are transitioning out of alternative care experience significantly higher rates of mental health problems than their peers. Mental health problems among children and caregivers can drive child–family separation, undermine placement stability, and hinder successful reintegration. These realities underscore a central message of this paper: **mental health and psychosocial support (MHPSS) must be integrated throughout the continuum of care to improve outcomes for children, adolescents and caregivers.**

Despite widespread recognition of the need for mental health-sensitive services, governments and practitioners have lacked practical guidance on how to operationalize MHPSS across the continuum of care. This paper, developed by United Nations Children’s Fund Europe and Central Asia Regional Office (UNICEF ECARO), responds to that gap by introducing a *mental health and well-being lens* to child protection and care reform. It provides conceptual clarity, regional evidence, and actionable guidance for governments and UNICEF Country Offices to integrate promotion-, prevention-, and care-focused MHPSS into policy, service delivery, and workforce practice. It is grounded in a literature review and consultation with 18 UNICEF Country Offices and expert advisors.

### Key concepts

The paper adopts UNICEF’s [Global Multisectoral Operational Framework for MHPSS of Children, Adolescents and Caregivers Across Settings](#), defining MHPSS as the full range of promotion, prevention and care interventions that protect psychosocial well-being and address mental health conditions. A central message is that MHPSS is *everyone’s responsibility* — not only that of mental health specialists — and can be effectively integrated into the daily work of the social service workforce.

### Mental health needs across the continuum of care

1. **Children and adolescents in alternative care** experience higher rates of mental health problems and conditions, including depression, anxiety, post-traumatic stress disorder (PTSD), conduct disorders, reactive attachment disorder, and suicidality than the general population. These are linked to adverse childhood experiences (ACEs), attachment disruptions, and instability before and during alternative care.
2. **Parents and caregivers** along the continuum of care experience psychological distress that undermines caregiving quality and directly influences children’s well-being, protection and prospects of successful reintegration.
3. **Frontline workers across sectors** face chronic stress, burnout and secondary trauma affecting workforce well-being, retention and service quality. As a result, workforce well-being is both an ethical responsibility and a prerequisite for high-quality, stable care systems.
4. **At-risk groups**, including children with disabilities, those affected by gender-based violence, minority ethnic groups, refugees and asylum seekers, and children at risk of coming into or in conflict with the law, face overlapping vulnerabilities requiring tailored MHPSS approaches.
5. **Humanitarian contexts**, such as the conflict in Ukraine and regional displacement, amplify the mental health risks of children, caregivers, and professionals, necessitating the integration of MHPSS into emergency child protection responses.

### Applying a mental health and well-being lens

The paper highlights the importance of prioritizing MHPSS to prevent child–family separation and at high-risk ‘flashpoints’ where mental health needs often escalate, such as entry into alternative care,

placement changes, exposure to violence, family reunification, and transitioning to independent living.

It outlines practical steps that governments and partners can take to integrate MHPSS principles and practices across the continuum of care (family support, alternative care, reunification, and transition to independent living), including:

- **Trauma-informed, participatory, strength- and resilience-based approaches** that prioritize safety, trust and empowerment.
- **Culturally safe, inclusive and gender-responsive programming** to reduce disparities and stigma.
- **Systematic screening, assessment and referral mechanisms** embedded within case management
- **Cross-sectoral coordination** between child protection, health, education, justice and community services, and **coordination between youth and adult services** to ensure continuity of care and equitable access.
- **Capacity strengthening and well-being support** to the social service, MHPSS specialist, and multisectoral workforces.
- **Evidence generation, policy alignment and sustained funding** to support continued progress.

## Mental health and psychosocial support activities across the continuum of care

The paper identifies a range of evidence-informed MHPSS activities that can be applied across the continuum of care, according to the needs of children, caregivers and families:

- **Universal promotion and prevention activities** target *all* children and caregivers with activities such as psychoeducation, parenting support, social and emotional learning, peer support, and other initiatives that build resilience, coping skills and supportive relationships.

- **Focused, non-specialized care** addresses emerging or moderate mental health needs through structured group interventions, family strengthening programmes, and other scalable psychological activities delivered by trained non-specialists, including the social service workforce.
- **Specialized care** is required for children and caregivers with significant mental health conditions and includes psychotherapeutic interventions and psychiatric care delivered by mental health specialists.

Across all levels, MHPSS activities must be adapted to reflect individual needs, disability inclusion requirements, cultural and linguistic contexts, and the realities of different care settings. **Importantly, within residential care, MHPSS should support – but never replace – progressive deinstitutionalization and the transition towards family-based alternatives.**

## Mental health and psychosocial support in humanitarian contexts

In humanitarian emergencies, including conflict and displacement, children and caregivers face heightened distress and increased risks of child–family separation. The paper emphasizes that MHPSS in these contexts should prioritize **preventing child–family separation** by supporting caregiver mental health, restoring parenting capacity, and strengthening family and community coping mechanisms.

MHPSS should be embedded within emergency child protection and family support services across the continuum of care, with targeted support for children exposed to trauma and for caregivers under acute stress. Where separation cannot be avoided, children should be placed in family- and community-based alternative care, with sustained psychosocial support for kinship and foster families. Ensuring continuity and coordination between humanitarian responses and national care systems is critical, as is supporting the mental health and well-being of frontline responders.

## Key recommendations

The paper calls on governments, with support from UNICEF Country Offices and other partners, to:

1. Prioritize MHPSS as part of early intervention and family support to prevent child–family separation.
2. Ensure all children and caregivers in alternative care, and those leaving care, have access to appropriate promotion, prevention, and care-oriented MHPSS.
3. Address the harms of residential care through progressive deinstitutionalization supported by, but never replaced with, MHPSS.
4. Strengthen coordinated and multidisciplinary service delivery across sectors and across the life course.
5. Equip the social service workforce with core MHPSS competencies and sustained supervision.
6. Build the capacity of MHPSS specialists and multisectoral professionals to respond to the needs of children and caregivers across the continuum of care.
7. Invest in the mental health and well-being of the workforce at agency, supervisory, peer and individual levels.
8. Integrate MHPSS within humanitarian preparedness and response for children and caregivers across the continuum of care.
9. Strengthen research, data and evidence generation on MHPSS across the continuum of care.
10. Embed MHPSS principles in policy, legislation, funding, awareness and communications, and accountability frameworks.

## Conclusion

Integrating MHPSS across the continuum of care in Europe and Central Asia is essential for high-quality care reform which ensures the rights of the child. A mental health and well-being lens can help to strengthen families and prevent separation, support stable and nurturing family-based alternative care, enable safe and sustainable reintegration, and prepare young people for independent living.

# **1. Background and context: Mental health and psychosocial support along the continuum of care in Europe and Central Asia**

## 1.1. Background and rationale

Mental health and well-being should always be a core consideration for services that prevent child–family separation, support children and their caregivers in alternative care settings, and assist children and young people leaving care through family reunification or their transition to independent living. Across the continuum of care (see Box 1), children and adolescents, and their parents and caregivers, experience higher levels of mental health problems than their peers in the general population. At the same time, mental health problems among both children and their parents and caregivers are directly associated with children entering alternative care placements (See Box 4). Having entered alternative care, children continue to experience high levels of distress and mental health problems, which not only affect children in residential care,<sup>1</sup> but also those in family

and community-based alternative care,<sup>2</sup> as well as their caregivers.<sup>3</sup> Mental health problems are also a pervasive challenge for children who leave alternative care to be reunified with their families<sup>4</sup> and for adolescents who transition from alternative care to independent living.<sup>5</sup> Children who have been in alternative care have higher rates of suicide attempts<sup>6</sup> and deaths by suicide<sup>7</sup> than their peers in the general population. As demonstrated by a recent evaluation of the care reform process in Europe and Central Asia, failure to address mental health problems across the continuum of care not only has potential to affect children throughout their lives, but may also negatively impact on their own future parenting capacity, contributing to an intergenerational cycle of increased mental health problems and child–family separation.<sup>8</sup>

### Box 1. Defining the continuum of care and related key terms

The **'continuum of care'** refers to the full range of services and interventions for children and adolescents, and their parents and caregivers, in situations where children are at risk of removal or have been removed from parental care. These include:

- Early intervention, [family support](#) and child protection services to prevent child-family separation.<sup>9</sup>
- Family and community-based alternative care, such as kinship care and [foster care](#).<sup>10</sup>
- Residential alternative care including [small-scale residential care with individualized support](#)<sup>11</sup> and large-scale residential care.<sup>12</sup>
- The reintegration of children from alternative care into their biological families.<sup>13</sup>
- Services for adolescents transitioning out of alternative care into independent living.<sup>14</sup>

A **parent** is a child's biological mother or father, or another adult who has legally adopted the child, while a **caregiver** is a broader term for those responsible for the care of children and adolescents, including family members such as mothers, fathers, grandparents, siblings and others within an extended family network (including kinship carers). The term also includes non-family members who play a caregiving role, such as foster carers and residential care professionals.

To meet these needs, **mental health and psychosocial support (MHPSS)** (see Box 2) must be part of a multi-layer package of critical support for children, adolescents, their caregivers, and practitioners across the entire continuum of care. Mental health challenges affecting children and caregivers are both a cause and a consequence of

child–family separation, highlighting the critical importance of early, prevention-focused MHPSS for families at risk. Evidence-based MHPSS activities for children – and their caregivers and families – who are already in alternative care, and those transitioning out of alternative care, are similarly vital.

### **Box 2. Defining mental health and psychosocial support (MHPSS)**

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental health conditions.<sup>15</sup> A common misconception is that MHPSS refers only to the treatment of individuals with diagnosed mental health conditions, and therefore must be delivered exclusively by specialists such as clinical psychologists, psychiatrists or physicians. **In reality, MHPSS is relevant to all children and families across the continuum of care.** Most children will experience distress linked to adversity, instability, or potentially traumatic experiences before and during their time in alternative care; however, only a minority will develop a diagnosable mental health condition. While specialized care remains a vital component of MHPSS, of equal importance are the promotion and prevention activities that support well-being and help reduce the risk of mental health problems developing or worsening among all children and caregivers. These activities, such as providing safe and nurturing relationships, strengthening positive coping methods, supporting caregivers, and referring for further care, can be delivered effectively by non- MHPSS specialists, including members of the social service workforce. **In this way, MHPSS is best understood as a shared responsibility of all providers working with children and families,** not solely the domain of mental health specialists.

Nearly half a million children in countries across Europe and Central Asia live in residential care facilities.<sup>16</sup> In recent decades, many European and Central Asian countries have pursued a ‘care reform’ agenda, attempting to reduce the number of children living in harmful residential care by closing such facilities, and instead developing stronger family support services to prevent separation, as well as providing family and community-based alternative care.<sup>17</sup> MHPSS has

a key role to play in care reform by helping to prevent child–family separation, strengthening family-based care alternatives to residential care, and by supporting children who are leaving care. This paper proposes that this agenda can be accelerated by integrating MHPSS across the entire continuum of care (including for children in residential care, while *never* becoming a substitute for deinstitutionalization).

### Box 3. Child rights and family life

A number of international instruments uphold children's rights in regard to family life:

- The United Nations Convention on the Rights of the Child asserts that children should “grow up in a family environment, in an atmosphere of happiness, love and understanding”. Where this is not possible, States should ensure alternative care.<sup>18</sup>
- The Convention on the Rights of Persons with Disabilities recognizes that “children with disabilities have equal rights with respect to family life” and that “where the immediate family is unable to care for a child with disabilities, [States must] undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting”.<sup>19</sup>
- The United Nations ‘Guidelines for the Alternative Care of Children’ assert that all efforts should be directed towards enabling children to remain with or return to the care of their parents, or where appropriate, other close family members. When this is not possible, even with support, the Guidelines call for States to provide alternative care to protect children’s rights and ensure their best interests.<sup>20</sup>

Many European and Central Asian countries also grapple with the need to support children, adolescents and families along the continuum of care in humanitarian contexts. Continuum of care services are important pillars of the emergency response to the conflict in Ukraine, as well as in other countries supporting Ukrainian refugees. Similar services are provided to refugee and migrant children and families arriving in the region who have travelled from Africa, the Middle East and South Asia, and children and families repatriating to the region from Iraq and Syria. Many of these children, adolescents, and families have experienced highly stressful and potentially traumatic events which significantly increase their risk of mental health problems, including conditions such as post-traumatic stress disorder (PTSD).<sup>21</sup>

While there is broad consensus that MHPSS should be integrated across the continuum of care, governments and practitioners have called for more guidance on how to do this.<sup>22</sup> UNICEF’s [Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings](#) similarly calls for those working in social welfare and child protection to become more ‘MHPSS-sensitive’ in their work, and for a scaling up of high-quality

MHPSS interventions in both development and humanitarian contexts. This paper is designed to support countries in responding to these calls.

The paper is primarily written for governments and the social service workforce who are working across the continuum of care (although it may also benefit other actors such as civil society organizations and MHPSS professionals). It is relevant to decision makers who design and mandate systems and services, as well as practitioners who develop and implement these services. Although the focus is on the child protection and social service systems, this paper highlights the importance of a multisectoral approach to MHPSS to support children in alternative care and includes considerations designed to strengthen MHPSS across sectors, including attention to the role of the health sector. This paper proposes that continuum of care professionals can strengthen MHPSS through 1) clarity on what constitutes MHPSS; 2) better understanding of the MHPSS needs of children, caregivers and service providers across the continuum of care; 3) applying a ‘mental health and well-being lens’ to social services and strengthening workforce capacity; 4) implementing MHPSS promotion, prevention, and care activities; and 5) adapting these considerations for emergency

contexts. The following sections of this paper address each of these areas in turn. They also respond to specific questions and challenges raised by UNICEF Country Offices in Europe and Central Asia, including difficulties their government counterparts are facing in providing MHPSS.

## 1.2. Methodology

To develop this paper, UNICEF's Europe and Central Asia Regional Office (ECARO) set out to understand the mental health needs of children and adolescents, their parents and caregivers, and the social service workforce across the continuum of care services in Europe and Central Asia. UNICEF also explored the organizational and systems-level challenges faced by UNICEF Country Offices and governments in integrating and delivering MHPSS services, while identifying examples of good practice to address these needs. The following research activities were conducted:

1. *A literature review* of academic and grey literature including academic articles, evaluations, government and civil society reports, and intervention model websites to understand mental health and systems-level needs and good practice across the continuum of care services, with a particular focus on the Europe and Central Asia region.
2. *An online survey* with UNICEF Europe and Central Asian Country Offices concerning MHPSS services being delivered along the continuum of care services in their countries. Eighteen UNICEF Country Offices responded: Albania, Armenia, Belarus, Bulgaria, Croatia, Czech Republic, Italy, Kazakhstan, Moldova, Montenegro, North Macedonia, Poland, Romania, Slovakia, Türkiye, Turkmenistan, Ukraine and Uzbekistan.
3. *Key informant interviews* with staff in nine UNICEF Country Offices (Armenia, Croatia, Kazakhstan, Moldova, Poland, Romania, Turkmenistan, Ukraine and Uzbekistan) to attain a deeper understanding of mental health needs and MHPSS being delivered along the continuum of care services in their countries.
4. *Early research findings were presented at regional conferences* in Tashkent, Uzbekistan (Forum on Building Resilient Communities in Central Asia – Fostering Child, Youth, Women and Family Wellbeing Through Social Work and Social Services, September 2024), and Zagreb, Croatia (CARE 2024: Transforming Childcare Across Europe, September 2024), inviting constructive feedback and dialogue with participants.
5. *An expert reference group* was convened with representatives from UNICEF Country Offices across Europe and Central Asia, UNICEF ECARO and UNICEF Headquarters, as well as external organizations and academic institutions with technical expertise in the areas of care reform and MHPSS. The Group reviewed and provided invaluable written and verbal feedback on draft versions of the paper.

## 1.3. Structure of the paper

During the consultation for this paper, UNICEF Country Offices across the Europe and Central Asia region highlighted questions and challenges they and their government counterparts are facing in providing MHPSS across the continuum of care. These questions and challenges frame the structure of the paper, as follows:

### **Section 2: What is mental health, well-being, and mental health and psychosocial support?**

aims to clarify what constitutes MHPSS by concisely defining key MHPSS terminology, and outlining frameworks and conceptual models. Further information on MHPSS concepts, communication guidance, and relevant MHPSS policy frameworks is available in Appendix 1.

### **Section 3: What are mental health and well-being needs across the continuum of care?**

draws from the social ecological framework to provide an overview of the mental health and well-being of children (including at-risk groups), caregivers, and service providers across the continuum of care.

**Section 4: How can the social service workforce apply a mental health and well-being lens across the continuum of care?** explores the question of how European and Central Asian governments – with support from UNICEF Country Offices – can integrate a mental health and well-being lens into social service delivery along the continuum of care, and how to support the workforce to develop necessary capacity (a detailed training framework is provided in Appendix 2).

**Section 5: What mental health and psychosocial support activities can be used across the continuum of care?** provides a short overview of specific evidence-based MHPSS activities designed to support children and their caregivers along the continuum of care, with a more detailed description available in **Appendix 3**. These include promotion and prevention activities which can be implemented by the broader social service workforce, and specialized interventions that should be implemented by MHPSS professionals. This section also includes considerations for MHPSS for at-risk groups, children in residential care, and care leavers.

**Section 6: How can mental health and psychosocial support be used across the continuum of care in emergency contexts?** considers mental health reactions in emergency settings and good practices for addressing these needs.

**Section 7: Conclusion and recommendations: Mental health and psychosocial support across the continuum of care.** This section concludes with key learning points and recommendations for practitioner and policy maker audiences.

Throughout these sections, case studies and examples from the Europe and Central Asian region have been included to illustrate what MHPSS looks like in practice. Links to key resources and tools have also been included throughout the paper.

It is important to note that this publication should not be considered as a comprehensive guide to MHPSS across the continuum of care services. Rather, it provides an introduction to this complex topic with the aim of supporting professionals – including those developing programmes and policies, and those in direct support roles in early intervention, family support services, children's care and the wider social service workforce – to include MHPSS considerations in their work. When designing and implementing MHPSS within these areas of work, additional support from MHPSS technical experts may be needed.

## **2. What is mental health, well-being, and mental health and psychosocial support?**

Consultations with UNICEF Country Offices<sup>23</sup> highlighted a lack of clarity in some settings regarding what constitutes MHPSS, who needs or benefits from MHPSS, and what types of service providers can deliver MHPSS. To further clarify the meaning and purpose of MHPSS, this section outlines key MHPSS terms and conceptual models used throughout the paper.

## 2.1. Key definitions and conceptual models: The mental health and well-being continuum

UNICEF's [\*Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings\*](#) provides an essential foundation for shaping UNICEF's approach to MHPSS. The framework outlines key terms and concepts, including **mental health**, which is defined as follows:

Mental health encompasses people's emotional, psychological and social wellbeing. It affects how they think, feel and act, and determines how they handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Good mental health is defined as a state of well-being in which individuals realize their own potential, can cope

with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their communities.

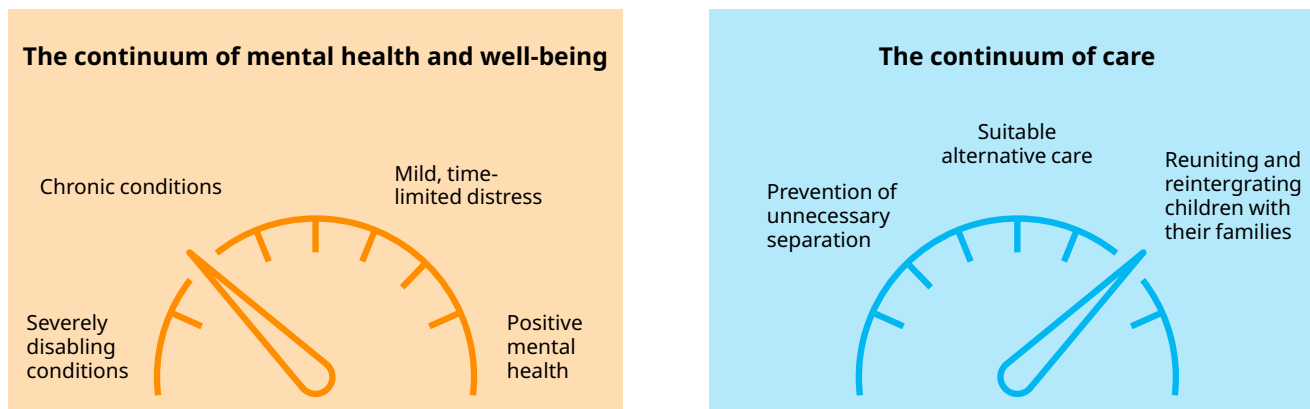
Good mental health is related to mental and psychosocial well-being. UNICEF's work to improve the mental health of children, adolescents, families and communities includes the promotion of mental health and psychosocial well-being; the prevention of mental health conditions; the protection of human rights; and the care of children, adolescents and caregivers affected by mental health conditions.<sup>24</sup>

The *Framework* defines **well-being** as:

... a positive state of being when a person thrives. In children and adolescents, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child's or adolescent's ability to grow, learn, socialize, and develop to her or his full potential.<sup>25</sup>

The **mental health and well-being continuum**<sup>26</sup> ranges from positive mental health to long-term and severely disabling mental health conditions. Children in care and protection may experience mental health reactions across the continuum of mental health and be at any part of the care continuum (see Figure 1).

**Figure 1. The continuum of mental health and well-being and the continuum of care**



Source: adapted from United Nations Children’s Fund, Andalusia Regional Government and the European Commission, Integrated Collaboration Framework for mental health and wellbeing support of children in the care and protection system in Andalusia, UNICEF, Geneva / Seville / Brussels, 2026.

Everyone sits somewhere on the mental health and well-being continuum, and most people move along it at some stage – from experiencing good mental health to anything from short-term distress to a long-term mental health condition. This includes common reactions to stressors and adversity faced prior to and while in alternative care, such as sadness, anxiety, irritability and sleep difficulties, which individuals may recover from with basic support.

## 2.2. Mental health and psychosocial support

The Framework defines **MHPSS** as:

A composite term used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing or prevent or treat mental disorders. Originally coined by the Inter-Agency Standing Committee (IASC) MHPSS reference group for use in emergency settings, this term is now widely accepted and used by UNICEF and partners across settings to safeguard the dynamic relationship between psychological aspects of experience (a person’s thoughts, emotions, feelings and behaviour), the wider social experience (relationships, traditions), and values and culture.<sup>27</sup>

Although UNICEF and many other agencies tend to use the composite term ‘MHPSS’, in some settings, ‘mental health’ support or services may be more easily understood, and in this case can be used instead of MHPSS.

