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MAPPING OF MENTAL HEALTH AND PSYCHOSOCIAL SERVICES FOR CHILDREN AND YOUNG PEOPLE IN KOSOVO

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AUGUST 2026

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Acknowledgements

The mapping report was commissioned by the UNICEF Kosovo[1] and implemented by the Institute of Psychology, University of Prishtina. The team extends its sincere gratitude to all those who contributed to the successful completion of this report. This report is the product of the research, insights, expertise, and collaborative efforts of many individuals and organizations. We particularly acknowledge all the members of the Technical Committee who played a critical role in development of this mapping report. We are deeply appreciative of the leadership and staff of the UNICEF Kosovo Office, whose leadership and consistent support provided the foundation for this work. In particular, we wish to acknowledge and thank Mr. Benjamin Samuel Fisher, Ms. Teuta Halimi, Mr. Laurat Raca and Ms. Hana Ilazi for their continuous guidance, facilitation, and support at every stage. We further recognize the contributions of central and municipal stakeholders, implementing partners who generously shared their time, perspectives, and expertise. All of the inputs have been instrumental in shaping the findings and recommendations presented here.

[1] All references to Kosovo shall be understood in the context of UNSCR 1244 (1999)

Abbreviations

BHIS	Basic Health Information System
CAMH	Child and Adolescent Mental Health
CBT	Cognitive Behavioural Therapy
CPD	Continuing Professional Development
CSW	Centre for Social Work
DKA	Municipal Education Directorate
DSHMS	Directorate of Health and Social Welfare
ECI	Early Childhood Intervention
EASE	Early Adolescent Skills for Emotions
EMIS	Education Management Information System
ESPAD	European School Survey Project on Alcohol and Other Drugs
FGD	Focus Group Discussion
FMC	Family Medicine Centre
HAT	Helping Adolescents Thrive
IFSP	Individualized Family Service Plan
KAS	Kosovo Agency of Statistics
KII	Key Informant Interview
KAS	Kosovo Agency of Statistics
KPSh	Primary Health Care / Kujdesi Paresor Shendetesor
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and Intersex
MES	Ministry of Education and Science
MDT	Multidisciplinary Team
MFLT	Ministry of Finance, Labour and Transfers
MHPSS	Mental Health and Psychosocial Support
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NEET	Not in Education, Employment or Training
NGO	Non-Governmental Organisation
ECI	Early Childhood Intervention
OGG	Office for Good Governance
PHC	Primary Health Care
PTSD	Post-Traumatic Stress Disorder
QKUK	University Clinical Centre of Kosovo
QRShP	Regional Public Health Centre
SEN	Special Educational Needs
SLT/OT	Speech and Language Therapy / Occupational Therapy
EMIS	Education Management Infrmation system
SOP	Standard Operating Procedure
UCC / UCCP	University Clinical Centre (Prishtina)
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Executive Summary

1. Context and Rationale

Kosovo has one of the youngest populations in Europe, with more than 423,000 children under the age of 18 years, representing around one-quarter of the population. This demographic profile creates a major opportunity for human capital development but also places a clear obligation on institutions to protect and promote the mental health and psychosocial well-being of children and adolescents. A child born in Kosovo today is expected to reach only 57 percent of their potential, largely due to constraints in health and education. Poverty, unemployment, low participation of women in the labor market, and the high proportion of young people not in education, employment, or training create structural pressures that affect children, families, and communities.

Children and adolescents in Kosovo grow up in a context where multiple risks converge. Available evidence points to high levels of emotional distress, anxiety, low mood, trauma-related symptoms, substance use, digital risks, bullying, violence in schools, and at home. Children from vulnerable groups, including children from Roma, Ashkali, and Egyptian communities, children with disabilities, those living in rural areas or low-income households, children affected by migration or repatriation, and children from other minority communities, are disproportionately affected and face additional barriers regarding safety, inclusion, and access to essential services.

These challenges underscore the importance of ensuring that mental health and psychosocial support services are accessible, equitable, and responsive to the diverse needs of children and adolescents. To better understand the capacity of existing systems to address these needs, UNICEF commissioned the mapping of mental health and psychosocial support services for children and adolescents in Kosovo conducted in partnership with the Institute of Psychology at the University of Prishtina. The purpose of the mapping was to assess how existing systems are prepared to respond to the needs of children and adolescents, identify service gaps and inequities, and propose practical priorities for a more coherent, multi-sectoral Mental Health and Psychosocial Support Services (MHPSS) response.

2. Methodology

The mapping used a mixed method and participatory design. It combined a desk review of legal, policy and strategic documents with a review of available evidence on child and adolescent mental health in Kosovo. Primary data collection included 16 key informant interviews with central and local stakeholders and 12 focus group discussions with more than 90 participants. Participants included children and adolescents from urban and rural areas, children from Roma, Ashkali and Egyptian communities, Serbian youth, parents and caregivers, school psychologists and MHPSS service providers.

A Technical Committee co-chaired by the Office for Good Governance/Office of Prime Minister and UNICEF guided the design and implementation process as well as validation of findings. The analysis was organized around UNICEF's social-ecological model and the tiered MHPSS framework, with attention to child, family, school, community, and enabling-environment factors, and to the continuum from universal promotion and prevention to targeted psychosocial support and specialized care. The study received ethical clearance from the Health Media Lab Institutional Review Board. The findings should be interpreted in light of several limitations, including the

predominantly qualitative design, purposive sampling, and the lack of routine, disaggregated data on child and adolescent mental health.

3. Key findings on the needs and risks

The mapping confirms a high and growing burden of mental health and psychosocial concerns among children and adolescents in Kosovo. Available evidence shows substantial levels of anxiety, depression, somatic complaints, and trauma-related symptoms among adolescents, with higher levels of distress reported among girls, young people in poverty, and children exposed to family or school violence. Kosovo also carries a post-conflict legacy, with evidence of intergenerational transmission of trauma from parents to children. This makes child and adolescent mental health not only a clinical issue, but also a broader social and developmental concern.

One of the most urgent findings relates to suicidal ideation and attempts among 15- and 16-year-old students, which have increased markedly across European School Survey Project on Alcohol and Other Drugs (ESPAD) rounds with self-reported suicide attempts increasing from 3.4 per cent in 2011 to 10.0 percent in 2024 among Kosovo students. These trends point to the need for stronger prevention, early identification, crisis response and suicide surveillance. At present, Kosovo does not have a unified suicide registration and monitoring system that can provide reliable, age-disaggregated data on adolescent suicide deaths, attempts, risk factors, and service contact.

Risks are present throughout the child's