MHPSS encompasses promotion, prevention and care approaches.

### Universal promotion and prevention approaches

target all children and caregivers, regardless of their specific mental health needs.

**Promotion** is focused on enhancing protective factors, including the strengths, capacity and resources of individuals and communities to enable them to increase control over their mental health, create meaning and purpose, and therefore promote positive well-being;<sup>28</sup> while prevention entails reducing the incidence, prevalence and severity of mental health conditions.<sup>29</sup>

**Care** approaches are designed to support children and caregivers with existing mental health problems. These include **focused care**, such as scalable psychological curricula, which can be facilitated by non-MHPSS specialists with training and supervision, as well as **specialized care**, provided by MHPSS specialists such as psychiatrists and clinical psychologists. Specialized interventions

include psychotherapy and psychotropic medications, and are designed to support those with mental health conditions that significantly impede functioning.<sup>30</sup>

As mentioned earlier, **MHPSS is relevant for all children and caregivers across the continuum of care.** All children and caregivers can benefit from promotion activities (for example activities that foster positive mental health and well-being, including promoting healthy lifestyles, building life skills, and creating supportive environments). Some will benefit from prevention activities (for example psychoeducation to help cope with distress). A smaller number of children and caregivers may have more significant or ongoing mental health problems and can benefit from focused or specialized care interventions.

Historically, there has often been the assumption that mental health services are specific to care or treatment of people with mental health conditions. **However, promotion and prevention activities are equally critical and require prioritization.** This is a key consideration for children and families across the continuum of care, who are often at increased risk of mental health problems (discussed further in the following section). Utilizing promotion and prevention activities can help to support such children before mental health problems become acute and require specialized care, thus reducing distress and preserving resources. In some cases, such approaches may also prevent child–family separation.

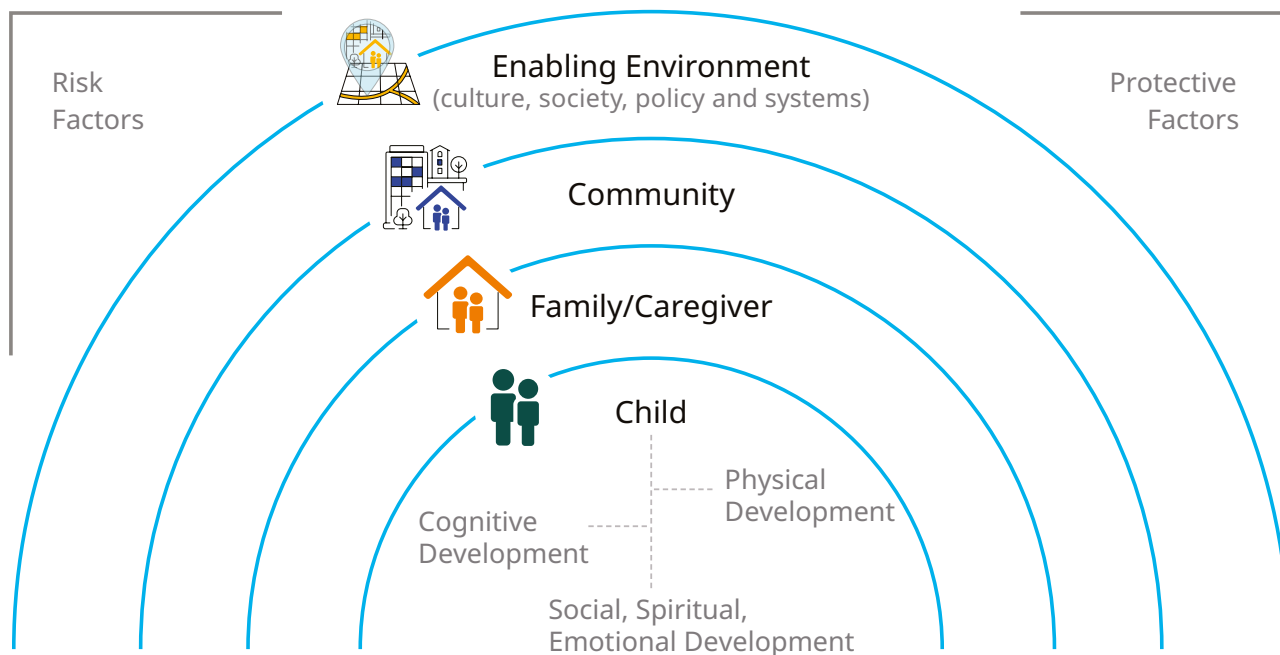
## 2.3. Mental health and psychosocial support and the social ecological model

The social ecological model covers four domains, within which risks and protective factors exert influence over children and adolescents along the continuum of care, affecting their mental health and well-being.<sup>31</sup> These domains are as follows:

- 1. Children and adolescents:** This concerns the child's own knowledge, attitude and behaviour, which are associated with their cognitive, physical, social, spiritual and emotional development.
- 2. Parents, caregivers and wider family:** This concerns the child's parents, caregivers and wider family members.
- 3. Community:** This concerns the formal and informal rules, practices, characteristics and ethos of organizations and social institutions with which the child is connected, such as social workers, health workers, MHPSS service providers, and schools.
- 4. Enabling environment:** This concerns cultural and societal values, and the relationship between institutions and these wider networks. It also concerns local, regional and national laws and policies, as well as other societal systems and structures, which have an impact on the child and their caregivers.

The social ecological model highlights how important it is for MHPSS initiatives to target all four domains, in order to achieve better outcomes for children and families.

**Figure 2. The social ecological model.**



Source: Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings.

Other key concepts are discussed further in [Appendix 1](#), including:

- The **Inter-Agency Standing Committee (IASC) Intervention Pyramid**, which categorizes mental health interventions into four levels, from universal and selective prevention to focused and specialized care. The pyramid's structure illustrates that while most people benefit from basic services (for instance safe housing, food, and social support), a smaller portion will require more focused or specialized interventions, such as psychotherapy or psychiatric treatment.
- The **life course approach**, which emphasizes that mental health and well-being must be understood through the lens of developmental stages, and that MHPSS must be responsive to the evolving needs and vulnerabilities of children and families throughout different phases of life.
- Guidelines for **communicating about mental health and well-being**, which demonstrate a move away from overly medicalized and stigmatizing language towards strength-based, clear, and culturally sensitive communication. Using terms like 'distress' or 'adverse experiences' instead of 'trauma' and avoiding diagnostic language unless professionally confirmed helps reduce stigma, empower communities, and support recovery through accessible and appropriate services.
- **Policy frameworks** legitimizing and guiding MHPSS implementation in Europe and Central Asia. These include the Astana Declaration,<sup>32</sup> European Union (EU) and Council of Europe strategies on children's rights,<sup>33</sup> the World Health Organization (WHO) European framework for action on mental health,<sup>34</sup> and the European Commission's comprehensive mental health approach.<sup>35</sup> These frameworks emphasize integrated care, early intervention, accessibility, and combating stigma, signalling growing international consensus on the importance of mental health and well-being for overall human development.

### **3. What are mental health and well-being needs across the continuum of care?**

This section draws on the social ecological model introduced above to provide an overview of the mental health and well-being of children and adolescents, parents and caregivers, and service providers across the continuum of care. This sets a foundation for the remainder of the paper, which proposes how these needs can be met.

### 3.1. Mental health and well-being of children and adolescents along the continuum of care

Mental health problems in early life are predictive of later outcomes, shaping the long-term well-being and development of individuals.<sup>36</sup> Pregnancy, infancy, and early childhood represent critical developmental windows in which children's experiences, and the well-being and caring capacity of their caregivers, can have lasting effects that extend into adulthood.<sup>37</sup> Adolescence is another pivotal stage: many mental health problems emerge or intensify during this period of transition from childhood to adulthood.<sup>38</sup>

In the EU, an estimated 11 million children and young people aged 19 and younger (13 per cent) experience mental health problems. Prevalence rises with age, from around 2 per cent of children under the age of 5 to around 19 per cent of young people aged 15 to 19.<sup>39</sup> Globally, at least one in five adolescents experience mental health problems in any given year, but these often go undetected, sometimes because adolescents may be reluctant to report mental health problems to caregivers or professionals.<sup>40</sup> Common mental health problems among adolescents include anxiety, depression, eating disorders, and substance misuse,<sup>41</sup> with some experiencing self-harm and suicidal ideation.<sup>42</sup> Suicide is the second most common cause of death (after traffic accidents) among young people aged 15 to 19 in the EU, accounting for approximately one in six deaths among this age group.<sup>43</sup>

Children and adolescents in alternative care, as well as those reunified with their families or who are leaving care, experience even higher levels of mental health problems than their peers in the general population.<sup>44</sup> Most of these children experience some degree of distress at different points in their lives, often linked to prior adversity or current stressors, and may move back and forth along the mental health continuum as they develop. Yet, despite these challenges, many children function well in daily life and demonstrate significant resilience. With supportive relationships, stable environments, and access to social, cultural and programmatic resources, children and adolescents in alternative care frequently show strong adaptive capacities and strengths.

A smaller proportion of children experience more severe or persistent mental health conditions that substantially affect functioning at home, in school, and in their peer relationships. A recent systematic review found that children in foster care have higher rates of mental health conditions compared to their peers in the general population, and that the most common diagnoses include oppositional defiant disorder / conduct disorder, major depressive disorder, PTSD, and reactive attachment disorder.<sup>45</sup> Children in foster care also have higher rates of suicidality than children in the general population. These difficulties can extend into adulthood, with care-experienced adults experiencing elevated mortality linked to mental health challenges, self-harm, and suicide.<sup>46</sup> Nonetheless, children and adults with chronic or disabling conditions can benefit greatly from specialized mental health services (provided by clinical psychologists and psychiatrists) and, with appropriate, sustained support, many recover, achieve stability and thrive.

The reasons why children experience high rates of mental health problems before, during and after being in alternative care are complex and vary widely across individuals. However, evidence consistently highlights strong associations between mental health difficulties, attachment problems, and adverse childhood experiences (ACEs).

**Attachment problems:** Early childhood is a critical period for brain development, during which children are especially sensitive to their caregiving environments.<sup>47</sup> Secure attachment to a primary caregiver is a key protective factor for supporting healthy neurodevelopment, emotional regulation, and the capacity to cope with stress. When secure attachment is lacking or disrupted, due to neglect, inconsistent caregiving, or early separation, a child's neurodevelopment may be compromised, heightening sensitivity to environmental stressors and weakening the brain's ability to regulate emotions and behaviour. Over time, these disruptions can manifest as internalizing problems (such as anxiety and depression), externalizing behaviours (such as aggression, substance misuse, disordered eating, risky sexual behaviour, and suicidal ideation),<sup>48</sup> or other attachment-related conditions. Research suggests a bi-directional relationship between attachment difficulties and psychological problems: poor attachment can increase mental health risks, while children's emotional and behavioural difficulties may, in turn, strain or disrupt the caregiver-child attachment bond.<sup>49</sup> Attachment problems are particularly common among children who have spent their early years in residential care<sup>50</sup> and may also develop in family-based care settings marked by disrupted, unresponsive or inconsistent caregiving.<sup>51</sup>

**Adverse childhood experiences (ACEs):** ACEs are highly stressful or potentially traumatic events occurring before the age of 18 that can increase the risk of mental health problems later in life.<sup>52</sup> Common ACEs include abuse, neglect, parental mental health problems or substance misuse, domestic violence, imprisonment of a family member, and parental separation. In Europe, around 40 per cent of individuals are estimated to have suffered at least one ACE while growing up, with 20 per cent having experienced multiple ACEs.<sup>53</sup> Children in alternative care have often experienced higher than average levels of ACEs prior to being in alternative care,<sup>54</sup> and they may continue to experience adversity while being in alternative care.<sup>55</sup> Research has consistently linked ACEs to depression, suicide attempts, substance

misuse, teenage pregnancy, and poor physical health,<sup>56</sup> with the risk of mental health problems increasing exponentially with the number of ACEs experienced.<sup>57</sup> Reducing exposure to ACEs, including through early intervention, family support, and safe, stable caregiving, has a direct and measurable impact on reducing mental health difficulties.<sup>58</sup>

Mental health challenges linked to ACEs and attachment issues also connect to wider social problems, such as school and peer difficulties, family violence, criminality, poverty, and unemployment.<sup>59</sup> These factors heighten risk of child protection intervention and family breakdown, sometimes leading to a child being placed in alternative care.

**Mental health and the alternative care experience.** While experiences before being placed in alternative care contribute heavily to children's mental health problems, the experience of entering and living in alternative care also has significant effects. Removal from harmful environments, such as those associated with exposure to ACEs or attachment difficulties, can bring long-term benefits. However, even when removal is in the child's best interest, the transition into alternative care often brings new challenges. Disrupted or temporary relationships with caregivers,<sup>60</sup> the quality and consistency of care provided,<sup>61</sup> and the stigma associated with being in alternative care<sup>62</sup> can all negatively impact on mental health and well-being. Still, longitudinal studies show improvements in mental health among some children in alternative care, particularly when high-quality, stable, and nurturing care is provided, emphasizing that outcomes depend less on the status of being in alternative care and more on the quality of care received.<sup>63</sup>

The type of alternative care placement also matters. Children in kinship care generally experience better mental health outcomes than their peers in foster care,<sup>64</sup> while children in residential care are at highest risk of mental health problems.<sup>65</sup> The institutionalization of children in residential care is

shown to impede physical and mental health and well-being and cognitive function, due to an absence of consistent nurturing relationships and individualized attention.<sup>66</sup> It is particularly associated with attachment problems which can result in later mental health and behavioural problems. The longer the time spent in residential care, the more significant these problems become, including long-term symptoms of anxiety and depression and cognitive delay. **While highlighting the severe harms of residential care compared to family-based care is important for deinstitutionalization efforts, it is crucial to recognize that all children in alternative care, regardless of the type, have increased mental health problems overall in comparison to the general population.** In summary, both pre-alternative care and in-alternative care experiences contribute to a cycle of mental health difficulties for children and adolescents.<sup>67</sup>

**Transitioning out of care.** Young people leaving care face many of the same underlying risk factors discussed above, but the process of leaving care and adjusting to independent living adds additional pressures.<sup>68</sup> Challenges such as unemployment, housing insecurity and financial difficulties can trigger or worsen distress.<sup>69</sup> Mental health problems may in turn further undermine the ability to secure employment and gain financial security, creating a cycle of disadvantage.<sup>70</sup>

**Reintegration with families.** Children reintegrating into their families after being in alternative care also face distinct risks. Outcomes are strongly influenced by experiences before and during alternative care,<sup>71</sup> as well as the quality of preparation and support provided to the family during the reintegration process.<sup>72</sup> Unaddressed issues, such as previous abuse, neglect, or placement instability can undermine reintegration.<sup>73</sup> Without appropriate support, children with mental health problems are more likely to re-enter alternative care.<sup>74</sup> For children harmed in a family environment, reunification may worsen mental health compared to remaining in alternative care,<sup>75</sup> emphasizing the importance of

fully addressing reasons for placement in alternative care before reunification. At the same time, for some children, the prospect of reunification provides hope, strengthens identity and belonging, and can support positive outcomes when carefully planned and supported.<sup>76</sup>

### 3.2. At-risk groups across the continuum of care: Gender, disability, and children at risk of entering the justice system

While all children across the continuum of care are likely to experience some level of distress, certain groups face heightened risk of more significant or persistent problems. These include children who have been victims or witnesses of violence, including gender-based violence, children with disabilities, children with complex emotional and behavioural needs at risk of coming into conflict with the law, and children from minority, migrant, refugee, asylum-seeking, and other discriminated groups, including unaccompanied and separated children (UASC).

Children and their caregivers may experience multiple and intersecting risks, leading to overlapping causes of discrimination, disadvantage and harm, and requiring coordinated involvement from several services.<sup>77</sup> While a comprehensive overview of the mental health needs of children who are part of at-risk groups is beyond the scope of this paper, some pertinent considerations are provided below.

#### Gender

A gender lens is essential to understanding the drivers of mental health problems, patterns of help-seeking, and barriers to accessing care.<sup>78</sup> UNICEF and WHO recognize gender as a critical determinant of mental health, noting that gender inequalities and restrictive social norms often shape roles and responsibilities in ways that limit opportunities, restrict behaviour, and constrain expectations and self-expression, all of which can negatively influence mental health and well-being.

Research from Europe and Central Asia shows clear gendered patterns in adolescent mental health, with some evidence showing that girls are at increased risk of mental health problems in comparison to boys.<sup>79</sup> Adolescent girls are more prone to internalizing mental health symptoms, such as symptoms of depression and anxiety, while boys are more likely to exhibit externalizing behaviours, such as behavioural problems.<sup>80</sup> Within the alternative care system however, some evidence suggests slightly higher rates of mental health problems among boys than girls,<sup>81</sup> possibly because externalizing behaviours are more readily identified and referred in alternative care settings.

Gender norms may also impact help-seeking and access to services. Some evidence from Europe suggests that adolescent boys have less knowledge about mental health services than girls, and are less likely to access services in some settings.<sup>82</sup> Likewise, some parents reportedly find it harder to accept mental health support for their sons than for their daughters.<sup>83</sup> Conversely, in some settings, women and girls may face structural or cultural barriers that limit their access to services of all kinds, including MHPSS.<sup>84</sup>

Gender-based violence poses major risks across the continuum of care, with devastating effects on the physical and mental health of children and adolescents. Evidence shows that girls in alternative care and children with disabilities and diverse gender identities and sexual orientations face heightened risk of sexual violence, exploitation, and abuse.<sup>85</sup> Aspects of alternative care settings, such as inadequate safeguarding policies, unsafe physical environments, and insufficient staff training can increase risk. This issue, including recommended strategies to integrate consideration of gender-based violence into care systems, is discussed in detail in UNICEF ECARO's forthcoming technical guidance on 'Gender-based violence and the alternative care system'.<sup>86</sup>

### **Children from cultural and ethnic minority groups, including refugees, asylum seekers, and unaccompanied and separated children**

Across Europe and Central Asia, children from ethnic minorities and migrant, refugee, and asylum-seeking communities often face elevated risks of child–family separation and are overrepresented in alternative care.<sup>87</sup> These risks are shaped by structural inequalities, poverty, discrimination, language barriers, insecure legal status, and limited access to services.

For refugee and asylum-seeking children, mental health difficulties may reflect exposure to conflict, forced displacement, family separation, and hazardous migration journeys, alongside post-migration stressors such as discrimination, exclusion, and fear of deportation. These experiences can undermine trust in authorities and create significant barriers to engaging with formal MHPSS services. Unaccompanied and separated children (UASC) face particularly high levels of psychological distress due to loss of caregivers, displacement, exposure to violence, and prolonged uncertainty regarding their future. Mental health needs and MHPSS strategies to support refugee families and others in emergency contexts are discussed in detail in Section 6.

### **Children with disabilities**

Mental health problems among children with disabilities are reinforced by broader social inequities. Children with disabilities are more likely to experience poverty, face barriers in accessing and completing education, and be exposed to gender-based violence.<sup>88</sup> Children with disabilities are 30 times more likely than their peers to be separated from their family and placed in residential care where they may face stigma, discrimination and overmedicalization.<sup>89</sup> For example, evidence from the UK's *Lenahan review* highlights the experiences of young people diagnosed with learning disabilities and / or autism who also have co-occurring mental health conditions. Due to a lack of community-based services, many of these young people are placed in medicalized residential care settings far from home.<sup>90</sup> In some such facilities, use of restraints and solitary confinement can result in traumatic experiences with long-term mental health consequences.<sup>91</sup>

People who are autistic and / or have learning disabilities may experience co-occurring anxiety, depression, bipolar disorder, psychotic disorders, obsessive-compulsive disorder, sleep disorders and behavioural problems at higher rates than the general population.<sup>92</sup> The caregivers of autistic children may also experience elevated stress, depression and anxiety which pose risks to family stability and child well-being.<sup>93</sup> These realities underscore the urgent need for early intervention and family support services, such as respite care, parenting support, and integrated community-based MHPSS, to prevent escalation and reduce reliance on crisis-driven placements, including residential care.<sup>94</sup>

### **Children with complex emotional and behavioural needs at risk of coming into conflict with the law**

Children with persistent emotional and behavioural difficulties are also at increased risk of entering residential care or justice-linked placements. This group of children includes 1) those under the minimum age of criminal responsibility who have committed an act that would otherwise be considered a criminal offence; and 2) children of any age involved in behaviour which does not meet the threshold of a criminal offence but risks escalating into offending behaviour without appropriate support.<sup>95</sup>

This group of children is often regarded as 'delinquent', 'anti-social', or 'uncontrollable' and are at risk of being subject to mandatory out-of-home placements in a residential setting (for instance, a 'boarding school'<sup>96</sup>) or other form of residential care, or in a psychiatric care setting.<sup>97</sup> Yet the behaviours in question often reflect underlying, untreated needs. Child offending is driven by a range of interconnected factors associated with the child and their family environment, social relationships, as well as community and systems-level conditions.<sup>98</sup> Many of these children have experienced high levels of ACEs, including abuse, neglect, family violence, or household instability. ACEs are strongly linked to mental health problems and neurodevelopmental conditions, which can

amplify behavioural patterns and increase the likelihood of conflict with the law.<sup>99</sup> These children are therefore best supported through coordinated, therapeutic, community-based services rather than punitive or institutional responses.

### **3.3. Parent and caregiver mental health and well-being**

Parental mental health is a key determinant of children's well-being. When parents experience mental health problems, their capacity to provide consistent, nurturing, and safe care can be compromised, with significant implications for children's mental health and cognitive, emotional and social development.<sup>100</sup> Globally, 10-23 per cent of children live with at least one parent with mental health problems, and up to half of these children experience elevated cognitive, emotional, social, physical and behavioural challenges.<sup>101</sup> Parental mental health problems are often linked to child-family separation and entry into alternative care (see Box 4), shaped by both genetic and environmental influences, including parenting style, parent-child interactions, and broader family stressors. Research shows that parental depression and anxiety during pregnancy and early childhood can have lasting impacts on a child's mental health.<sup>102</sup> Parental substance misuse similarly contributes to elevated risk of child mental health problems and risk of child-family separation.<sup>103</sup> Parent and child mental health often influence one another in a bidirectional manner: a parent's distress can affect the child's well-being, and children's difficulties can increase parental stress, creating a reinforcing cycle of family distress.<sup>104</sup>

As mentioned earlier, in kinship-care families, children generally experience better mental health outcomes than children in other types of alternative care, likely due to continuity of relationships, familiarity, and cultural connectedness.<sup>105</sup> However, conversely, kinship carers themselves tend to experience higher levels of mental health problems than other types of caregivers.<sup>106</sup> This may be due to having lower levels of personal, social and economic resources; receiving less monitoring by

social workers; and having poorer support networks. Kinship carers often have more physical health problems, higher parenting stress levels, lower levels of education and lower incomes compared to other types of alternative caregivers. Additionally, the circumstances that led to a child being placed in kinship care, such as the death of a relative or a parenting 'failure', further complicate caregivers' mental health. Kinship carers, often grandparents, may also face the added challenge of taking on caregiving responsibilities later in life, contributing to isolation and stress.<sup>107</sup>

The mental health of parents has implications for the success of family reintegration. Children whose parents have mental health problems are less likely to be successfully reintegrated into their families.<sup>108</sup> Parent-child attachment problems increase the risk of reintegration difficulties, highlighting the need for interventions which address these issues prior to reunification.<sup>109</sup> Parental substance misuse is also associated with higher risk of children re-entering alternative care, and with elevated rates of child mental health and behavioural problems.<sup>110</sup>

Studies show that children reintegrated into their birth families after enduring years of child-family separation and residential care often face significant emotional and behavioural challenges, such as suppressed sadness and difficulties in managing anger and frustration, which can increase stress for parents.<sup>111</sup> Parents may also struggle with emotional regulation, instead demonstrating emotional volatility and inconsistent or punitive parenting, including use of physical punishment. These dynamics can create "a negative cycle as children ... [become] fearful, angry and more guarded as a result of unhelpful or negative interactions with their caregiver, despite attempts to foster healthy and secure environments."<sup>112</sup>

### 3.4. Workforce mental health and well-being

Across the continuum of care, children and families interact with a wide range of professionals, including social service workers and residential care staff, community workers, educators, health-care providers, law enforcement and justice personnel, as well as mental health specialists such as psychiatrists and psychologists. Collectively, these multisectoral workers form the backbone of support for children, adolescents and families along the continuum of care. Their well-being is therefore integral to the quality, safety and continuity of care.

Many of these professionals operate in high pressure environments. Social service workers, and child welfare workers in particular, play a crucial role in supporting vulnerable children, adolescents and families, often managing cases of abuse, neglect and complex needs.<sup>113</sup> Their work involves high stakes decisions, heavy workloads, exposure to distressing stories and tense or aggressive interactions, and the constant risk that mistakes could harm children.<sup>114</sup> Similar pressures are experienced by frontline health workers who treat children with injuries resulting from violence; child psychiatrists who support those with mental health conditions; teachers who work with children with behavioural and emotional difficulties; and justice professionals working with children in conflict with the law.

These pressures are often compounded by systemic constraints such as understaffing, limited supervision, administrative burden and bureaucratic inefficiencies, and inadequate coordination between sectors. Often, staff struggle with the limits of their ability to support children in compromised systems. In some contexts, negative public or media narratives can fuel a culture of blame, especially when adverse events occur.<sup>115</sup>

Given the cumulative demands placed on these workforces, high levels of stress, burnout, and various physical and mental health issues are common.<sup>116</sup> A recent systematic review found that approximately half of social workers in the social services sector experienced burnout (defined as a state of physical, mental, and emotional exhaustion stemming from work stress) and other physical and mental health issues.<sup>117</sup> Exposure to the traumatic experiences of children puts all frontline workers at risk of secondary and vicarious trauma, potentially resulting in more serious mental health problems if unacknowledged and unsupported.<sup>118</sup> These experiences can also fuel compassion fatigue, reduce empathy, and diminish the ability of workers to make sound professional judgments.<sup>119</sup>

If unaddressed, these challenges undermine not only workforce well-being but also service quality, consistency, and stability across sectors.<sup>120</sup> They contribute to high turnover, difficulties with recruitment and retention, and disruptions in continuity of care. These disruptions have direct consequences for children, who are often especially sensitive to breaks in relationships with supportive and trusted adults. Strengthening workforce mental health and well-being is therefore a foundational component of a resilient, high-quality child protection and care system.

# 4. Applying a mental health and well-being lens across the continuum of care

While the previous section outlines MHPSS needs across the continuum of care, the remainder of the paper explores ways to address these needs. The current section proposes ways that governments in Europe and Central Asia can, with support from UNICEF Country Offices, integrate MHPSS principles and practices into social service delivery along the continuum of care. These approaches apply across all stages of the continuum of care (that is: families at risk of separation, children in alternative care, family reintegration, and transitioning into independent living) and types of care (for instance kinship care, foster care, residential care). Section 5 provides further details on specific evidence-based MHPSS activities, including their relevance to various parts of the continuum.

## 4.1. The social service workforce and mental health and psychosocial support

Consultations with UNICEF Country Offices<sup>121</sup> highlight a lack of clarity in some settings regarding what services are and are not considered to be MHPSS, when and for whom MHPSS should be used, and which types of professionals – in the social service workforce and wider workforce – can offer MHPSS. A common misconception is that MHPSS refers only to therapeutic interventions for treating diagnosed mental health conditions and that it falls exclusively under the remit of the healthcare sector, requiring delivery by medical professionals such as clinical psychologists, psychiatrists and medical doctors. Sometimes members of the social service workforce hold this view, with some social care workers viewing MHPSS as ‘health responsibilities’ that are ‘out of their field’, particularly in already overstretched systems.<sup>122</sup> In reality, as described further below, MHPSS encompasses promotion, prevention, and care

interventions, and is a shared responsibility of all staff in the care system.

The following sections clarify what constitutes MHPSS in the care system, including the unique and critical role of the social service workforce, and address key organizational and systems-level considerations for strengthening MHPSS integration.

## 4.2. When and for whom should mental health and psychosocial support be used?

As outlined earlier in this paper, MHPSS is relevant across the mental health continuum – from promotion and prevention through to focused and specialized care – and across the continuum of care. UNICEF recommends **prioritizing strong investment in MHPSS for children and families at risk of separation**. Well-designed support provided at this stage has the potential to help to prevent child–family separation by reducing key risk factors, such as untreated parental mental health difficulties, and by strengthening protection factors like parenting capacity and family cohesion. Preventing child–family separation can in turn support child and family well-being, including by preventing exposure to adversities associated with some forms of alternative care that can exacerbate mental health problems.

A prevention approach has a compelling economic as well as human rationale. There is strong evidence that family support services, which prevent child–family separation, are less costly than alternative care placements, especially residential care placements.<sup>123</sup> Likewise, this approach lessens the long-term societal burden of untreated mental health conditions.

#### **Box 4. The causal pathway between poor mental health and child–family separation, and the role of MHPSS in preventing separation**

A growing body of evidence demonstrates the link between mental health problems and child–family separation and placement in alternative care, and the role of MHPSS in addressing risk factors that can lead to child–family separation. While few studies directly test the impact of MHPSS on reducing entry into alternative care, the causal pathways are well established. Effective MHPSS:

- Improves caregiver mental health and parenting capacity, including in regard to behaviours which may result in a child being placed in alternative care (such as substance misuse).
- Improves child mental health and reduces behavioural issues, reducing the likelihood of a child being placed in alternative care as a result of being in conflict with the law.
- Strengthens family functioning and cohesion overall, thus enhancing factors that protect against child-family separation.

Several studies focus on the link between mental health problems and child–family separation. In England, parental mental health conditions have now overtaken domestic violence as the leading cause of child protection referrals,<sup>124</sup> which can result in children being placed in alternative care. In the UK and New Zealand / Aotearoa, parental mental health problems are shown to be a significant cause of children being placed in kinship care.<sup>125</sup> Research from Finland has found that mental health problems among both young people and their parents are directly associated with adolescents entering alternative care.<sup>126</sup>

Other studies point more directly to the **prevention potential of integrated MHPSS interventions**. For example, one review found that mothers in integrated treatment programmes for substance use which include MHPSS elements were significantly less likely to have their children removed from their care, more likely to complete substance use treatment, and more likely to reduce their alcohol consumption and drug use.<sup>127</sup> Although not directly measuring entry into alternative care, a wide body of evidence (often in humanitarian contexts) demonstrates that MHPSS can strengthen family functioning, parent and child well-being, and other factors that reduce the likelihood of separation.<sup>128</sup> For example, the Caregiver Support Intervention (a structured MHPSS programme for parents affected by war) has been shown to improve parental mental health, reduce psychological distress, and enhance positive parenting practices, which in turn contributed to better psychosocial outcomes for children.<sup>129</sup>

Further evidence to support these connections is demonstrated through the experience of UNICEF Country Office programmes across the Europe and Central Asia region:

- The **Family Associate model**, developed by the Government of Croatia, provides psychosocial support to strengthen functioning of families in which children are at risk of neglect, social exclusion, and child–family separation.<sup>130</sup> The programme provides emotional support, parenting skills and practical assistance in daily life, such as household management and financial planning. Target groups include families in which parents have mental health problems. An internal UNICEF assessment noted that some parents explicitly reported depression, anxiety, substance use and suicidal thoughts, and found that the emotional and motivational support provided by family assistants helped families build confidence and skills to create lasting positive change.<sup>131</sup>

- UNICEF Armenia's **Peer Support Volunteers programme** was established during a large-scale displacement crisis in which 115,000 ethnic Armenians, including 36,000 children, were forced to flee their homes and seek refuge in Armenia, overstressing the capacity of existing services and exacerbating vulnerabilities in the host population. Peer Support Volunteers are professionally trained local community members who provide basic MHPSS activities, with a focus on addressing the needs of women, children and adolescents. They act as trusted and approachable local community resources to foster well-being through empathy, engagement and empowerment, as well as making referrals to specialized MHPSS services when needed. Monitoring data suggests that the programme has resulted in some parents feeling more confident and capable of caring for their children, meaning they do not resort to placing them in residential care out of desperation.<sup>132</sup>

### Flashpoints requiring prioritized MHPSS

In addition to prioritization of MHPSS for families at risk of separation, actors should be aware of 'flashpoints' across the continuum of care when mental health needs among children and caregivers are likely to spike and MHPSS should be prioritized. These include:

- **Exposure to abuse** as well as other potentially traumatic or highly stressful events can cause acute distress and adverse long-term outcomes.
- **Entry into the alternative care system and adjustment to new placements** represent a time of uncertainty and loss, requiring targeted emotional and practical support to promote stability and security.
- **Reintegration with families** is a complex process that can trigger mixed emotions, relationship tensions, and the need for ongoing adjustment support for both children and parents.
- **Transition to independent living** is a significant life change that can be highly stressful for young people leaving care, often accompanied by feelings of isolation, anxiety, and uncertainty about the future.

These flashpoints represent windows of heightened risk but also of opportunity, when timely, well-designed MHPSS interventions can mitigate harm and support positive outcomes. However, these are

by no means the only moments in which MHPSS matters. Rather, a key recommendation is that all workers associated with the care system adopt a 'mental health and well-being lens' such that MHPSS considerations are integrated into their ongoing, daily responsibilities and interactions with all the children with whom they engage. This concept is discussed in detail below.

### 4.3. Adopting a mental health and well-being lens: Principles and practices of mental health and psychosocial support

Promoting the emotional well-being of care-experienced children is a shared responsibility among all staff associated with the care system.<sup>133</sup> The social service workforce can play a central role by integrating MHPSS into their everyday responsibilities across the continuum of care – in other words, adopting a 'mental health and well-being lens'. Doing so involves the following elements, each of which are discussed in more detail throughout this section:

- Applying MHPSS frameworks and approaches, such as trauma-informed, participatory, strength-based, and culturally informed care, in everyday practice.
- Facilitating coordination and integration of MHPSS across sectors and between child and

adult services, including through implementation of a case management system.

- Ensuring systematic MHPSS screening, assessment and referral to appropriate services for children and families.
- Providing foundational and ongoing training and supervision for the social service workforce to strengthen core MHPSS competencies, including provision of basic psychosocial support and identification and referral of children and family members in need of additional support.
- Providing training and supervision to the multisectoral workforce (for instance, health, education, and justice professionals) and to MHPSS specialists to strengthen their understanding of the specific needs and barriers to care faced by children and families across the continuum of care.
- Prioritizing the well-being of the workforce itself, recognizing that staff must be supported in order to effectively care for others.

Adopting a mental health and well-being lens does *not* mean that social service and other workers who are not qualified mental health professionals are expected to provide specialized MHPSS (such as psychotherapy). Rather, their responsibility is to understand the limits of their role, make referrals when needed, and apply appropriate practices within their scope. Some MHPSS activities are designed to be facilitated by non-MHPSS specialists with training and supervision and can be used by the social service workforce (see Section 5 and Appendix 3).

### Trauma-informed approach

A trauma-informed approach (also called trauma-informed care or practice) is not a specific intervention but a way of working with children and caregivers that recognizes the impact of past adversity and promotes well-being. It shifts the focus from 'What's wrong with you?' to 'What happened to you?'. This approach can be implemented by all members of the workforce,

including non-specialists.<sup>134</sup> Despite its title, a trauma-informed approach is not only relevant to those who have experienced a traumatic event or have trauma-related symptoms; rather it is a way of working with all children and families that takes potential exposure to adversity (including loss and chronic stress associated with instability and uncertainty) into account.

This approach helps caregivers and staff understand how adversity affects emotions, behaviour and relationships, guiding the creation of safe, culturally sensitive environments that encourage trust and engagement. It also addresses staff well-being, recognizing the impact of working with children who have experienced adversity. Ultimately, the goal is to promote well-being and prevent harm, including re-traumatization, for all stakeholders involved: children, caregivers, and the workforce alike.

Becoming a fully trauma-informed agency entails not only training staff but also strengthening workplace policies and protocols to maximize well-being, all the while maintaining safety and effectiveness. A trauma-informed approach can ultimately be implemented at a systemic level across organizations and government services, resulting in a "whole-of-system recognition of the impact of trauma."<sup>135</sup> For example, the Safeguarding Board for Northern Ireland has integrated a trauma-informed approach across all statutory services, including family support and alternative care,<sup>136</sup> and provides a toolkit<sup>137</sup> and training modules to support practice and policy.<sup>138</sup>

Research shows promising effects of the trauma-informed approach for children in the alternative care system,<sup>139</sup> including young people in residential care.<sup>140</sup> Findings suggest that, while services for children in care often fail to consistently recognize the impact of adverse events on mental health and behaviour, trauma-informed practices can mitigate these risks<sup>141</sup> and help children feel safer in discussing their distressing experiences and mental health.<sup>142</sup>

### Box 5. The six principles of trauma-informed practice<sup>143</sup>

Trauma-informed practice is grounded in six underlying principles: **safety, trust, choice, collaboration, empowerment, and cultural sensitivity**. Examples of ways to apply these principles include the following:

Children in alternative care often come from unsafe environments. It is critical to promote both **physical and emotional safety** such that:

- The physical environment (for instance in residential care facilities, social service delivery settings, or foster homes) is safe, comfortable, and welcoming.
- Clear safeguarding policies and confidentiality measures are in place and appropriate boundaries are maintained.
- Communication is supportive, empathetic, and non-judgmental and children can express themselves without fear of judgment or punishment.
- Predictability, routine, and transparent information sharing is established.

Children in alternative care who have experienced trauma and loss often find it challenging and frightening to build **trusting relationships** with caregivers and other providers. Approaches that can help include:

- Setting clear expectations, sharing accurate information and avoiding overpromising, and clearly explaining the rationale for actions and decision-making.
- Establishing consistency and reliability and following through on commitments.
- Understanding that challenging behavioural and emotional reactions may be a response to past trauma or adversity and responding appropriately, with empathy, validation and authenticity.

In many cases, children in the alternative care system have had limited control over their outcomes. Allowing children to make **choices** and to have a voice in decision-making and goal-setting is especially important, for instance by:

- Actively listening to the needs and wishes of children and families and providing transparent explanations of available options, including daily activities such as what to wear, activities, foods, as well as care options.

Likewise, a **collaborative approach** is key, to acknowledge the value of children's experiences and expertise. Steps that can be taken include:

- Actively involving children in their care by allowing them to identify their needs and working collaboratively to meet those needs.
- Creating opportunities for exchange of peer support both formally and informally.

Trauma can result in feelings of helplessness and low self-worth, so **empowering** children by highlighting strengths and building self-esteem is especially important. This can be done by:

- Acknowledging and validating children's efforts, strengths, hobbies, talents.
- Strengthening problem-solving, emotional regulation, and communication skills.

Children in alternative care come from diverse cultural backgrounds, and have the right to have these respected and nurtured. This can be done by:

- Ensuring staff and caregivers are trained in **cultural humility, sensitivity and competency** and skilled in respecting and responding to diverse backgrounds.
- Respecting the child and caregiver's cultural practices, values, and beliefs, for instance by facilitating access to language, food, social networks, and events, including healing rituals.

Finally, it is important to note that a 'trauma-informed' approach should not be confused with **'trauma-focused' psychotherapy**. The latter term refers to a specialized therapeutic intervention for individuals with psychological symptoms associated with trauma exposure, often with a diagnosis of PTSD. Trauma-focused interventions, such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), aim to reduce symptoms through

specialized techniques such as gradually exposing people to reminders of their traumatic experiences, to desensitize them to these reminders and reduce fear and distress. These sorts of approaches should only be facilitated by mental health professionals such as clinical psychologists or psychiatrists with training in these models and with ongoing clinical supervision.

### **Box 6. Trauma-informed care training in North Macedonia**

UNICEF North Macedonia supported the development of a trauma-informed training programme for frontline workers in child protection and justice, including a training package, a 'train the trainers' module, and a service delivery methodology. The programme has been delivered to judges, prosecutors, lawyers, police officers, social workers and teachers. Participants learned about the impact of trauma on the brain, attachment issues, effects of poverty, intergenerational trauma, restorative justice, and professional burnout, enabling them to better support children in the system. Details are provided in the [Trauma-Informed Handbook](#).<sup>144</sup>

In partnership with the University Clinic of Psychiatry, UNICEF North Macedonia also trained professionals working with at-risk children and those in state care on basic psychosocial support. The intervention was conducted in collaboration with the Institute for Social Activities, responsible for accrediting social workers, and the training module was placed on their [Digital Learning Platform](#) to ensure ongoing access for social work professionals.

## **Participatory approaches**

Children have the right to participate meaningfully in decisions affecting them, as outlined in the United Nations Convention on the Rights of the Child and reinforced in the 2019 United Nations Resolution on the Rights of the Child.<sup>145</sup> Likewise, the principle of 'nothing about us without us' has become a central tenet of care leavers' self-advocacy.<sup>146</sup> Child participation also has important

benefits for children's well-being. Trauma-informed practice recognizes that decision-making is particularly important for those who have experienced trauma or adversity over which they had no or very limited control. Therefore, children should be active participants in and at the centre of decision-making about their needs, preferences and well-being.<sup>147</sup> As demonstrated by the CHIMES systematic review (see Box 7), when children cannot

express their views concerning MHPSS activities, they may feel disempowered, which can reduce effectiveness of the intervention.

In the UK, the THRIVE Framework allows children and caregivers to define their own needs through shared decision-making with professionals, rather

than a diagnostic-led approach.<sup>148</sup> Initial evidence shows that by focusing on accessibility and using a common language which children and their families can understand, THRIVE helps improve children's mental health.<sup>149</sup>

### **Box 7. The CHIMES review of interventions for the mental health of care-experienced children**

The Care-experienced children and young people's Interventions to improve Mental health and well-being outcomes Systematic review (CHIMES) synthesized evidence on interventions targeting mental health and well-being among care-experienced young people under 25 in high-income countries.<sup>150</sup> It identified factors that support or hinder the effectiveness of MHPSS interventions, highlighting the critical role of workplace cultures and contextual factors. The review findings included the following:

- Heavy workloads and unsupportive workplace cultures reduce social service professionals' engagement with and use of MHPSS training.
- Caregivers often feel interventions insufficiently recognize their knowledge and experience, emphasizing the need for approaches which are more responsive to young people's needs and caregiving contexts.
- Care-experienced children and adolescents are highly sensitive to workplace environments and language. If they feel unable to express opinions or are blamed when interventions fail, they feel disempowered, reducing intervention effectiveness or causing harm.
- Children also disengage if they perceive the intervention as a cognitive or emotional burden on professionals. Instead, children value positive, authentic relationships with caregivers and professionals, especially caregivers and professionals with alternative care experience.

CHIMES underscores the importance of supportive caregiving and workplace cultures that recognize the experiences of children, caregivers, and professionals. Strong, meaningful relationships and sensitive MHPSS-related language acknowledging children's life stories and experiences of care are vital. These recommendations align with a recent evaluation of care reform in Europe and Central Asia, which emphasized supporting the social service workforce to ensure "consistent care, personalized attention, and timely interventions",<sup>151</sup> and consultations with UNICEF Country Offices, which highlighted concerns over overly medicalized and stigmatizing language.<sup>152</sup>

In sum, the review's findings carry important implications for participatory approaches to MHPSS and for delivering culturally adapted and culturally safe care.

## Strengths-based and resilience-building approaches

A strengths-based approach to MHPSS focuses on children's capabilities and resources, rather than solely on risks, problems, or symptoms. While assessing risks remains important, this approach also identifies and nurtures the resources and protection factors which can be used as motivators and tools to improve well-being.<sup>153</sup> A strengths-based approach entails using positive and empowering language, conducting motivational interviewing, collaboratively identifying children's strengths and protection factors, encouraging positive coping strategies, and celebrating progress towards goals.<sup>154</sup> This approach is broadly adopted as good practice in MHPSS, and is critical when working with care-experienced children and adolescents who are often defined by their 'problems' related to past adversity or the reasons for entering alternative care.<sup>155</sup>

Closely related is a resilience-focused approach. Resilience is defined as "the ability to overcome adversity and positively adapt after challenging or difficult experiences."<sup>156</sup> A resilience-focused approach entails acknowledging that even for those who have experienced extreme hardship, long term mental health problems and other negative outcomes are not inevitable. It recognizes that individuals have inner resources and strong potential to function well and ultimately to thrive, especially when provided with basic support. Relatedly, many individuals may experience post-traumatic growth – positive psychological, relational, or developmental changes that emerge through the process of adapting to highly challenging life experiences – highlighting that adversity can, in some cases, catalyse meaningful strengths and capacities.<sup>157</sup> As with the strengths-based approach, shifting the focus from problems towards developmental strengths enables young people to better cope with current and future adversity. In practice, this may involve activities such as encouraging a care-experienced child to reflect and share coping skills they have developed along the way, to enable them to think ahead and plan their future lives.<sup>158</sup>

## Culturally adapted and culturally safe care

As mentioned, across Europe and Central Asia, minority groups and migrant and asylum-seeking communities are often at higher risk of child–family separation and of being overrepresented in alternative care.<sup>159</sup> As the CHIMES review has shown (see Box 7), the outcomes of MHPSS interventions are influenced by the extent to which they are tailored to participants' gender, ethnic, cultural and linguistic identities.<sup>160</sup>

For children, adolescents and families from communities that have experienced historical oppression, discrimination, or state-imposed harms, culturally safe MHPSS requires practitioners to acknowledge these realities, not only as historical events but as experiences that continue to shape well-being today through mechanisms such as intergenerational trauma. This includes recognizing how systemic inequities, social exclusion, and discriminatory practices can undermine trust in services and contribute to reluctance to engage with formal support systems.

International examples highlight the importance of cultural safety. In Australia, for instance, Aboriginal and Torres Strait Islander communities have been profoundly affected by colonization, forced child removals (the 'Stolen Generations'), and the suppression of cultural practices.<sup>161</sup> These historical and ongoing injustices have contributed to the disproportionate representation of Indigenous children in alternative care, and poorer outcomes across multiple domains. As a result, Australian care providers emphasize the need for practitioners to understand the historical context of colonization, to engage in continuous cultural learning, and to adopt culturally safe, community-informed approaches.<sup>162</sup> The same principles apply across Europe and Central Asia. Practitioners must ensure that MHPSS services respect cultural identity, acknowledge community histories and lived experiences, involve cultural mediators where appropriate, and are co-designed with affected communities.

## Tackling stigma and promoting help-seeking

Stigma regarding mental health and use of MHPSS services remains a pervasive barrier to support. It can prevent children, adolescents and caregivers from seeking help or delay access to care.<sup>163</sup> Children and adolescents in alternative care may be particularly hesitant to seek or engage with mental health services, due to past negative experiences with systems and / or adult caregivers, mistrust of authority, or concerns about being judged or misunderstood.<sup>164</sup> When children and their caregivers do seek help, there is often a preference for informal sources of support (such as through friends or the internet), driven by concerns about confidentiality, fear of stigma, limited service accessibility, or the perception that formal services do not fully understand their lived experiences. A lack of meaningful participation in decision-making processes within alternative care settings can further reduce willingness to seek formal support.<sup>165</sup> Gender norms also play an important role; data from Europe, for example, indicate that adolescent boys are less likely than girls to access mental health services, often due to expectations around masculinity and reluctance to disclose distress.<sup>166</sup>

To address these barriers, MHPSS programming should include social and community-level awareness-raising initiatives aimed at reducing stigma, increasing mental health literacy, and fostering positive attitudes towards help-seeking.<sup>167</sup> Importantly, such initiatives are most effective when they are co-designed with the populations they aim to reach. For example, campaigns intended to promote help-seeking among adolescent boys in alternative care should be developed *with* boys in care to ensure relevance, authenticity, and resonance.

## 4.4. A multidisciplinary and coordinated approach to mental health and psychosocial support

Although this paper is primarily focused on MHPSS within the social service system, it is essential to recognize that meaningful support for children and families depends on a multidisciplinary approach. Children along the continuum of care routinely interact with the health, education, justice and social protection sectors. Effective MHPSS therefore requires coordinated action across all these systems.

Specialized mental health services such as psychiatry and psychotherapy are often provided primarily within the health-care system. This raises practical challenges: overburdened health services may struggle to respond to the needs of children in alternative care or to coordinate consistently with social service providers. Although a detailed discussion of the role of the health system in supporting children in alternative care is beyond the scope of this paper, several principles are critical. Children in alternative care must receive equitable access to specialized mental health services relative to other children with similar levels of needs. This requires identifying and addressing the unique barriers faced by children in alternative care which may impede equitable access. For example, in some settings, children in alternative care may lose their place on service waitlists due to placement instability (instability that is sometimes exacerbated by mental health problems). They may require close to or in-home care or have unique needs requiring culturally adapted care or specific language accommodation, resulting in longer wait times. Histories of disrupted relationships may mean that they require a longer period to develop trust and require leniency around missed sessions (which can sometimes result in being dropped from services), and may make them especially vulnerable to the effects of changing service providers. These realities underscore the need for health systems to assess the barriers and facilitators affecting service access for children across the continuum of care, and to take proactive steps to ensure equity.

Both a review of the available research and internal UNICEF consultations highlight challenges in cross-sector coordination of MHPSS. Referral pathways between social services, health care, education, and other government services are often fragmented or incomplete. Moreover, civil society and private actors also frequently provide MHPSS; while these services often fill critical gaps, they can add complexity and variation in quality if not effectively coordinated.<sup>168</sup> For example, a UNICEF assessment in Andalusia, Spain<sup>169</sup> found that some children in alternative care were seeing multiple mental health professionals (for instance, a psychiatrist through the health system, a psychologist through the protection system, a school social worker, and a specialist assigned to provide support related to sexual abuse) at the same time, with little coordination between these professionals.

The need for better integration spans not only horizontal integration (across sectors) but also vertical integration (between child and adult services).<sup>170</sup> Research from Europe shows that adolescents often 'get lost' in the transition to adult services due to fragmentation, poor communication, and differing eligibility thresholds between child and adult mental health services.<sup>171</sup> The researchers argue that splitting services between child and adult systems is inefficient, creates barriers to access and retention, and

impedes early intervention. They emphasize the need for community-based early detection and intervention models targeting both adolescents and young adults. This is a particular problem for care leavers who may face significant mental health problems during their transition to independent living, which coincides with their transition from child to adult mental health services.<sup>153</sup>

In order to address these challenges, governments should strengthen:

1. **Horizontal coordination** across sectors and between government and non-governmental service providers. Effective referral systems, multidisciplinary teams, and information sharing improve access, choice, retention<sup>172</sup> and outcomes.<sup>173</sup>
2. **Vertical integration and / or coordination** of children's and adults' mental health services to ease potentially difficult transitions between these age-restricted services, when young people's mental health needs may be peaking.<sup>174</sup> For example, in England, the Children's Commissioner has called for Child and Adolescent Mental Health Services to be extended to care leavers until the age of 25, along with personal advisors to help them to access these services.<sup>175</sup>

### **Box 8. Multidisciplinary and coordinated services to prevent child–family separation**

The role of MHPSS in early intervention and family support services – including during pregnancy – is critical, considering the known impact of ACEs and attachment issues on child and family mental health. Providing timely, holistic support can positively shape a child's long-term mental health trajectory and help prevent child–family separation. Extensive research highlights the value of multidisciplinary and well-coordinated family support services.<sup>176</sup> Good practice in coordination entails relationship-building, strategic leadership, multi stakeholder and multisectoral partnerships, services and teams, the 'co-location' of practitioners from across different sectors, joint decision-making and coordinated interventions, and co-production between service users and professionals. Multiagency 'front door' services which allow for information-sharing, joint decision-making, and coordinated interventions are also recognized as effective models.<sup>177</sup>

Several examples of evidence-based MHPSS services illustrate how coordinated, community-based approaches can prevent child-family separation while also supporting children already in alternative

care. These models address mental health and behaviour needs, as well as problems such as bullying or family conflicts, physical and sexual health needs, alcohol and substance use, and vocational skills.<sup>178</sup>

[Forward Thinking Birmingham](#) in the UK provides mental health support for individuals aged 0–25, integrating child and adult services. It coordinates care through partnerships between government and civil society organizations, offering drop-in clinics, online resources, and professional referral options. The service emphasizes individual choice and promotes emotional well-being via information, training and consultation.

[The Well Centre Model](#), also in the UK, supports young people aged 11–20 with family-oriented, culturally sensitive, evidence-based approaches. It integrates multidisciplinary services, including youth workers, counsellors, doctors, schools, social services, justice systems and civil society organizations, providing holistic care with vertical integration, and both professional and self-referral options.

## The role of case management

The designation of case managers for children and families in the alternative care system can help to ensure that both horizontal and vertical integration and coordination occurs effectively. Case managers coordinate mental health services across sectors (health, child protection, education and justice) and between child and adult services. Core responsibilities may include conducting an MHPSS needs assessment when a young person enters alternative care, setting support goals and service and care planning, convening case conferences with multisectoral professionals and otherwise ensuring appropriate information sharing, and monitoring progress.<sup>179</sup> A case manager can be mandated to inform service providers about a child's status in the alternative care system and their current placement, and can be given authority to share information, such as care plans, among providers to ensure alignment.

Ideally, case managers have a holistic role, in which they coordinate child and family services across sectors for all children in alternative care, including

but not limited to mental health services. In some settings (for instance, the United Kingdom and the United States), a holistic case management system may already be in place, but could be improved by strengthening the MHPSS capacity of case managers. In other settings, there may be no case management system in place. In this case, a minimum standard is the development of a mental health case management system to ensure support to children with identified mental health needs (including coordination across all services, not just mental health services), with implementation of a system for all children in alternative care as a longer-term aim. A case manager who supports children and families with mental health needs should have foundational training in MHPSS competencies, consistent with the topics described below ([see p 40](#)). In some settings, case management systems may also play a critical role in linking displaced populations to mental health and other services, with the aim of preventing child–family separation and supporting children in alternative care (for example, see UNICEF Czech Republic's guidelines on case management in social work with Ukrainian youth<sup>180</sup>).

### Box 9. Enhancing coordination between child protection and mental health systems in Andalusia, Spain

UNICEF's Technical Support Instrument (TSI) project in Andalusia aims to develop an integrated framework linking child protection and health services to support the mental health and well-being of children in alternative care. An assessment with children and professionals from primary health, mental health, and care systems found a need to strengthen referral procedures and coordination protocols, and to develop standardized criteria for referral. Recommendations include establishing clear referral pathways and sustainable, coordinated follow-up. A designated case manager for each child in alternative care would conduct mental health screening at entry, convene case conferences, develop support plans, monitor progress, and coordinate MHPSS interventions across multiple services. For children receiving care in multiple settings, the case manager would ensure information sharing and alignment of care plans.<sup>181</sup>

## 4.5. Gatekeeping, screening and assessment of mental health and well-being

Mental health is a central consideration in gatekeeping decisions which determine whether it is necessary for a child to enter alternative care and, if so, in planning the type of alternative care setting that is most suitable to meet their individual needs, including their mental health needs.<sup>182</sup> Gatekeeping decisions should always be informed by a comprehensive assessment that should include a mental health and well-being screening or assessment.

These may be repeated at key transitions (for instance, moving to a new placement) and / or on a periodic basis (such as every six months). Screening should be clearly distinguished from clinical assessment.

- **Screening** is a brief procedure designed to identify potential concerns and the need for referral. It may be conducted by case managers, social workers, health-care providers, or other trained non-specialists using standardized, validated instruments.
- **Assessment** is more extensive, used to develop goals for services and, in some cases, inform diagnosis. Depending on the system, assessments may be conducted by social service

professionals or health-care staff; however, diagnostic assessments should always be undertaken by a psychiatrist or clinical psychologist.

A key element is the assessment of **risk of suicide and self-harm**. Suicide risk assessments should be linked to safety planning and crisis protocols, including rapid referral pathways ('fast-tracking') for high-risk youth to specialist care. WHO and UNICEF's [EQUIP: Ensuring Competency in Psychosocial and Mental Health Care](#) platform includes a training protocol<sup>183</sup> and risk assessment protocol<sup>184</sup> appropriate for adolescents and adults.

For the social service workforce, screening and assessment tools are not intended for diagnosis but are valuable in:

- Clarifying children's mental health and well-being, including both difficulties and strengths.
- Guiding referrals to MHPSS, including specialized services and well as promotion and prevention activities (such as peer support, psychoeducation and stress management, and caregiver support).
- Informing support goals and service and care planning, as well as assessing progress towards goals and revising plans as needed.
- Supporting caregivers.

- Maintaining stability in alternative care placements.<sup>185</sup>

Assessment should include documentation of mental health reactions and impact on functioning in settings such as home, school, and with peers. Importantly, it should also include assessment of strengths, including internal (for instance, coping mechanisms) and external (for instance, a strong social network) resources.

All **screening and assessment tools** have strengths and weaknesses and should be selected according to the context of the child being assessed and the skills and comfort level of providers.

Examples include:

- The Strengths and Difficulties Questionnaire (SDQ)<sup>186</sup> is a questionnaire commonly used in Europe for children in alternative care, and well-suited for monitoring children's behaviour and well-being over time.<sup>187</sup> It is available in many languages for children aged between 2 and 17, and includes versions to be completed by children, caregivers, and educators.
- The Paediatric Symptom Checklist (PSC) is another commonly used tool covering a broad range of problems, including attention, internalizing (anxiety, depression), and externalizing (conduct) issues for children aged 2-17. The tool is available in a version with 35 questions (PSC-35) and a version with 17 questions (PSC-17) with child and parent report components.<sup>188</sup>
- The ReachNow<sup>189</sup> tool developed by War Child, originally for use in humanitarian contexts, uses a scenario-based approach in which a brief, culturally adapted case study is used to help non-specialist providers to identify needs and make appropriate referrals.

In the United Kingdom, local authorities must ensure that all children entering alternative care undergo a physical, emotional and mental health assessment by a registered medical practitioner,<sup>190</sup>

and social workers have a key role in facilitating this process.<sup>191</sup> An evaluation of new assessment models has been trialled in the United Kingdom with all children entering alternative care, with positive results.<sup>192</sup> These models have used existing assessment tools, such as the SDQ, accompanied by additional guidance on being empathetic, validating, attentive and curious; accessing assistance from a 'virtual mental health lead'; and prioritizing the perspective of the child and others in their social network regarding their mental health and well-being.

Protocols for screening and assessment of **parent and caregiver mental health** are also critical. Brief tools, such as the Kessler-10 and Kessler-6, which assess general distress among adults, are useful for screening purposes.<sup>193</sup> In some cases, assessment of parental stress may also be useful: the Parental Stress Scale (16 or 18 items) measures both opportunity costs and limitations on personal resources (stress and lack of control experienced by parents), as well as the rewarding aspects of parenting, such as fulfilment and personal growth.<sup>194</sup>

## 4.6. Strengthening the knowledge and skills of the social service workforce in mental health and psychosocial support

Strengthening the MHPSS capacity of the social service workforce is a key responsibility of governments and other actors. All members of the social service workforce should have access to foundational and ongoing MHPSS training that can help them to apply a mental health and well-being lens in their daily work. Staff should also access ongoing supervision, peer learning exchange sessions, and periodic refresher training as relevant to consolidate learning. Key topics for capacity strengthening include the following domains, drawn from the IASC *Mental Health and Psychosocial Support Minimum Service Package*.<sup>195</sup>

1. **Foundational knowledge and frameworks.** MHPSS principles, cultural sensitivity, and approaches to reduce stigma through training and awareness.
2. **Understanding mental health reactions.** Child development, attachment, and the impact of adversity, alongside recognizing behavioural, emotional, and somatic signs of distress in children.
3. **Assessment and referral.** Screening, risk assessment, safety planning, and implementing referral pathways.
4. **Core helping skills.** Communication and supportive skills for working with children and caregivers, including stress management and crisis response.<sup>196</sup>
5. **Caregiver and family support.** Approaches to support caregiver well-being, supportive parenting practices, and family-based approaches.
6. **Staff well-being.** Addresses burnout and vicarious trauma with organizational, supervisory, team, and self-care strategies.
7. **Intervention-specific training.** Includes evidence-based structured group activities, social-emotional learning, and scalable psychological interventions (with a focus on models that can be facilitated by non-MHPSS specialists).

A more detailed training framework is available in Appendix 2.

## 4.7. Strengthening capacity of mental health and psychosocial support specialists and multisectoral professionals

In addition to calling for additional training for the broader social service workforce, UNICEF Country Offices have also recommended increased human resources and better training for MHPSS specialists (such as clinical psychologists and psychiatrists) in the health and social care systems, to allow them to better meet the specialized mental health needs of

children and families.<sup>197</sup> Research from Europe also points to gaps in specialist training, including sensitivity to child and adolescent mental health in general, and to the specific needs of children in alternative care.<sup>198</sup> Timely access to specialized mental health support is often challenging,<sup>199</sup> and frequent delays and long waitlists may lead to premature dropout from services,<sup>200</sup> a risk that is higher for boys and minority groups.<sup>201</sup>

To help to address these gaps, MHPSS specialists should receive tailored capacity strengthening, including training on specific forms of adversity and associated mental health needs experienced by children across the care continuum, and specialized intervention approaches shown to be effective with this population. In many cases, specialists will benefit from similar training topics to those described for the social service workforce, with a focus on MHPSS for children and families, which is not always sufficiently addressed in specialist training programming; and on ACEs, attachment difficulties, and trauma-informed practice in particular. Specialists may also benefit from briefings on the child-care system and experiences of children in alternative care (ideally including input from those with lived experience) to help them to fully understand the context and implications for mental health reactions. This training can help to prevent specialists from misinterpreting child behaviours as signs of serious mental health conditions when in fact they are common and possibly short-term reactions to highly stressful circumstances related to alternative care. For example, specialists may benefit from guidance to differentiate between ADHD and 'acting out' related to stressful transitions.<sup>202</sup>

Likewise, professionals across sectors may benefit from many of the training topics listed above, contextualized to their settings and needs. This includes education professionals (school counsellors, teachers),<sup>203</sup> and justice and legal professionals (lawyers, judges),<sup>204</sup> as well as health professionals in primary health services (nurses, paediatricians, general practitioners or family doctors). General health-care professionals who

work in non-specialized health-care settings should be trained and supervised in evidence-based protocols such as the [WHO-UNHCR mhGAP](#)

[Humanitarian Intervention Guide \(mhGAP-HIG\)](#) or the [WHO mhGAP Intervention Guide \(mhGAP-IG\)](#).<sup>205</sup>

### **Box 10. Building the capacity of the social service workforce on MHPSS in Croatia**

As part of the For a Stronger Family initiative, implemented with the Government of Croatia from 2017 to 2022, UNICEF supported the development of a [comprehensive training curriculum for foster families](#), including modules on MHPSS for children in alternative care. The curriculum covers a wide range of topics: children's rights, child development, building healthy attachments, communication and cooperation with biological families, preparing children to enter or leave family-based placements, effective parenting methods, the importance of learning and education, recognizing and responding to trauma and child abuse, caregiver stress and coping strategies, intercultural foster care, children with disabilities and developmental delays, and children with behavioural problems.

Additional curricula were created to aid the social service workforce in supporting unaccompanied and separated children (UASC) with topics on understanding UASC, human trafficking, the legislative framework for guardianship, caring for children in diverse cultural environments, and preparing for leaving care. A further curriculum focused on children with behavioural problems, emphasizing the needs of children with complex challenges, as well as approaches to managing difficult behaviour.

The training package includes a handbook and learning materials for all professionals in the social service workforce, made accessible via Croatia's social welfare IT database.<sup>206</sup> To ensure sustainability, a training-of-trainers was organized to establish a network capable of disseminating knowledge across the workforce nationally. Importantly, Croatia has also integrated MHPSS elements into its assessment frameworks and other professional tools used within the social service system, strengthening long-term capacity to meet the needs of children in alternative care.

## **4.8. Supporting workforce mental health and well-being**

Strengthening the capacity of the social service workforce, MHPSS specialists, and the wider multisectoral workforce must go hand in hand with supporting their mental health and well-being. Addressing the mental health needs of the workforce who provide services across the continuum of care is vital for recruitment and retention, for improving service quality, and ultimately, for ensuring the best outcomes for children and caregivers.<sup>207</sup> Responsibility for workforce well-being exists at multiple levels – within agencies, among supervisors and teams, and at the individual level.<sup>208</sup>

- **Agency-level support:** Departments and agencies play a foundational role in creating organizational cultures that value and protect staff well-being. Evidence shows that workplaces perceived as supportive have higher retention rates, especially among newly recruited personnel. Agencies should adopt a participatory approach to developing comprehensive staff well-being policies, informed directly by staff input. Such policies may include access to MHPSS services (for instance, Employee Assistance Programmes), structured peer-support systems, regular supportive supervision, and training on topics such as recognizing burnout, preventing vicarious trauma, and practising healthy self-care. Leadership commitment is critical: senior

managers must champion well-being initiatives and model positive mental health practices themselves.

- **Supervisor support:** Supportive, skilled supervision is one of the strongest protective factors against staff stress, burnout and high turnover. Supervisors should be trained to build cohesive and caring team environments, provide regular supportive and reflective supervision, identify early signs of distress among staff, and encourage help-seeking when needed. Effective supervisors model empathy, clear communication, and healthy boundaries, reinforcing a culture where seeking support is normalized rather than stigmatized.
- **Peer support:** A caring workplace culture – where colleagues support one another – can significantly reduce stress, burnout and secondary trauma, while increasing resilience and retention. Peer support can include informal check-ins, shared problem-solving, buddy systems, or peer-led groups. Crucially, peer support also involves knowing when and how to encourage colleagues to seek professional MHPSS services and helping them navigate pathways to access.
- **Self-care:** While agencies and supervisors carry significant responsibility for creating healthy working environments, individuals also play an important role in maintaining their own well-being. This includes recognizing personal limits, practising healthy coping strategies, and knowing when and where to access MHPSS. Self-care should not be framed as an individual burden, but rather as a complementary practice supported and enabled by organizational systems.

## 4.9. Supporting legislation and policy, funding, research and advocacy for mental health and psychosocial support

For MHPSS to fulfil its essential role across the continuum of care, it must be systematically integrated into international, regional, and national

legislation and policy frameworks, and supported by sustainable, predictable funding. Embedding MHPSS within these frameworks ensures that services are not ad hoc or project-dependent, but form a consistent part of child protection and care systems.

Achieving this level of integration requires a strong foundation of high-quality research and evaluation to build a robust evidence base for MHPSS. Reliable evidence can clarify needs, guide development of tailored interventions, support policymakers in designing effective legislation and strategies, and strengthen advocacy efforts aimed at prioritizing MHPSS in policy agendas, budget allocations and sectoral reforms.

Investment in intervention research is especially critical, given the gaps and limitations in the current evidence base. Although there are many programmes on offer in various settings, reviews frequently describe the evidence as being inconclusive,<sup>209</sup> of varying effectiveness<sup>210</sup> and of mostly showing benefits in the short-term (up to six months) rather than the long-term.<sup>211</sup> There is also a notable lack of evidence on how intersecting identities – such as gender, ethnicity, disability, or migration status – shape the experiences and outcomes of care-experienced children and adolescents receiving MHPSS.<sup>212</sup> A shortage of disaggregated data limits the ability to design responsive services and to understand what works for whom.<sup>213</sup>

Routine monitoring and evaluation of outcomes remains inconsistent in many settings, further constraining learning.<sup>214</sup> In addition, there is a pressing need to strengthen and adapt high-quality assessment and measurement tools that are appropriate for children and adolescents across the continuum of care, and are sensitive to cultural and linguistic contexts.<sup>215</sup>

Sustained investment in research, policy engagement, and advocacy is therefore essential for advancing comprehensive, rights-based mental

health care for children and adolescents. Strengthening the evidence base, and ensuring it informs policy and funding decisions, can help

ensure that MHPSS is prioritized not only in principle but also in practice.

**Box 11. The National Action Plan on Mental Health and Wellbeing of Children and Adolescents in North Macedonia (2024-2030)**

In response to the COVID-19 pandemic and other challenges, the Government of North Macedonia noted a sharp rise in anxiety, depression, and self-harm among children, adolescents, and their caregivers. This led to the development of a [National Action Plan for the Mental Health and Wellbeing of Children and Adolescents in North Macedonia 2024-2030](#). The Plan was based on evidence-based research undertaken in North Macedonia<sup>216</sup> and created through a collaborative process involving UNICEF, WHO, three key ministries, government agencies, academic institutions and civil society organizations, coordinated by the University Clinic for Psychiatry.

The Action Plan establishes a comprehensive, multisectoral framework for strengthening mental health promotion, prevention and care. It envisions a holistic, child-centred approach that emphasizes early intervention and coordinated action across the health, education and protection sectors. Importantly, it includes targeted measures to address the needs of children in alternative care, their caregivers, and the social service workforce, recognizing their heightened vulnerability and the importance of consistent, community-based support.

A key element is strengthening the capacity of the social protection system to support children in alternative care. This includes building the capacity of the social service workforce to identify concerns early, provide psychosocial support, and make referrals. The Plan also prioritizes expanding specialized mental health services for children in alternative care and other vulnerable groups. Finally, it outlines key legislative priorities, such as developing a new Law on Mental Health and revising the Social Protection and Family Laws to ensure alignment.

# **5. Mental health and psychosocial support activities across the continuum of care**

Building on the previous sections – which outlined the mental health needs of children, adolescents, caregivers, and the workforce, as well as the system-level considerations for strengthening MHPSS – this section provides a brief overview of evidence-based MHPSS activities that can be used to support well-being across the continuum of care. This section is supplemented by Appendix 3 which provides more detailed descriptions of a larger number of MHPSS activities for both children and caregivers. This section and the accompanying Appendix are designed to aid governments and UNICEF Country Offices in designing and strengthening MHPSS programmes.

**Clarifying MHPSS.** To support programme design, it is helpful to distinguish clearly between activities that constitute MHPSS and those that do not. UNICEF uses the following criteria to define an MHPSS activity:

1. The activity should have a clear **MHPSS objective**, such that a primary aim of the activity is to improve mental health and psychosocial well-being of children and / or caregivers.
2. The activity should include **MHPSS components**, such as information about common stress reactions, emotions, coping skills, and so forth, and should be facilitated by individuals who are appropriately trained in MHPSS.
3. MHPSS activities should be measurable in terms of **MHPSS impact or outcomes**, namely an increase in participants' knowledge and / or skills, a change in attitudes, or improvement in mental health and psychosocial well-being over the course of an activity.

Importantly, there are many activities that can be good for children and families, but do not necessarily constitute MHPSS, such as recreational and sports activities (unless those activities include MHPSS components and meet the criteria above).

MHPSS activities span universal promotion and prevention for all children and caregivers, focused

care targeting those with emerging or moderate mental health problems, to specialized care for those with more extensive suffering and significant difficulties in daily functioning. Promotion, prevention, and focused activities can be provided by non-MHPSS specialists such as the broader social service workforce with appropriate training and supervision. Specialized care should be facilitated by MHPSS specialists, either within the alternative care system or through referral to programmes in health or community settings. It is important to note that the specific roles that constitute 'MHPSS specialists' may vary across settings and educational and licensure systems.<sup>217</sup>

While some activities in this section and in Appendix 3 were designed specifically for children in alternative care, in most cases these activities are used more broadly but have applicability for children along the entire continuum of care, including children at risk of child–family separation or those who have left alternative care ([Box 12](#)). When possible, evidence supporting the intervention and its adaptation and use with children along of the continuum of care is referenced.

Finally, this section introduces considerations for interventions with specific at-risk groups and considers how the mental health needs of children in residential care should be supported in the context of regional deinstitutionalization agendas.

**Current evidence limitations.** It is important to caveat this section with a note on the limitations of the evidence-base for the effectiveness of many MHPSS activities for children, adolescents and their caregivers along the continuum of care.<sup>218</sup> Appendix 3 attempts to indicate where there may or may not be strong evidence for a particular intervention or model referenced, but caution is always advised and further research and / or consultation with an MHPSS technical specialist should be undertaken before selecting a specific intervention for use with children and / or their caregivers.<sup>219</sup>

## 5.1. Mental health and psychosocial support activities for children, adolescents, parents, caregivers and families

For children and adolescents			
	Target group and purpose	Delivered by	Examples of activities
Promotion and prevention: Social / peer support and recreational activities with MHPSS components.	For all children and adolescents; designed to promote well-being, prevent development and worsening of mental health conditions.	Non-mental health specialists with training and supervision, or mental health specialists.	UNICEF's <a href="#">I Support my Friends</a> model is a Psychological First Aid (PFA) training intervention to equip children and adolescents (ages 9–17) to support their peers.
			<a href="#">The Adolescent Kit for Expression and Innovation</a> is a UNICEF product designed to bring together children aged 10–18 to enhance social support, strengthen coping, and promote social change.
			<a href="#">Team Up at Home Activity book</a> was developed for refugee children aged 6–18 but is relevant more broadly. It includes 14 group games that promote identifying and sharing emotions, social support, and relaxation and other coping skills.
Focused care: Scalable psychological interventions.	For children and adolescents with mental health problems; designed to prevent development and worsening of mental health conditions.	Non-mental health specialists with training and supervision, or mental health specialists.	<a href="#">Early Adolescent Skills for Emotions (EASE)</a> group psychological intervention for 10–15-year-olds affected by internalizing problems.
			<a href="#">Problem Management Plus (PM+)</a> for adults and older adolescents to reduce distress (including symptoms of anxiety and depression); includes individual and <a href="#">group</a> versions, both consisting of five sessions.
			<a href="#">Self Help Plus (SH+)</a> for adults and older adolescents experiencing stress; five-session course for large groups.

For children and adolescents			
	Target group and purpose	Delivered by	Examples of activities
Specialized care: Psychotherapy.	For children and adolescents whose suffering continues despite support already mentioned and who may have significant difficulties in basic daily functioning; designed to treat mental health conditions, prevent worsening of conditions.	Mental health specialists.	<a href="#">Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)</a> is an evidence-based structured intervention to address trauma-related symptoms, particularly PTSD among children and adolescents.
			<i>KidNET</i> , a form of TF-CBT in which “children are exposed to trauma memories in a safe environment to construct a coherent narrative of events with the aim of inhibiting the fear response”, has been shown to be particularly effective in reducing mental health symptoms for forcibly displaced children and adolescents in emergency contexts. <sup>220</sup>
			<a href="#">SNAP® (Stop Now and Plan)</a> is a trauma-informed multisystemic intervention targeting at-risk children under the age of 12 which combines cognitive-behavioural approaches with family and community-based interventions. Also includes parent training sessions and school advocacy.
			Child-Centred Play Therapy for children who are experiencing social, emotional, behavioural and relational disorders. <sup>221</sup>

For parents, caregivers and families			
	Target group and purpose	Delivered by	Examples of activities
Promotion and prevention: Social / peer support activities.	For all caregivers; designed to promote well-being, prevent development and worsening of mental health conditions.	Non-mental health specialists with training and supervision, or mental health specialists).	Group-based and peer-support interventions increase formal and informal social support for kinship care families, improve parenting skills and reduce social isolation. <sup>222</sup>
Focused care: Scalable psychological interventions.	For adult caregivers with mental health problems; designed to prevent development and worsening of mental health conditions.	Non-mental health specialists with training and supervision or mental health specialists	<a href="#">Problem Management Plus (PM+)</a> for adults and older adolescents to reduce distress (including symptoms of anxiety and depression); includes individual and <a href="#">group</a> versions, both consisting of five sessions.
			<a href="#">Self Help Plus (SH+)</a> for adults and older adolescents experiencing stress; five-session course for large groups.
			<a href="#">Thinking Healthy</a> , a WHO low-intensity intervention, has shown effectiveness in reducing perinatal depression, including when provided by peers. <sup>223</sup>

For parents, caregivers and families			
	Target group and purpose	Delivered by	Examples of activities
Parent and caregiver interventions	For all caregivers / for high-risk caregivers, including those with mental health problems or with children with mental health problems.	Non-mental health specialists with training and supervision, or mental health specialists.	UNICEF's <a href="#">Caring for the Caregiver</a> (CFC) model aims to build capacity of frontline workers to provide counselling and parenting support services that improve caregivers' emotional well-being and their social support, to enable nurturing care for improved child development outcomes.
			WHO's <a href="#">Caregiver Skills Training</a> for caregivers of children with developmental disabilities, including autism, consists of group and individual sessions focused on enhancing communication, engagement, daily living skills, challenging behaviour, and caregiver coping strategies.
			<a href="#">Incredible Years</a> and <a href="#">Triple P</a> are examples of promotion and prevention parenting programmes informed by social learning theory.
			<a href="#">Tuning into Kids</a> is an example of an emotion-focused parenting programme.
Family strengthening interventions.	For all families and for high-risk families (including families with parents and / or children with mental health problems).	Non-mental health specialists with training and supervision, or mental health specialists.	The <a href="#">Strengthening Families</a> programme is an evidence-based family intervention for both general population and high-risk families designed to strengthen protective factors and reduce risk factors that lead to both substance misuse and youth depression, through a focus on enhanced bonding, boundary-setting, and monitoring of child well-being.
			The United Nations Office on Drugs and Crime's (UNODC) <a href="#">Strong Families Programme for families under stress</a> targets families under stress to strengthen family functioning and healthy interactions, warm parenting style, rule setting, and good parental role modelling. It has been shown to be effective in preventing social and health problems, substance use, violence against children and youth crime, as well as benefiting parental and child mental health.

<b>For parents, caregivers and families</b>			
	<b>Target group and purpose</b>	<b>Delivered by</b>	<b>Examples of activities</b>
Family-focused psychotherapy.	For families with members who may have significant difficulties in basic daily functioning; designed to treat mental health conditions, prevent worsening of conditions, and promote family stability.	Mental health specialists.	Functional Family Therapy, <sup>224</sup> Multisystemic Therapy, <sup>225</sup> and Family Focused Practice <sup>226</sup> are examples of family-focused specialized interventions for families with members with mental health conditions, which aim to improve family dynamics, reduce mental health symptoms, and promote family stability.

### **Box 12. Integrating MHPSS into support programmes for care leavers**

Young people transitioning out of alternative care to independent living experience high levels of mental health problems, exacerbated by the process of leaving care and encountering practical obstacles such as unemployment and financial difficulties. While the MHPSS activities above may be helpful in these situations, it is also important to highlight ways in which MHPSS can be integrated into services specifically for care leavers.

**Extended care programmes** extend the age at which an adolescent is cared for in alternative care, or receive special allowances while living independently as an adult. This gives them more time to build maturity, identify goals, and develop skills to assist their transition.<sup>227</sup> In the United Kingdom, care leavers have the option to remain living with their foster carers until the age of twenty-one, or to move into supported independent living accommodation along with a package of practical and emotional support, provided by someone who they know and trust.<sup>228</sup> These bespoke programmes aim to help develop care leavers' confidence and skills for independent living, as well as their emotional well-being.<sup>229</sup> Studies consistently show that social support is associated with better mental health among care leavers, and care leavers themselves stress the importance of nurturing existing relationships, as well as feeling comfortable in being able to reach out for support.<sup>230</sup>

**Transitional support programmes for care leavers** are designed to help them prepare for their transition to independent living through support with education, employment, housing, and other elements of daily living.<sup>231</sup> They may take the form of training, coaching, peer support, intensive individualized support services, and / or transitional housing programmes.<sup>232</sup> Youth Villages LifeSet is an intensive transitional programme which supports care leavers for up to 12 months during their transition. It includes weekly, hour-long face-to-face support sessions and 24/7 crisis intervention involving skills-building for emotional regulation, psychoeducation on the effects of trauma, and counselling. Practitioners hold low caseloads and receive structured supervision to encourage adherence to the programme. A randomized controlled trial evaluation of the LifeSet model found that it led to reductions in depression and anxiety.<sup>233</sup>

**Personal advisors, coaching and peer support** involve ongoing advice and support to young people after leaving care. Personal advisors provide direct psychosocial support and / or facilitate access to mental health services through local authorities.<sup>234</sup> Better Futures is a coaching and peer support programme for care leavers which has been associated with improved mental health and independent living outcomes, such as access to further education and the development of self-determination skills in making choices to manage their own lives.<sup>235</sup> The programme is delivered by 'peer coaches' who have lived experience of the alternative care system and / or mental health challenges, and includes residential workshops, group mentoring workshops, and one-to-one peer coaching sessions.

## 5.2. Mental health and psychosocial support activities for children and adolescents with specific risk factors

UNICEF Country Offices have highlighted the need for MHPSS activities to support children facing specific risk factors (for instance, children with serious mental health conditions, children with disabilities and complex needs, children at risk of conflict with the law, and children from minority or discriminated groups). In many cases, these children and their caregivers will benefit from the same activities as others along the continuum care (such as those detailed above), but they may also require additional support tailored to their unique needs. In some settings, such services will be provided outside of the care system, with care workers tasked with identifying needs and making referrals. Although a comprehensive overview of interventions for at-risk groups is beyond the scope of this paper, we provide a few examples of unique approaches to support children affected by the risk factors most commonly cited in consultations.

**Children with serious mental health conditions** that impede their ability to function at home, socially, or at school (for instance, psychosis, severe depression or serious symptoms of PTSD) often require specialized interventions such as psychotherapy provided by a clinical psychologist or a psychiatrist, and / or prescription of psychotropic drugs by a psychiatrist. Some of the specialized interventions described above and in Annex 3 are applicable to support children with mental health conditions; for example, for children with PTSD, trauma-focused CBT or KidNET may be appropriate. In these cases, the role of the social service workforce professional is to apply a mental health and well-being lens as part of ongoing support, including identification of needs and referral to an MHPSS professional for a full psychological assessment and specialized care; maintaining ongoing coordination with a child's specialist care team; and promoting intensive community-based services over restrictive care placements.

Historically, children with mental health conditions are at high risk of being placed in restrictive residential care, such as residential psychiatric hospital settings or other residential care facilities. As well as potentially depriving them of liberty, the institutional culture in such settings is harmful for children (see section below on children and adolescents in residential care). Yet despite these problems, residential placements are sometimes used in the absence of adequate community-based services.

When properly resourced, wrap-around community-based MHPSS can allow children to receive intensive care while remaining with their families or in family-based alternative care. For example, **Therapeutic Foster Care (TFC)** allows children with mental health conditions to remain living in family-based care while receiving treatment.<sup>236</sup> This community-based, intensive intervention is designed to support children experiencing complex emotional, psychological and behavioural needs, and attachment difficulties, and / or who have histories of abuse and neglect.<sup>237</sup> While mainstream foster care generally does not provide interventions or trained carers to address complex needs, TFC does exactly this.<sup>238</sup> TFC is delivered by trained foster carers in a family-based care environment, with ongoing oversight and support from multidisciplinary teams including mental health professionals and social workers who provide support and supervision. It includes individually designed care and education plans for children and access to crisis intervention services available around the clock. There is strong evidence for the effectiveness of TFC in improving behavioural and emotional outcomes, including reduced aggression, improved attachment, and greater placement stability.<sup>239</sup>

As discussed earlier, **children with learning disabilities and / or autism** are also at high risk of child-family separation and placement in residential care.<sup>240</sup> Too often such children are dependent on crisis-oriented services. Evidence instead highlights the value of proactive, community-based interventions that strengthen

families' capacity to provide care and improve the well-being of all members, thereby reducing the likelihood of child–family separation. These include:

- **Parent-focused interventions:** A 2023 systematic review found that (semi-)structured support programmes for parents of children with neuro-developmental disabilities, specifically targeting parents' needs, have the potential to advance their health and well-being.<sup>241</sup>
- **Peer and social support:** A systematic review of mental health interventions for parents and caregivers of autistic children highlights the

effectiveness of peer and social support, such as parenting support groups.<sup>242</sup>

- **Professional support and skills training:** Other recommended approaches include professionally led workshops on stress management strategies and problem-solving skills, and access to accurate information about autism spectrum disorder (ASD). WHO and partners have developed the [Caregivers Skills Training](#), a group intervention for caregivers and families of children with developmental delays or disabilities designed to strengthen parenting skills and caregiver well-being.

### Box 12. Supporting families of children with disabilities in Slovakia

As part of an EU-funded Technical Support Instrument (TSI) project in Slovakia, UNICEF ECARO, the European Commission (EC) and the Ministry of Labour, Social Affairs and Family of the Slovak Republic (MLSAF), developed an integrated set of recommended MHPSS interventions to strengthen the well-being of families of children with disabilities across the continuum of care.<sup>243</sup> Recognizing that the moment of diagnosis can be a critical point of emotional vulnerability, the approach recommends ensuring immediate connection to trained social workers who could provide psychosocial first aid, emotional support, and clear, accessible information about the child's condition and available services. Recommended follow-up interventions include structured family counselling, facilitated peer-support groups to reduce isolation and share coping strategies, and ongoing access to psychologists for individual or family therapy. Practical support was integrated into the recommended MHPSS framework, including guidance on navigating entitlements, securing inclusive early education, and coordinating medical and rehabilitation services. The recommended interventions also promoted coordination between health, education, and social services to ensure consistent, family-centred support. This model aimed to demonstrate that embedding psychosocial support from the point of diagnosis through ongoing care can improve caregiver resilience, strengthen family functioning, and enhance the participation and development of children with disabilities.<sup>244</sup>

For **children with complex emotional and behavioural needs who are at risk of coming into conflict with the law**, promotion and prevention MHPSS interventions such as those discussed earlier are critical for helping to prevent mental health problems and offending behaviour from escalating, and in turn preventing a child's deprivation of liberty in residential care. However, when escalation does occur, these young people require focused and specialized MHPSS interventions provided by qualified MHPSS

professionals. TFC – as discussed above – also has a strong evidence-base as an effective intervention for children with complex emotional and behavioural needs.<sup>245</sup> Multidimensional Treatment Foster Care for Adolescents (MTFC-A) has been shown to be effective in reducing symptoms of depression, psychosis, and substance use among adolescents with a history of persistent offending behaviour and to be cost-effective in comparison to residential care.<sup>246</sup>

### **Box 13. Intervention for children and young people with complex emotional and behavioural needs in alternative care in Croatia<sup>247</sup>**

As part of the [Step Forward](#) programme aimed at improving assessment and interventions for children and young people in alternative care in Croatia, UNICEF developed two specialized interventions for adolescents with complex emotional and behavioural needs.

- **Dragon** is a 10-session programme designed for boys aged 9–14 with externalizing behaviours and difficulties with self-control. It helps participants develop self-regulation skills by managing thoughts, emotions, and behaviours in a safe, supportive environment.
- **The Important and Strong** is a 10-session programme tailored for girls in pre-adolescence and adolescence. It focuses on building emotional awareness, developing and sustaining healthy relationships, and strengthening resilience against peer pressure and other negative influences.

Both programmes were piloted, refined, and supported with practitioner handbooks. They have enhanced the capacity of Croatia's social service workforce and demonstrated positive outcomes in supporting children and adolescents with complex emotional and behavioural needs in alternative care.<sup>248</sup>

## **5.3. Mental health and psychosocial support for children and adolescents in residential care**

The institutionalization of children in residential care has been linked to significant harm, including immediate and long-term mental health problems, prompting many to argue that the best way to address the mental health needs of these children is by transitioning them to family-based placements. For example, the Bucharest Early Intervention Project in Romania demonstrated that children moved from residential care to foster care could recover developmental functions, especially when the transition occurred early in life.<sup>249</sup> A systematic and integrative review of evidence regarding the effects of institutionalization and deinstitutionalization on child development similarly found that leaving residential care for family-based care led to significant developmental recovery, while longer stays in residential care increased the risk of adverse outcomes and reduced chances for recovery.<sup>250</sup> The writers argue that every effort should be made to prevent child-

family separation and placement in residential care, and to bring about the deinstitutionalization of children currently in residential care. To this end, they promote prevention approaches which keep children in birth families when possible, and when not possible, in family-based alternatives including extended kinship networks, stable high-quality foster care, and adoption.

A review of an influential joint report by the Directorate of Health and Directorate for Children in Norway (aimed at improving mental health services for children in residential care) notes that the report stresses the need for early identification and assessment of health-care needs, strengthened primary care services that are better coordinated with child protection services, the increased use of digital tools, and the development of specialized residential care run by child protection services in cooperation with child and adolescent mental health services.<sup>251</sup> While the authors welcome the effort to move forward in the coordination of services, they criticize the report's focus on residential care at the expense of family-based care, given that very few children in Norway need specialized in-patient treatment. This reflects a broader risk in Europe and

Central Asia regarding continued over-reliance on specialized residential care over family and community-based care and services.

Another systematic review of interventions to improve health and psychosocial outcomes for children in residential care notes that, due to significantly higher rates of physical, behavioural, cognitive, social, relational and other mental health challenges among children in residential care, compared to the general population, there is a need for MHPSS interventions to be implemented in residential care to prevent further traumas as early as possible.<sup>252</sup> The authors cite evidence for use of trauma-informed care, psychoeducation, and prosocial behaviour and skills-building approaches to improve the well-being of young people in residential care. Other research similarly focuses on improving the quality of caregiving inside residential care<sup>253</sup> and using psychotherapeutic interventions<sup>254</sup> to reduce attachment problems and behavioural difficulties. Indeed, many of the MHPSS activities outlined above and in Appendix 3 are suitable for children in residential care.

Ultimately, this debate is less about the effectiveness of MHPSS interventions for children and adolescents in residential care – there are effective interventions which can be used – and more about the ethics of whether scarce resources should be used to prioritize MHPSS interventions over deinstitutionalization, or vice versa, and whether or not there is scope for both. We would propose that MHPSS interventions for children,

adolescents and caregivers in residential care should be provided *alongside* government plans and interventions to deinstitutionalize such facilities and transition the children to families, to other forms of family-based alternative care, or to supported independent living. **MHPSS as part of a package to address the harm caused by residential care should not become a substitute for deinstitutionalization.**

During consultations, UNICEF country offices shared approaches to strengthening MHPSS for children in residential care without investing heavily in residential care itself; for example, by training community-based workers in MHPSS and facilitating their access to children in residential care, either in the facility itself or in the community. As part of the deinstitutionalization process it is considered good practice to retrain parts of the residential care workforce so they can be redeployed in roles running new or improved family and community-based services.<sup>255</sup> MHPSS should become part of social service workforce retraining to support the challenging transition of children from residential to family and community-based care, as well as the longer-term sustainability of services which support these forms of alternative care. MHPSS should also become part of training for stakeholders with responsibility for implementing deinstitutionalization, including policy makers and other services providers who interact with residential care.

#### **Box 14. The Collaborating Families programme for children in residential care**

A Spanish intervention called Collaborating Families has been designed for young people in residential care to allow them to spend periods of time outside of their residential setting where they temporarily live in a family environment.<sup>256</sup> The aim of the programme is to help the young people establish healthy emotional bonds with others and expand their social support with carers who can offer them individualized support. Children in this programme demonstrated better “psychological adjustment” – defined as the “ability to function adequately in their environment through their cognitive, behavioural, emotional, and social resources” – compared with other young people in residential care.<sup>257</sup> Yet, despite the clear benefits of this intervention, it raises a broader systemic question: if these children are adapting well to and benefiting from these temporary family environments, why are they not being placed in family-based alternative care on a permanent basis?

## **6. How can mental health and psychosocial support be used across the continuum of child care in emergency contexts?**

## 6.1. The mental health needs of children, adolescents, parents, caregivers, and the social service workforce in humanitarian contexts.

Mental health needs across the continuum of care are often complicated or exacerbated in emergency or humanitarian contexts. Children, adolescents, parents and caregivers affected by regional emergencies – such as the conflict in Ukraine and displacement of refugees, ongoing migration through the Mediterranean and Balkans, and the repatriation of children and families from Syria and Iraq – face significant challenges. They may have experienced violence, conflict and forced displacement first-hand, and may face insecurity and instability in host countries.

### Child mental health and well-being

Refugee children who have experienced adverse events prior to or during displacement experience increased likelihood of mental health problems<sup>258</sup> such as anxiety, depression, post-traumatic stress, and sleep disturbances.<sup>259</sup> Research from Europe suggests that while refugee boys more often exhibit externalized reactions in the form of behavioural problems, refugee girls are more likely to exhibit internalized reactions in the form of loneliness and emotional distress.<sup>260</sup>

On arrival in destination countries, children often face stressors such as a prolonged asylum process, financial and legal insecurity, frequent dislocations such as changing home and schools, discrimination, loneliness, boredom and cultural dissonance.<sup>261</sup> Post-migration detention (with or without their families) is associated with increased risk of mental health problems<sup>262</sup> and immigration interviews can also be especially distressing for children, reinforcing negative experiences of authority encountered pre-migration.<sup>263</sup> Protective factors include home-based accommodation, the presence of wider kinship contacts and having visitors come to the family home, as well as living alongside people of the same ethnicity, especially

for children in foster care.<sup>232</sup> Despite these needs, some refugee children do not seek MHPSS due to barriers such as stigma, mistrust of services, and a lack of knowledge of rights and systems.<sup>264</sup>

Children and adolescents experiencing conflict are at risk of becoming separated from one or both parents, which can increase risk of child attachment problems and adverse social and emotional outcomes.<sup>265</sup> Separation from one's family is associated with symptoms of PTSD, depression and anxiety.<sup>266</sup> In emergencies, unaccompanied and separated children (UASC) are at highest risk of mental health problems, experiencing much higher levels of depressive symptoms than their accompanied peers.<sup>267</sup> For example, children independently returning to non-conflict settings after being involved in conflict, such as those being repatriated from Syria and Iraq to their homes and families in Central Asian countries, are at increased risk of PTSD, anxiety and depression, as well as externalizing behaviours such as aggression.<sup>268</sup> Risk is mitigated when even one family member is present in the host country.<sup>269</sup>

Children who are already in alternative care are affected by emergencies and displacement in unique and often profoundly challenging ways. While research is limited, it is clear that such children are at heightened risk of mental health problems due to pre-existing vulnerabilities, including prior exposure to ACEs and other forms of adversity. Emergencies can further strain alternative care systems through staff shortages, disrupted operations, or forced relocations of children in residential care. UNICEF consultations in Ukraine, for example, highlighted significant mental health needs of children in residential care who were displaced to neighbouring countries, including those later reintegrated into family-based care in Ukraine. Children who enter the care system following child–family separation related to the emergency (including in the setting they have been displaced to) are also highly vulnerable, particularly as care systems are often unprepared to handle an influx of children from different cultural and linguistic backgrounds.

## Parent and caregiver mental health and well-being

Parents are also at risk of increased distress in emergency settings. Research has consistently demonstrated the critical role of parent and caregiver mental health, family dynamics, and parenting skills on the mental health outcomes of conflict-affected and displaced children. The mental health of both parents – and in particular a mother's emotional sensitivity, ability to regulate emotions, and attachment style – can have significant impact on child psychological outcomes.<sup>270</sup> Parents who have been exposed to traumatic events may be less warm and harsher with their children, which can negatively impact child adjustment.<sup>271</sup> Positive parental mental health and strong parenting skills act as protection factors, mitigating the development of mental health problems in refugee children.<sup>272</sup>

Importantly, emergencies also bring new challenges for **workforce well-being**, as workers may be personally affected by the emergency and may suffer from secondary or vicarious reactions associated with work with children and families who have suffered extreme adversities.

## 6.2. Mental health and psychosocial support activities in humanitarian contexts

As detailed above, children and their caregivers in emergencies face high risk of mental health problems. MHPSS is therefore critical to address immediate needs and to help preserve family unity and stability, and prevent unnecessary entry into alternative care. Many good practice principles and interventions outlined earlier also apply in emergencies. The [IASC MHPSS Minimum Services Package](#) provides a comprehensive repository of MHPSS activities, including specific resources for UASC.<sup>273</sup>

A central priority in humanitarian contexts is to **prevent child–family separation**, and where separation is unavoidable, to **ensure placement in safe, family- and community-based**

**alternative care with ongoing access to MHPSS**. Supporting continuity of relationships, nurturing care, and access to culturally appropriate MHPSS is essential for mitigating harm and promoting stability.

Given the collective nature of conflict and ways that displacement can disrupt social networks, MHPSS activities should prioritize **social connection, community support, and family dynamics** rather than focusing solely on individual coping mechanisms.<sup>274</sup> This is especially relevant for children across the continuum of care, whose key social ties may have been significantly disrupted. Group and peer-support activities provided in classroom and community environments – including those that aim to strengthen social cohesion among refugee and host community youth, as well as cultural events and recreational and sports activities – can have far-reaching benefits for well-being.<sup>275</sup>

Support to children must also include **supporting parent and caregiver well-being and strengthening parenting skills**. MHPSS for parents and caregivers can promote responsive caregiving despite their own mental health struggles, thus promoting healthier child development in the face of adversity.<sup>276</sup> A variety of caregiver support resources are available,<sup>277</sup> including UNICEF's evidence-based [Caring for the Caregiver package](#) designed to strengthen the capacity of frontline workers to support caregiver stress management, self-care, and parenting skills. Informal caregiver groups that promote peer support and development of social networks can also provide critical social support and peer learning opportunities. By addressing parental mental health and supporting positive parenting practices, interventions can help mitigate intergenerational mental health problems and improve child well-being.

Likewise, **family interventions** targeting youth and parents or caregivers together can be particularly important for this population. UNODC's [Strong Families intervention](#) targets families in

humanitarian and other 'challenged' settings; pilot studies, including with Afghan refugees in Serbia, demonstrate significant improvement in child behaviour and well-being and improved parental functioning.

However, despite the clear value of caregiver and family-focused interventions, families often do not engage in MHPSS interventions, their reluctance to participate stemming from barriers such as cultural norms and stigma surrounding mental health, and immediate challenges faced by displaced families in securing basic needs like food, shelter and stable income.<sup>278</sup> To strengthen engagement and effectiveness, addressing stressors such as securing food and accommodation must be considered alongside MHPSS.<sup>279</sup>

A subset of children (often estimated at one in five) and caregivers in humanitarian contexts will develop a mental health condition and require **specialized care** from an MHPSS professional.<sup>280</sup> As detailed earlier in this paper, this may include psychotherapeutic interventions based on CBT such as narrative exposure therapy, sometimes alongside psychotropic medication. Research points to the need for mental health care not only during and immediately after an emergency, but also in the longer term. Some studies show that while PTSD is increased in the first years after resettlement, rates of depressive and anxiety disorders are found to be increased five years after resettlement.<sup>281</sup> This may be associated with compounding readjustment challenges and other stressors over time.

In humanitarian contexts, MHPSS interventions often require **cultural and linguistic adaptation**.

Programmes need to be socially and culturally meaningful to ensure they remain appealing and relevant.<sup>282</sup> Ideally, providers should work with community members to ensure delivery of culturally (and as relevant, religiously) appropriate information on coping mechanisms, raise awareness about harmful practices such as gender-based violence, and enable traditional mourning ceremonies and rituals. The [Inter-agency Guiding Principles on Unaccompanied and Separated Children](#) promotes culturally appropriate MHPSS for UASC and caregivers in emergency contexts, including use of culturally-tailored coping methods, awareness raising and support activities; the promotion of cultural and religious activities and traditions; and the strengthening of social networks.<sup>283</sup> Foster-care training curriculums developed in Croatia, with support from UNICEF, also include topics on intercultural foster care for foster families caring for UASC.<sup>284</sup>

A significant challenge in humanitarian settings concerns the skills, capacities, and well-being of the **workforce**. Many existing social service workers and MHPSS providers lack emergency-specific training and will benefit from training on the common MHPSS approaches in emergencies, intervention strategies described above, and cultural adaptation. Recruitment and certification of MHPSS providers from displaced communities can help bridge cultural and linguistic gaps. Agencies should implement emergency-specific staff well-being policies, including to support staff who are themselves affected by the emergency (flexible leave, for example), ensure access to MHPSS for staff, and train supervisors to support teams effectively during crises.

### **Box 15. The Light House Centre approach to providing MHPSS for children in foster care and their foster families**

The ongoing conflict in Ukraine has brought an influx of Ukrainian families to Poland, including foster families and children facing challenges related to mental health, adaptation, and access to services. While Polish authorities provide financial aid, many Ukrainian foster families remain outside the national child protection and foster care systems, creating gaps in support and

integration. In response, the One Heart Foster Parenting Association, in partnership with UNICEF, established the Light House Centre – a community-based initiative providing tailored assistance for foster families. The Light House Model is an innovative approach to strengthening foster care by addressing the specific needs of children and caregivers. It supports both Ukrainian and Polish foster families, particularly those caring for children with disabilities and complex needs.

The Centre's approach includes:

- **Integrated service delivery:** A holistic package of services such as psychological support, speech therapy, physiotherapy, educational classes, and targeted interventions for children with disabilities, coordinated under comprehensive case management.
- **Capacity building:** Training foster families and social service professionals to improve their skills in supporting children affected by adversity.
- **Community and social integration:** Creating links between Polish and Ukrainian foster families to build understanding and cohesion.
- **Policy and systemic advocacy:** Documenting and sharing the Light House Model to inform policy changes and promote replication.
- **Support for foster care candidates:** Recruiting, training, and supervising new candidates, including Ukrainian families wishing to qualify under Polish law.

**A key feature of the model is the provision of MHPSS.** The Centre offers safe spaces for therapeutic and psychosocial activities with social workers and community specialists trained in Trust-Based Relational Intervention (TBRI) to strengthen attachment between children and caregivers. Activities such as TBRI summer camps further reinforce child-caregiver bonds. Training and mentorship equip caregivers to manage trauma-related behaviours, manage disabilities, and build emotional resilience in children. Newly certified foster families receive guidance during the critical early stages of fostering, supporting stability and success. These programmes combine practical guidance with emotional support, helping caregivers create nurturing environments for children. The model also fosters integration between Ukrainian and Polish families through workshops and joint activities that promote inclusion and community cohesion. Central to the Light House approach is empowerment and child participation, ensuring children's voices are heard and their rights upheld.

Early results are promising. For example, some children with disabilities have joined inclusive mainstream schools for the first time. The model's success has inspired replication: in July 2025, with UNICEF's support, a second Light House Centre opened in Lodz, offering crisis intervention, family therapy, and specialized support for children with Fetal Alcohol Spectrum Disorder. Discussions with other municipalities indicate strong potential for nationwide adoption and lasting impact on foster care nationwide.

# **7. Conclusion and recommendations: Mental health and psychosocial support across the continuum of care**

This paper aims to support governments and partners in the Europe and Central Asia region to systematically integrate MHPSS into child protection, family support, and care-reform strategies. Drawing on regional evidence, consultations, and practice examples, it demonstrates why a mental health and well-being lens is essential to effective care reform and outlines concrete actions to operationalize this approach. Key conclusions and recommendations are summarized below.

## 7.1. Conclusions

### **Mental health and family stability are deeply interconnected.**

Children exposed to adverse childhood experiences (ACEs) and attachment difficulties are significantly more likely to develop mental health problems, which in turn increase the risk of child–family separation and entry into alternative care. Similarly, when caregivers face untreated mental health problems, children’s emotional well-being is often compromised, and the risk of child–family separation grows.

### **Children across all forms of alternative care face elevated and complex mental health needs.**

Children entering family-based or residential alternative care often carry the cumulative effects of earlier adversity, including ACEs and attachment difficulties. These children enter alternative care with pre-existing vulnerabilities, and many continue to face stressors within the care system itself. As a result, children in alternative care have higher rates of anxiety, depression and behavioural difficulties than their peers.

### **Promotion, prevention, and care-focused MHPSS is essential to successful care reform.**

Care reform aims to improve child protection and family support systems, so they prevent child–family separation, strengthen family-based alternative care, and reduce reliance on residential care. Without integrating MHPSS promotion, prevention and care activities into these reforms, children and

caregivers remain vulnerable to unaddressed mental health challenges, risking cycles of child–family separation and entry into alternative care. MHPSS is therefore essential for sustainable care reform.

### **Effective MHPSS requires coordinated, system-wide responses.**

Children and families along the continuum of care interact with multiple sectors, including social services, health, education, justice, and civil society. Fragmented systems undermine access, continuity and effectiveness. Integrated and multidisciplinary approaches, including coordination between child and adult services, are critical to ensuring that mental health needs are identified early and addressed consistently.

### **Workforce capacity and well-being are foundational to quality care.**

Social service and multisectoral professionals across the continuum of care work under high pressure, with heavy caseloads, complex decision-making, and exposure to adversity and secondary trauma. Without adequate training, supervision and organizational support, these conditions lead to burnout, reduced effectiveness and high turnover. Strengthening workforce capacity through ongoing, trauma-informed and culturally safe MHPSS training – alongside supportive supervision, peer support, and access to MHPSS – is essential to delivering consistent, high-quality services and sustaining care reform over time.

### **Evidence generation, policy alignment, and sustained funding are critical to long-term progress.**

Despite growing recognition of need, major gaps persist in evidence on what MHPSS approaches work best for children, caregivers, and specific at-risk groups along the continuum of care. Investment in monitoring and evaluation, research and disaggregated data is required to guide effective service design and policy decisions. This must be matched by sustained and protected financing to take proven interventions to scale and avoid fragmented, short-term programming.

### **Humanitarian crises heighten mental health risks and reinforce the need for robust MHPSS systems.**

Conflict, displacement and emergencies intensify stress for children, caregivers, and staff. Embedding MHPSS into emergency response and preparedness helps prevent child–family separation, strengthens family functioning, and ensures continuity of support for children in or at risk of entering alternative care.

## **7.2. Recommendations**

UNICEF recommends governments and partners do the following:

### **1. Prioritize MHPSS for families at risk of separation**

MHPSS should be embedded within a multi-layered package of early intervention and family support services to address the impacts of ACEs and attachment problems in children, and to respond to caregiver mental health and substance use problems while strengthening parenting capacity and family cohesion. Well-designed MHPSS can prevent problems from escalating, reducing the likelihood of child–family separation and limiting reliance on alternative care – which can be costly for systems and destabilizing for children – ultimately safeguarding the long-term well-being of children and families.

### **2. Ensure MHPSS is provided to all children and caregivers in alternative care and those leaving care**

MHPSS should be systematically integrated into services for children and their caregivers at all stages of alternative care, including entry, placement, reintegration to families, and transitioning to independent living. Mental health and well-being considerations should inform assessments, gatekeeping, and placement decisions. All children and caregivers in alternative care should have access to evidence-informed MHPSS promotion and prevention activities with focused and specialized care provided when needed. Targeted MHPSS should be provided at high-risk ‘flashpoints’ such as entry into alternative

care, placement changes, experiences of violence or abuse, family reunification, and leaving care.

### **3. Address the harm of residential care through deinstitutionalization supported by MHPSS**

The harms of residential care are most effectively addressed through clear government strategies to prevent children entering residential care, and responsibly closing existing facilities by reunifying children with families or transitioning them into family-based alternative care and independent living. MHPSS should be used to support children in residential care as part of this process, but it should never be used as an alternative or replacement for deinstitutionalization. MHPSS should also be integrated into training for all stakeholders with a responsibility for implementing deinstitutionalization, including policy makers, the residential care workforce, and other services providers who interact with residential care.

### **4. Ensure coordinated and multidisciplinary service delivery**

Governments and partners should improve both horizontal, cross-sectoral coordination (across health, social care, education, justice, and NGOs), and vertical coordination (between child and adult services) to improve access, continuity, and outcomes across the continuum of care. This includes establishing joint case management, shared screening and assessment tools, and clear referral pathways, as well as multidisciplinary teams, cross-sector training and coordination forums. Eligibility for care leavers to access child and adolescent mental health services should be extended up to age 25, along with transitional support to help them access these services.

### **5. Equip the social service workforce to apply a mental health and well-being lens**

MHPSS should be embedded as a core competency for all social service workforce professionals who work with children, adolescents, and caregivers. This requires foundational and ongoing training on the impact of adversity and on trauma-informed, strength and resilience-based, participatory and

culturally safe approaches to MHPSS. The workforce should be equipped with practical skills in basic psychosocial support, early identification of mental health needs, and safe referral to specialized services when required. In addition, social service workers should receive training in evidence-based MHPSS activities for children, caregivers, and families that can be facilitated by non MHPSS specialists and can be scaled up in alternative care settings. Structured supervision and peer support mechanisms are essential to sustain quality and protect staff well-being.

### **6. Strengthen the capacity of MHPSS specialists and multisectoral professionals**

Psychologists, psychiatrists, primary health workers, educators, justice professionals, and other multisectoral actors should receive targeted training to understand unique care-related adversity and associated mental health needs of children and caregivers across the continuum of care. These professionals should also be supported to work collaboratively with the social service workforce and other sectors through shared care planning, coordinated referrals, and in delivering and supervising evidence-based MHPSS activities for children, caregivers, and families.

### **7. Invest in the mental health and well-being of the workforce**

Child welfare and related care sectors are among the most complex, stressful and emotionally demanding areas of work and require dedicated, system-wide well-being support. Governments and agencies should invest in workforce well-being by establishing agency-level well-being policies, procedures and a supportive organizational culture; ensuring that workers have access to supportive supervisors who receive ongoing leadership and staff well-being training; and fostering peer support mechanisms to encourage mutual support. In addition, workers should be

equipped with knowledge, tools and access to MHPSS to support self-care and help-seeking.

### **8. Prioritize MHPSS in emergency contexts**

MHPSS for children and caregivers in emergency contexts is critical to support child and caregiver well-being and prevent child-family separation. Emergency preparedness and response should integrate MHPSS across the continuum of care, with a strong focus on strengthening family functioning and caregiving capacity. When family separation cannot be avoided, children should be provided with family and community-based alternative care with sustained, tailored MHPSS support. Caregivers, including kinship and foster carers, should receive MHPSS to support their own well-being, strengthen parenting skills, and facilitate access to family-focused and specialized services when needed. Re-establishing and strengthening social and community networks should be prioritized as a foundational component of emergency response.

### **9. Strengthen research, data and evidence generation on MHPSS across the continuum of care**

Robust evidence is essential to inform policy, improve service design, guide workforce training, and sustain funding and investment in MHPSS. Governments and partners should invest in high-quality research and evaluation of MHPSS interventions for children and caregivers across the continuum of care; strengthen routine data systems to track mental health needs, service access, quality, and outcomes disaggregated by age, gender, disability, care status and other relevant characteristics; and develop culturally and contextually appropriate screening, assessment, and outcome measurement tools. Evidence should be actively used to inform policy reform, funding decisions, implementation strategies and accountability mechanisms.

## **10. Embed MHPSS principles in policy, funding, awareness and communications, and accountability frameworks**

To ensure the sustainability and system-wide uptake of a mental health and well-being lens, governments should integrate trauma-informed, strength and resilience-based, participatory, and culturally safe approaches into legislation, standards, guidelines and workplace policies, using non-stigmatizing and de-medicalized language that promotes potential for growth and resilience. Children and adolescents in care, care leavers, and families should be meaningfully involved in shaping MHPSS policies, programmes, and services. Stigma reduction strategies and co-designed awareness campaigns should be implemented, particularly targeting groups that are less likely to seek support. Dedicated and sustained funding for MHPSS ring-fenced within child protection and alternative care budgets is essential, alongside clear accountability mechanisms to ensure that governments and service providers deliver on MHPSS commitments.

## Glossary

<b>Adolescents</b>	Individuals in the 10- to 18-year age group. <sup>285</sup>
<b>Adverse childhood experiences (ACEs)</b>	Highly stressful, and in many cases, potentially traumatic events or circumstances occurring before the age of 18 that have been shown to increase the risk of mental health problems later in life. <sup>286</sup> Common ACEs include abuse, neglect, parental separation or divorce, witnessing domestic violence, parental incarceration, or living with someone with substance abuse or mental health problems.
<b>Alternative care</b>	A formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his or her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents. Alternative care includes family-based care which includes kinship care, foster care and other forms of family-based care placements; and residential care which is care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities. <sup>287</sup>
<b>Attachment</b>	Attachment is a clinical term used to describe “a lasting psychological connectedness between human beings” (John Bowlby). Attachment theory highlights the importance of a child’s emotional bond with their primary caregivers. Disruption to or loss of this bond can affect a child emotionally and psychologically into adulthood and have an impact on their future relationships. <sup>288</sup>
<b>Care interventions</b>	Care interventions are a form of mental health and psychosocial support (MHPSS) designed to address mental health problems through personalized care delivered to individuals or groups. Care includes both focused services provided by non-MHPSS specialists with training and supervision, and specialized services provided by MHPSS specialists. These include but are not limited to counselling and psychotherapy, pharmacology, case management services, hospitalization, support groups, self-help plans and strategies, recovery and rehabilitation approaches, and peer support.
<b>Care-experienced children and adolescents</b>	Children and adolescents who have been or are currently in alternative care.
<b>Caregiver</b>	A broad term for those responsible for the care of children and adolescents to ensure their physical, emotional, intellectual and social needs are being met. As well as including family members such as mothers, fathers, grandparents, siblings and others within an extended family network, including kinship carers, it also includes non-family members who play a caregiving role, such as foster carers and residential care professionals.

<b>Child</b>	A human being below the age of 18 years. <sup>289</sup>
<b>Children with disabilities</b>	Children with long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. <sup>290</sup>
<b>Complex needs</b>	Multiple physical, mental, sensory or learning-related needs which impact on the daily life of a child or adolescent, usually requiring support from multiple services.
<b>Externalizing behaviours</b>	Negative acting-out behaviours directed towards others or objects, such as aggression, defiance, or a lack of emotional and self control. These behaviours are characterized by outward manifestations of difficulty, unlike internalizing behaviours that are focused inward.
<b>Family</b>	The United Nations Convention on the Rights of the Child and the United Nations ‘Guidelines for the Alternative Care of Children’ adopt a broad concept of ‘family’, sometimes using the terms ‘parents’ and ‘family’ interchangeably and acknowledging that in some cultures and societies, care by ‘customary caregivers’ (who have care of the child “as provided for by local custom”) or ‘close family’ (immediate family members) should not be considered alternative care (Articles 5 and 3.2 of the Convention on the Rights of the Child). Article 20 of the Convention on the Rights of the Child emphasizes that alternative care is required when a child is “deprived of his or her family environment” rather than specifically “parental care”, and article 3 of the Guidelines notes that State efforts should be on ensuring a child is kept in the care of parents or “other close family members”. ‘Family’ is increasingly recognized as a complex and ever-changing social formation <sup>291</sup> involving a full breadth of individuals and relationships that might be referred to as ‘a family’, and which may include extended family, or “people who choose to spend their lives together in a kinship relationship despite the lack of legal sanctions or blood lines”. <sup>292</sup> Children themselves define family more in terms of relationships characterized by emotional security and other aspects of care, love and support, than of legal or biological criteria. <sup>293</sup> A range of different family types can have equal value in children’s lives, and they are important sources of support, care and identity. <sup>294</sup>
<b>Family support services</b>	Measures or services that are prescribed in legislation to support families and protect children. This means that all children and families have a right, in law, to receive these services and support measures and that they are intended to strengthen families, improve care provided to children, prevent unnecessary separation, and support reintegration. This means they will be linked closely to the factors driving child–family separation in each country. <sup>295</sup>
<b>Foster care</b>	Situations where children are placed by a competent authority in the domestic environment of a family other than the children’s own family that has been selected, qualified, approved and supervised for providing care. Formal foster care can take many forms, including emergency foster care, short or medium-term foster care, long-term foster care, specialized foster care (including for children with disabilities), respite or short-break foster care, fostering to adopt or pre-adoption foster care, and parent and baby fostering (where a parent and child go together into foster care to support parenting skills). <sup>296</sup>

<b>Gatekeeping</b>	A recognized and systematic procedure to ensure that alternative care for children is used only when necessary and that the child receives the most suitable support to meet their individual needs. <sup>297</sup> Placing a child in alternative care should always be preceded by an assessment of the child's physical, emotional, intellectual and social needs, matched to whether the placement can meet these needs.
<b>Institutional culture</b>	An institutional culture means a care environment where children are separated from their families, isolated from the broader community and / or compelled to live together; where children and their families do not have sufficient control over their lives and the decisions which affect them; and where the requirements of the organization take precedence over the individualized needs of the children. <sup>298</sup>
<b>Integrated services</b>	Services across health care, social care, education, justice and other sectors that are connected through effective coordination, referral and information-sharing mechanisms and also often multidisciplinary teams. Integration can be both horizontal (across sectors) and vertical (for example, between child and adult services). <sup>299</sup> The aim of integrated services is to create a unified and seamless experience for users.
<b>Internalizing behaviours</b>	Emotional and psychological processes that are directed inward rather than outward, often involving difficulties in regulating mood and emotions, which may not always be immediately visible to others. Common examples include anxiety, depression, social withdrawal, and somatic complaints such as headaches or stomach aches without a medical cause.
<b>Kinship care</b>	Family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature. Kinship care can include varying degrees of parental contact, short or long-term care arrangements, children moving between households, and arrangements that may be forced upon children due to circumstances. <sup>300</sup>
<b>Mental health</b>	Mental health encompasses people's emotional, psychological and social well-being. It affects how they think, feel and act, and determines how they handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Good mental health is defined as a state of well-being in which individuals realize their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their communities. Good mental health is related to mental and psychosocial well-being. UNICEF's work to improve the mental health of children, adolescents, families and communities includes the promotion of mental health and psychosocial well-being; the prevention of mental health conditions; the protection of human rights; and the care of children, adolescents and caregivers affected by mental health conditions. <sup>301</sup>

<b>Mental health and psychosocial support (MHPSS)</b>	A composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Originally coined by the Inter-Agency Standing Committee (IASC) MHPSS reference group for use in emergency settings, this term is now widely accepted and used by UNICEF and partners across settings to safeguard the dynamic relationship between psychological aspects of experience (a person's thoughts, emotions, feelings and behaviour), the wider social experience (relationships, traditions), and values and culture. 'MHPSS' captures the broad range of mental health and psychosocial support services across prevention, promotion, and care services. Although UNICEF and many other agencies tend to use the composite term 'MHPSS', in some settings, 'mental health' support or services may be more easily understood, and in this case can be used instead of MHPSS. <sup>302</sup>
<b>Mental health conditions</b>	Mental health conditions include a wide range of disorders that affect an individual's cognition, emotion or behaviour, and interfere with a person's ability to learn and function in the family, at work and in society. In many circumstances, conditions can be successfully prevented or treated. Mental health conditions include mental and substance use problems, severe psychological distress, intellectual disabilities and suicide risk. <sup>303</sup>
<b>Mental health problems</b>	This term refers to the broad spectrum of mental health and psychosocial complaints that are not strictly medical or somatic. These can be psychological or social in nature, affecting an individual's functioning in daily life, her or his environment or life events. <sup>304</sup>
<b>Parent</b>	A child's biological mother or father, or another adult who has legally adopted the child.
<b>Prevention activities</b>	Prevention activities aim to stop mental health problems from developing, getting worse or reoccurring. UNICEF programming may include primary or universal prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health problems. <sup>305</sup>
<b>Promotion activities</b>	Promotion activities increase protection factors, including healthy behaviours and coping skills that promote well-being and reduce the risk of developing mental health problems. <sup>306</sup>
<b>Psychoeducation</b>	A form of intervention that involves providing individuals and their families with information, resources and skills related to mental health reactions and conditions in order to enhance understanding, strengthen coping mechanisms, encourage help-seeking and inform care planning, reduce stigma, and ultimately improve well-being. Psychoeducation can be delivered in individual or group sessions, or through written or online resources. It is often used as a component of broader MHPSS interventions.

<b>Psychology</b>	The scientific study of the mind and behaviour. It seeks to understand how people think, feel and behave, and includes subfields such as clinical, cognitive, developmental and social psychology. <sup>307</sup> Clinical psychologists focus on the assessment and treatment of mental health conditions.
<b>Psychotherapy</b>	A specialized mental health intervention which helps people to overcome stress, emotional and relationship problems as well as behavioural difficulties. Psychotherapeutic approaches include cognitive behavioural therapies (CBT), psychoanalytic therapies, arts and play therapies, and others.
<b>Psychiatry</b>	Psychiatry is a medical specialty focused on the diagnosis, treatment, and prevention of mental health disorders. It combines psychological understanding with medical knowledge to treat mental health conditions, often including the use of medication. <sup>308</sup>
<b>Residential care</b>	Care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities, including group homes. <sup>309</sup>
<b>Secondary trauma</b>	A type of psychological trauma that can occur when someone is exposed to the traumatic experiences of others. Similarly, vicarious trauma is a negative reaction to exposure to trauma experienced by others. These reactions can be caused by hearing disturbing descriptions of traumatic events and can affect those working in the social service and healthcare workforce.
<b>Small-scale residential care</b>	A public or private, registered, non-family based arrangement, providing temporary care to a group of four to six children, staffed by highly trained, salaried carers, applying a key-worker system, with a high caregiver-to-child ratio that allows for individualized attention for each child, based on a professionally developed case plan, which takes into account the voice of the child. <sup>310</sup>
<b>Social service workforce</b>	Paid and unpaid, governmental and non-governmental professionals and paraprofessionals who work to ensure the healthy development and well-being of children and families. The social service workforce focuses on programmes that support families and children in communities by alleviating poverty, reducing discrimination, facilitating access to services, promoting social justice, and preventing and responding to abuse and family separation. <sup>311</sup>
<b>Specialized interventions</b>	Interventions which are suitable for those with serious mental health conditions and require an MHPSS specialist (for instance clinical psychologist, psychiatrist) to facilitate.
<b>Trauma</b>	A psychological and emotional response to an event or series of events that are deeply distressing or disturbing, such as abuse, violence, natural disasters, or loss. It overwhelms an individual's ability to cope, often leading to feelings of fear, helplessness, or horror. Trauma can affect mental, emotional, and physical well-being and may result in long-term consequences such as anxiety, depression, or post-traumatic stress disorder (PTSD). It can be acute (from a single incident), chronic (repeated events), or complex (multiple, prolonged traumatic experiences). The impact of trauma is particularly profound in children and adolescents, influencing their development and functioning.

**Trauma-informed approach**

The trauma-informed approach is not an intervention or activity, but rather a way of understanding and engaging with children and caregivers that takes into account the potential impact of past exposure to adversity, including potentially traumatic events. The approach is often described as shifting the focus from ‘What’s wrong with you?’ to ‘What happened to you?’. When done well, trauma-informed practice moves beyond a focus on the impact of trauma to consider the impact of adversities and stressors more broadly, including loss and grief, chronic stress associated with instability and uncertainty, and other factors. This approach aims to deepen understanding of how exposure to adversity and resulting mental health reactions can profoundly affect individuals and communities, influencing their ability to feel safe and build trusting relationships with care staff. It aims to enhance both the accessibility and quality of services by guiding service providers to create safe, culturally sensitive environments that foster trust and encourage individuals to engage meaningfully with the services available to them. It empowers practitioners to collaborate with participants, allowing them to make informed choices about their health and well-being.

**Trauma-focused psychotherapy**

A specialized therapeutic intervention for individuals with psychological symptoms associated with trauma exposure, often with a diagnosis of PTSD. Trauma-focused interventions, such as trauma-focused cognitive behavioural therapy (TF-CBT) aim to reduce symptoms through specialized techniques such as gradually exposing people to reminders of their traumatic experiences to desensitize them to these reminders and reduce fear and distress. These approaches should only be facilitated by mental health professionals such as clinical psychologists or psychiatrists with training in these models and with ongoing clinical supervision.

**Well-being**

A positive state of being when a person thrives. In children and adolescents, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child’s or adolescent’s ability to grow, learn, socialize, and develop to her or his full potential.<sup>312</sup>

## Appendices

The following appendices provide additional and more detailed information about some of the core concepts, ideas and MHPSS activities explored in the main body of the paper.

### Appendix 1 – Additional mental health and psychosocial support concepts, language and frameworks

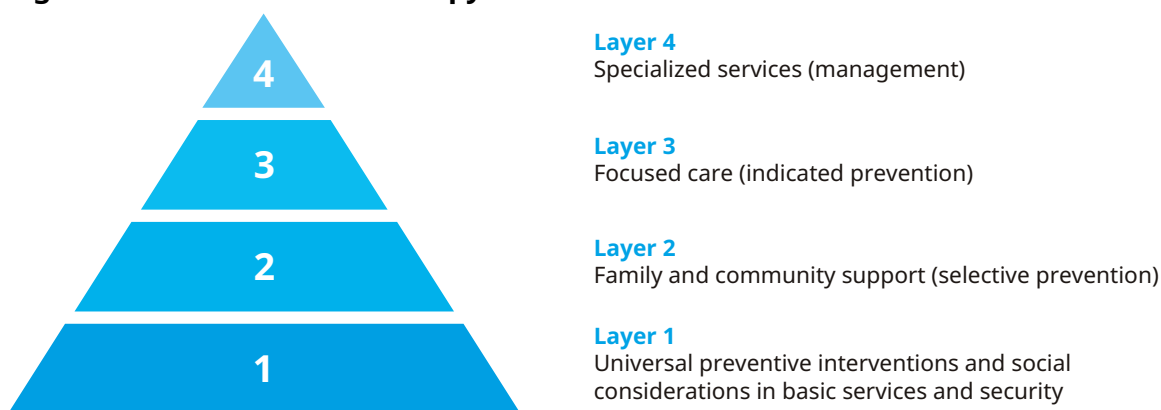
This appendix builds on Section 2 by providing information about additional MHPSS concepts, language and frameworks.

#### Inter-Agency Standing Committee (IASC) intervention pyramid

The IASC intervention pyramid, originally developed as part of the *IASC Guidelines on MHPSS in Emergency Settings*,<sup>313</sup> was initially designed for humanitarian settings but is now also used widely in development settings as well. The IASC intervention pyramid recognizes that people are affected in different ways and require different kinds of services and support. It illustrates the range of complementary support that is required. The foundation of the pyramid begins with **universal prevention** interventions for all families (Level 1). These interventions include social considerations in basic services and security (such as food, shelter, water) in a way that is participatory, safe and socially appropriate to ensure the dignity and well-being of all children and community members. **Selective prevention** (Level 2) includes family and community support, for

instance parenting programmes and activation of social networks. **Focused care** (Level 3) is provided to a smaller number of people who require more focused individual, family or group interventions, for instance psychological interventions. People without a professional license or qualification in mental health care (sometimes known as paraprofessionals or non-specialized staff) can deliver scalable psychological interventions<sup>314</sup> to address these problems if they are well trained, supervised and supported. **Specialized** psychological or psychiatric support (Level 4) targets a small percentage of individuals whose suffering, despite the levels of support already mentioned, is intolerable and who may have significant difficulties in basic daily functioning, including individuals with mental health conditions.<sup>315</sup> This type of support is provided by MHPSS specialists such as clinical psychologists and psychiatrists. The shape of the pyramid is designed to demonstrate that fewer people will need support as the levels increase and become more specialized.

Figure A1.1. IASC intervention pyramid



Source: Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings, p. 13.

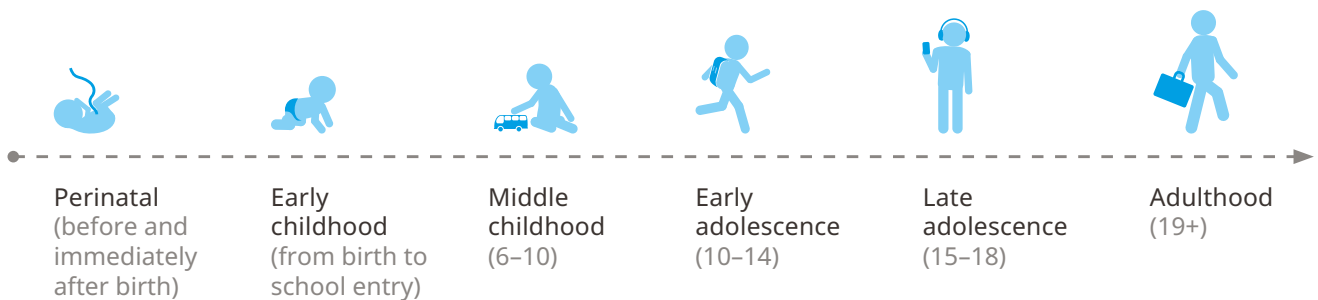
## Life course approach

The life course approach to MHPSS recognizes that child well-being and resilience is directly linked to a child's developmental stage and environmental elements that influence a young person's risk and protection factors. As children and families span

across developmental stages, it is important to ensure that the support provided is informed by the full range of needs, vulnerabilities and strengths experienced at different stages of life.

### Figure A1.2. The Life Course Approach

The life course approach breaks down developmental stages into general age ranges



Source: Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings, p. 10.

## Communicating about mental health and well-being

In recent years, the field of MHPSS has shifted its focus away from a medicalized view centred on deficits and disorders towards a broader understanding that encompasses a variety of responses to stress and trauma, with a strong emphasis on growth and resilience. As part of this shift, there has been a renewed focus on the language and terminology used to discuss mental health. The words used can profoundly impact well-being, stigma, and the willingness of individuals to seek help. Therefore, it is essential to be mindful and deliberate when talking about mental health.

While medical and clinical terms (for instance, trauma, disorder, symptoms, psychotherapy) are appropriate when used accurately and within clinical settings, these terms are often misused or overused. The excessive or incorrect use of vulnerability-focused or medicalized language can lead to the pathologization of what may be natural

responses to stressful situations. Such language may cause individuals to believe they have or will inevitably develop mental health conditions, or that they can only recover with professional help, which is not always the case. This can increase stigma and deter people from seeking help.

UNICEF encourages the use of clear, appropriate, and resilience-focused terminology which provides accurate information about common stress reactions, promotes strengths, and facilitates access to information and MHPSS services. This approach empowers individuals and helps reduce stigma.

- **Limit medicalized or diagnostic language:** Unless it is confirmed that someone has been diagnosed with a mental health condition by a qualified professional (that is, using diagnostic criteria in the ICD-11<sup>316</sup> or DSM-5-TR<sup>317</sup>), it is important to avoid assuming that someone experiencing distress has or will develop a mental health condition. Terms like symptoms can imply a clinical condition; instead, phrases

such as *reactions to difficult situations* are often more appropriate. Similarly, rather than referring broadly to *mental illness*, the term *mental health conditions* is more accurate and flexible. It is also useful to avoid suggesting that specialized services are always required; most people benefit from general MHPSS activities, with only a small proportion needing specialized care.

- **Use of the term ‘trauma’ carefully and avoid overgeneralization:** The term *trauma* is often misapplied to describe any distressing or uncomfortable experience. While some individuals may experience trauma or be diagnosed with PTSD or other trauma-related conditions, it is important not to generalize. Individuals experience and react differently to the same experiences. Some may experience grief, others low mood or anxiety, and most will recover over time. Rather than using *trauma* as an umbrella term for various experiences that increase the risk of mental health issues, it is often more accurate to refer to *adversity*, for instance *adverse childhood experiences (ACEs)*, *distressing events*, or *potentially traumatic experiences*. Instead of referring to individuals as ‘traumatized’, consider use of terms like ‘severely distressed’ or ‘showing signs of distress’.  
Importantly, *trauma-informed care* is a useful approach for working with people who have experienced adversity, including across the continuum of care (see p. X for further discussion). Despite its title, this approach does not necessarily require that someone who has experienced a traumatic event or has trauma-related symptoms; rather it is way of working with all participants that takes potential exposure to adversity into account.
- **Avoid stigmatizing / offensive terms and review translations to ensure appropriate language:** It is essential to refrain from using language that can be harmful or disrespectful, such as terms like ‘crazy’ or ‘mentally weak’. Common expressions such as these can perpetuate stigma. To ensure sensitivity, it is important to engage with community members

to understand the cultural nuances of these terms and identify preferred, respectful language. An MHPSS expert should always conduct, or at least review translation of MHPSS content to ensure accuracy and cultural appropriateness.

By using thoughtful and precise language, we can reduce stigma, foster understanding, and create an environment where individuals feel empowered to seek the help and support they need. Further information on this topic is available through the *IASC MHPSS Minimum Service Package*<sup>318</sup> and the *IASC MHPSS Advocacy Guidelines*<sup>319</sup>. Pre-drafted key messages on MHPSS for children and families are available through UNICEF’s MHPSS Key Message Bank.<sup>320</sup>

## MHPSS policy frameworks

The importance of MHPSS in Europe and Central Asia is legitimized in several global and regional policy frameworks.

**The 2018 Declaration of Astana**<sup>321</sup> aims to ensure physical and mental health problems are addressed through promotive, protective, preventive, curative, rehabilitative and palliative care with a focus on caring for people rather than diseases or conditions. It prioritizes key health system functions aimed at individuals, families and the population as central elements of integrated service delivery across all levels of care. It also addresses the broader determinants of physical and mental health through evidence-informed public policies and systems. It envisages individuals, families and communities as co-producers of health and social services, and as self-carers and caregivers to others.

**The EU Strategy on the Rights of the Child 2021-24**<sup>322</sup> recognizes the importance of promoting children’s mental health and well-being, including encouraging national mental health strategies and building networks that support children’s mental health. It also recognizes the importance of supporting the mental health of migrant and asylum-seeking children.

**The Council of Europe Strategy for the Rights of the Child (2022-2027)**<sup>323</sup> recognizes mental health difficulties faced by children in the EU and difficulties in accessing mental health services. It also recognizes that children in alternative care, among other disadvantaged groups, are more likely to experience mental health difficulties. It is committed to “fostering children’s access to mental health support, dealing with the root causes of children’s mental health difficulties, and promoting children’s mental well-being, including through support for parents, carers, professionals and volunteers working with children to raise awareness and fight taboos about children’s mental health”.<sup>324</sup>

**The WHO European framework for action on mental health 2021–2025**<sup>325</sup> advocates efforts to mainstream, promote and safeguard mental well-being, to counter stigma and discrimination associated with mental health conditions, and to promote investment in accessible high-quality mental health services.

**The European Commission’s Communication on a comprehensive approach to mental health**<sup>326</sup> recognizes the impact of COVID-19 and other crises on the mental health of EU citizens, especially among the young and those with pre-existing mental health conditions. To tackle this, the European Commission has put mental health on a par with physical health by introducing 20 flagship initiatives and €1.23 billion in funding from different financial instruments.

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## Appendix 2 – Mental health and psychosocial training framework for the social service workforce

This appendix elaborates on the abbreviated MHPSS training framework provided in Section 4.

### 1) Foundational knowledge and frameworks.

- Introduction to MHPSS frameworks and guiding principles.
- Cultural sensitivity in MHPSS:
  - Understanding the influence of cultural and community norms on mental health beliefs, stigma, and manifestation of mental health reactions.
  - Cultural adaptation of MHPSS interventions.
- Knowledge, attitudes and practices (KAP) training, including:
  - Addressing and challenging stigmatizing beliefs about mental health among service providers.
  - Addressing stigma and promoting mental health help-seeking across settings.

### 2) Understanding and identifying mental health reactions.

- Child development, attachment, and adversity:
  - Overview of developmental stages, attachment, and protective and risk factors.
  - Impact of ACEs and adversity more broadly (trauma, chronic stress, loss and grief) on children and families.
- Common mental health reactions among children:
  - Recognizing and responding to behavioural, emotional, and somatic manifestations of distress in children of different ages and developmental stages.
  - Understanding risk and protection factors.
  - Recognizing needs and providing appropriate support to at-risk groups such as children with disabilities or those at risk of involvement with the justice system.

### 3) Assessment, identification, and referral.

- Identifying MHPSS reactions and recognizing when additional care is needed.
- Use of screening and assessment tools by non-MHPSS specialists.
- Assessing risk to self and others and safety planning; managing disclosures of abuse.
- Implementation of referral pathways and follow up protocols.

### 4) Core helping skills for use with children.

- Communication and basic psychosocial support skills for use with children and caregivers, including communicating with children of different ages and abilities; engagement and relationship building; normalization of feelings, validation and empathy; active listening; avoiding judgment.
- Supporting children in distress, including stress management, stabilization, and relaxation techniques, supporting children to identify and manage strong emotions, supporting children through grief and bereavement, and responding to crises, suicide and self-harm.
- Training in related models such as Psychological First Aid (PFA) and Foundational Helping Skills (see [EQUIP](#)).

### 5) Parent, caregiver and family MHPSS.

- Understanding the impact of caregiver mental health and parenting capacity on child well-being.
- Supporting caregiver mental health and well-being:
  - Identifying signs of caregiver stress and mental health reactions; risk and protection factors.

- Supporting the mental health and well-being of caregivers and families, including through psychoeducation and destigmatization, emotional support and basic psychosocial support (for instance PFA), family-based and community-based approaches, and referral to specialized services when needed.
- Promoting parent self-care.
- Supporting parents and caregivers to support children:
  - Educating caregivers on child development, nurturing care, communicating effectively with children, children's stress reactions, and coping strategies.
  - Supportive caregiving practices and parenting skills, including managing challenging behaviour and positive discipline.

### 6) Staff well-being and support.

- Defining and identifying risk and protective factors for burnout and vicarious traumatization.
- Organizational strategies for workforce mental health, including supervisory and peer support mechanisms.
- Self-care and team-strengthening activities.

### 7) Intervention-specific training (when relevant and feasible)

- Training in structured group activities, social and emotional learning curricula and scalable psychological interventions appropriate for non-specialist providers (see MHPSS activities section below for more information), to include guidance on when such interventions are appropriate and when to refer for specialist help.

## Appendix 3 – Mental health and psychosocial support activities across the continuum of care

This appendix builds on Section 5 to provide a more detailed overview of evidence-informed MHPSS activities which can be used to support the mental health and well-being of children, adolescents and caregivers along the continuum of care. As in Section 5, it is important to caveat this appendix with a note on the limitations of the evidence-base

for the effectiveness of many MHPSS activities, and the need for caution and further research before selecting a specific activity for use with children and / or their caregivers. Activities should ultimately be selected based on individual needs, on the context, and on the resources available.

### 1. Activities for children and adolescents

The following activities directly target children and adolescents along the continuum of care. An overview of additional resources is available at [Mental Health and Psychosocial Support \(MHPSS\) in Child Protection at UNICEF | Child Protection](#) and in the IASC [MHPSS Minimum Services Package](#).

**Type of intervention:** Social support and peer support interventions for children and adolescents.

**Target participant:** All children and adolescents.

**Stage of child-care continuum:** All.

**Facilitator:** Non-MHPSS specialist.

**Description of intervention:** There is extensive evidence that social and peer support can help prevent and address mental health problems among children and adolescents.<sup>328</sup> Peer support interventions can have positive effects both by facilitating access to support and by creating opportunities to provide support to others, which can be empowering and create a sense of meaning and purpose. These interventions may be particularly helpful when participants feel isolated or misunderstood and / or lack access to other sources of social support or to mental health service providers. Peer support can be delivered informally through family and friends or others with lived experience of mental health problems, or can be facilitated by trained peer support workers.

- **General Peer Support interventions:** The [I Support my Friends](#) model, developed by UNICEF in partnership with Save the Children / MHPSS Collaborative and WHO is a Psychological First Aid (PFA) training intervention to equip children and adolescents (ages 9–17) to support their peers.
- **Non-MHPSS interventions to support social connection and well-being:** Although they do not constitute MHPSS, there are innovative examples of initiatives for social support and well-being. For example, a pilot study in the United Kingdom offers care leavers free broadband for the first twelve months of living independently, with the aim of keeping individuals connected and thereby combatting feelings of isolation.<sup>329</sup> Leeds City Council in the United Kingdom offers free gym access to care leavers until the age of 21 to promote well-being and mental health.<sup>330</sup>

**Type of intervention:** Recreational, sport, and structured activities with MHPSS components.

**Target participant:** All children and adolescents and their caregivers.

**Stage of child-care continuum:** All.

**Facilitator:** Non-MHPSS specialist.

Description of intervention: Physical activity has been shown to positively influence the mental health and well-being of care-experienced children and adolescents by providing meaningful enjoyment as well as developing relational trust, skills, and emotional regulation.<sup>331</sup> Other recreational, creative and social activities have similar benefits. These activities may constitute MHPSS when they have MHPSS objectives and include MHPSS components (for instance, exchange of peer support, learning coping and self-regulation skills, psychoeducation and emotional identification).

- The [Team Up At Home Activity book](#) was developed by Save the Children for refugee children aged 6–18 but is relevant more broadly. It includes 14 group games that promote identifying and sharing emotions, social support, and relaxation and other coping skills.
- UNICEF's [The Adolescent Kit for Expression and Innovation](#) is a package of guidance, tools, activities, and supplies to support adolescents aged 10–18, especially those who are affected by humanitarian crises. The Kit aims to bring about positive change in adolescents' lives through arts and innovation and promotes bringing groups of adolescents together in a safe space on a regular basis to have fun, build social connections, learn to cope with difficult experiences, and take action to create positive change together.

**Type of intervention:** Scalable psychological interventions for children and adolescents.

**Target participant:** Children and adolescents with mental health problems (and their caregivers).

**Stage of the child-care continuum:** All stages.

**Facilitator:** Non-MHPSS specialist with training and supervision provided by a specialist.

**Description of intervention:** Scalable psychological interventions aim to reduce mental health reactions using approaches that can be adapted and scaled up to efficiently and effectively reach large numbers of people. The intervention examples below are evidence-based and include curriculum manuals available in various languages. Scalable interventions are designed to be relatively brief and can be implemented by non MHPSS-specialist providers with training and supervision.<sup>332</sup>

- [Early Adolescent Skills for Emotions \(EASE\)](#), developed by UNICEF and WHO, is a group psychological intervention to help 10–15-year-olds affected by internalizing problems (for instance, stress and symptoms of anxiety, depression) in communities exposed to adversity.
- [Problem Management Plus \(PM+\)](#), developed by WHO for adults and older adolescents, is designed to reduce distress (including symptoms of anxiety and depression), drawing from techniques such as CBT. It includes individual and [group](#) versions, both consisting of five sessions.
- [Self Help Plus \(SH+\)](#), developed by WHO for adults and older adolescents experiencing stress, is a five-session course designed to be provided by non-specialist facilitators to large groups of up to 30 people using an illustrated handbook ([Doing What Matters in Times of Stress](#)) and pre-recorded audio to teach stress management skills. SH+ is well-suited for use as an introduction to MHPSS and can be used alongside other mental health interventions.

**Type of intervention:** Cognitive Behavioural Therapies (CBTs).

**Target participant:** Children and adolescents with mental health problems, including trauma-related conditions.

**Stage of child-care continuum:** All stages.

**Facilitator:** MHPSS Specialist.

**Description of intervention:** CBT aims to help children and adolescents change their thoughts and behaviours to manage their mental health and other problems they are facing. It is a structured therapy that analyses thoughts, feelings, and behaviours to identify unhelpful patterns, and helps participants to learn strategies to change overly negative and inaccurate thinking. CBT interventions have been shown to be effective in reducing symptoms of PTSD, depression and anxiety, especially when combined with other MHPSS interventions.<sup>333</sup> Some forms of CBT specifically target trauma-related symptoms through exposure therapies, including Narrative Exposure Therapy,<sup>334</sup> which guides participants to create coherent narratives of traumatic events (and life stories more broadly) to process and integrate their experiences. CBT-based therapies with a strong evidence-base for children and adolescents include the following:

- [Trauma-Focused Cognitive Behavioural Therapy](#) (TF-CBT) is an evidence-based structured intervention designed to address trauma-related symptoms among children and adolescents.<sup>335</sup> It incorporates development of coping skills, gradual exposure to trauma-related memories, and caregiver involvement to enhance emotional and behavioural outcomes.
- [SNAP® \(Stop Now and Plan\)](#) is a trauma-informed multisystemic intervention targeting at-risk children under the age of 12 which combines cognitive-behavioural approaches with family and community-based interventions, and focuses on teaching self-control, emotion regulation, and problem-solving skills. It also includes parent training sessions and school advocacy.
- **KidNET** is a child-adapted form of Narrative Exposure Therapy in which children safely revisit traumatic memories in a supportive environment to build a coherent narrative of events, helping to reduce fear responses. Evidence shows that KidNET is effective in reducing mental health symptoms for forcibly displaced children and adolescents in emergency contexts.<sup>336</sup>
- **Life Story Work** is a therapeutic intervention that uses a biographical narrative approach offering individuals an opportunity to talk and think about their lived experiences.<sup>337</sup> It has been used support children in alternative care affected by complex trauma, grief and loss, and challenges with identity formation and healthy attachment with carers. The intervention can be carried out by a social worker or specially trained professional along with the involvement of caregivers including foster carers, residential care workers and members of the child's birth family.<sup>338</sup> It involves helping a child to develop a narrative history of their life experience, sometimes through a *Life Story Book*. Data on the efficacy of Life Story Work is limited, but studies show that children in alternative care and caregivers value this approach, and that it has "the potential to help the unaddressed mental health needs" of care-experienced adolescents.<sup>339</sup> However, there are also reports of there being a lack of training and support in how to use it properly.<sup>340</sup>

**Type of intervention:** Play therapy.

**Target participant:** Young children with mental health problems.

**Stage of child-care continuum:** All stages.

**Facilitator:** MHPSS specialist.

**Description of intervention:** Child-Centred Play Therapy is designed for children who are experiencing social, emotional, behavioural and relational disorders. It is provided in a therapeutic, consistent and safe space and delivered using a structured approach. It has been shown to be beneficial to children who have been forcibly displaced in emergency contexts, while unstructured play does not produce the same mental health benefits.<sup>341</sup> As an example, play therapy has been provided to Ukrainian refugee children in residential care in Croatia with encouraging results.<sup>342</sup>

### **Interventions for caregivers**

MHPSS interventions that target both the child or adolescent *and* their caregivers are generally shown to be effective at reducing mental health problems and improving well-being. This is especially true if the interventions focus on improving the caregivers' mental health, including building protective factors (such as secure attachment, parental empathy and a positive coparenting relationship),<sup>343</sup> as well as building the adult caregivers' overall skills and capacity to better support the children in their care.<sup>344</sup> Moreover, the caregivers' involvement as partners in their children's mental health care is shown to play an important role in mental health outcomes.<sup>345</sup> In these situations, it is important for professionals to find a balance between respecting the privacy of the child and involving their caregivers in care-related decision-making.<sup>346</sup>

**Type of intervention:** Prenatal and early years MHPSS interventions.

**Target participants:** All parents and other family-based caregivers, as well as young children.

**Stage of child-care continuum:** Early intervention and family support, family-based alternative care.

**Facilitator:** Non MHPSS specialist; MHPSS specialist.

**Description of intervention:** Prenatal and early infancy MHPSS programmes have shown effectiveness in various forms, including as part of nursing home visits to expectant mothers and their families in difficult social circumstances, school educational interventions, and home teaching to support low-income families and their preschool children.<sup>347</sup> There is evidence that these interventions can reduce child abuse, neglect, coming into conflict with the law, and the uptake of social welfare provisions.<sup>348</sup>

- **Preventing and treating perinatal and postnatal depression:** A study of a prevention programme for postnatal depression for mothers – Practical Resources for Effective Postpartum Parenting (PREPP) – has found it to be effective in reducing maternal symptoms of anxiety and depression.<sup>349</sup> CBT approaches have been shown to be effective in treating perinatal depression, especially when targeting catastrophic thinking.<sup>350</sup> A WHO low-intensity intervention, [Thinking Healthy](#), has shown effectiveness in treatment of perinatal depression, including when provided by peers.<sup>351</sup>
- Strengthening attachment: Parenting programmes targeting younger at-risk infants and toddlers are often influenced by attachment theory.<sup>352</sup> These are concerned with the caregiver's ability to react in a sensitive way to their child, increasing their awareness of their child's signals and needs.
  - **The Incredible Years programme** provides professionals and families with the skills to promote social-emotional learning, academic skills and positive behavioural outcomes for children. There is evidence that the programme is effective in improving parental mental well-being, praise and parenting skills, while evidence for improvements in children's behaviour is mixed.<sup>353</sup>
  - **Promoting First Relationships** is a home visiting parenting programme designed to address the social and emotional needs of early years children and their families, including a video-feedback component which uses a strengths-based approach to promote more sensitive parenting.<sup>353</sup>
  - **Early Relational Health** is a prevention-focused intervention approach, usually provided through home visiting services, to promote healthy attachment. This approach "infuses the concepts of child development, positive parenting and attachment" and focuses on the "earliest interpersonal interactions between infants and their caregivers."<sup>355</sup> These relational experiences aim to support physical, emotional, and cognitive development for children, while protecting against the toxic effects of extreme childhood adversity. For caregivers, these experiences aim to enrich maternal-infant bonding, decrease symptoms of maternal anxiety and depression, and improve stress resilience and physical health.<sup>356</sup>

**Type of intervention:** Parenting and caregiver well-being programmes.

**Target participants:** All parents and other family-based caregivers, sometimes accompanied by young children.

**Stage of child-care continuum:** Early intervention and family support; family-based alternative care.

**Facilitator:** Non-MHPSS specialist; MHPSS specialist.

Description of intervention: Parenting programmes have demonstrated effectiveness in both preventing and treating child mental health problems. They can also benefit parent well-being by increasing parental efficacy and addressing child behavioural problems that may cause distress for parents. Different and overlapping approaches are used in parenting programmes:

- Parenting programmes rooted in social learning theory have been referred to as the 'leading intervention' for tackling children's behavioural problems.<sup>357</sup> Social learning theory focuses on intervening in a harmful cycle whereby caregivers inadvertently reinforce difficult child behaviours, which in turn provoke a negative reaction in the caregiver, creating a problematic cycle. Social learning approaches seek to improve the caregiver's ability to influence their child's behaviour through praise and rewarding positive behaviour, and setting appropriate limits and consistent consequences for difficult behaviour. The [Incredible Years](#) and [Triple P](#) interventions are examples of evidence-based programmes informed by social learning theory.
- Emotion-focused parenting interventions use emotional communication skills to assist children and caregivers to understand and work through emotional experiences so they are less likely to impede healthy functioning. This may include emotion coaching and communication parenting programmes, emotion-focused family therapy, attachment-focused parenting interventions, mindfulness parenting programmes, and behavioural programmes with added emotion components. There is evidence to support emotion-focused parenting interventions in improving parental emotional competence, especially when used alongside behavioural strategies.<sup>358</sup> Emotion-focused activities are particularly important to improve the attachment relationship between children and caregivers. [Tuning into Kids](#) is an example of an emotion-focused parenting programme.<sup>359</sup>
- Caregiver support programmes are often paired or integrated into parenting programmes and aim to support not only parenting skills but also caregiver well-being. For example, [Caring for the Caregiver](#), developed by UNICEF, is a strength-based counselling approach designed to increase caregivers' confidence and help them develop stress management, self-care and conflict-resolution skills to support their emotional well-being.

**Type of intervention:** Social and peer support interventions for caregivers.

**Target participant:** All caregivers.

**Stage of child-care continuum:** All stages.

**Facilitator:** Non-MHPSS specialist.

**Description of intervention:** Access to social support and exchange of peer support are key mechanisms of change for many MHPSS interventions, including parenting and caregiver support programmes mentioned above. In addition, some interventions focus specifically and primarily on facilitating opportunities for peer support.

- **Group intervention for kinship carers:** As discussed earlier, some evidence suggests that kinship carers may experience higher levels of mental health problems than other types of caregivers. Evidence suggests that group interventions for kinship carers can help address these difficulties by improving parenting skills and reducing social isolation.<sup>360</sup> Such group-based and peer-support interventions are shown to increase formal and informal social support for kinship care families.

**Type of intervention:** Scalable psychological interventions for caregivers with distress.

**Target participant:** Caregivers with mental health problems.

**Stage of the child-care continuum:** All stages.

**Facilitator:** Non MHPSS specialists with training and supervision by MHPSS specialists.

**Description of intervention:** As described in the child-focused section, the following scalable psychological interventions target adults:

- **Problem Management Plus (PM+)**, developed by WHO for adults and older adolescents is designed to reduce distress (including symptoms of anxiety and depression), drawing from techniques such as CBT. It includes individual and **group** versions, both consisting of five sessions.
- **Self Help Plus (SH+)**, developed by WHO for adults and older adolescents experiencing stress, is a five-session course designed to be provided by non-specialist facilitators to large groups of up to 30 people using an illustrated handbook (*Doing What Matters in Times of Stress*) and pre-recorded audio to teach stress management skills. SH+ is well-suited for use as an introduction to MHPSS and can be used alongside other mental health interventions.

## Interventions for families

The following interventions target families as a collective unit. This may include birth families, including kinship families, as well as foster families.

**Type of intervention:** Family support interventions.

**Target participant:** Children, adolescents, caregivers, and their wider families.

**Stage of child-care continuum:** Family support, family-based alternative care.

**Facilitator:** Non-MHPSS specialist; MHPSS specialist

**Description of intervention:** Family support interventions aim to support families who do not necessarily have mental health problems but are exposed to significant stressors and therefore at risk of developing mental health problems and / or of child–family separation. Examples include:

- The [Strengthening Families](#) programme is an evidence-based family intervention for the general population and high-risk families designed to strengthen protection factors and reduce risk factors that lead to both substance misuse and youth depression, through a focus on enhanced bonding, boundary-setting, and monitoring of child well-being.
- The [UNODC Strong Families Programme for families under stress](#) aims to strengthen family functioning and healthy interactions, warm parenting style, rule setting, and good parental role modelling. It has been shown to be effective in preventing social and health problems, substance use, violence against children and youth crime, as well as benefiting parental and child mental health.

**Type of intervention:** Family-focused therapies.

**Target participant:** Children, adolescents and their wider families with mental health problems.

**Stage of child-care continuum:** Family support, family-based alternative care.

**Facilitator:** MHPSS specialist.

**Description of intervention:** Family focused therapies target families struggling with existing mental health problems and related challenges such as substance use, or children who are at risk of offending. Of the following interventions, the first two in particular have a strong evidence-base for supporting families with children at risk of being placed in alternative care:<sup>361</sup>

- **Functional Family Therapy**<sup>362</sup> is a family-centred intervention designed to enhance positive family dynamics while reducing intense negativity and dysfunctional behavioural patterns. It targets the cognitive, emotional and behavioural needs of each family member, addressing various risk and protection factors at the individual and family levels. Evidence has demonstrated its effectiveness in decreasing substance use and both internalizing and externalizing behaviours among children.
- **Multisystemic Therapy**<sup>363</sup> is an intensive family and community-based programme that addresses the multidimensional factors – including family, peers, school and community – which influence a child’s behaviour. It is shown to improve family functioning, decrease substance use, reduce mental health issues, and reduce the likelihood of young people being placed in alternative care.
- **Family-focused practice (FFP)** targets families in which at least one parent or caregiver has a mental health need, aiming to mitigate the significant risks associated with parental mental health difficulties to the well-being of children.<sup>364</sup> The intervention focuses on family relationships with both parents and children supporting each other’s mental health.<sup>365</sup> It is a ‘whole family approach’ to address complex needs, including care planning and goal setting, linkage with services, emotional and social support, assessment of family functioning, and coordinated wrap-around care. Providers may offer psychoeducation and other support to help children to understand and cope with their parents’ mental health problems. A systematic review of family-focused practice interventions<sup>366</sup> demonstrates positive outcomes including improved family functioning, better parent-child relationships, enhanced parental mental health and reduced substance misuse, as well increased knowledge of mental health issues and child development. Children showed improved behavioural and emotional functioning, stress reduction, and understanding of parental issues.

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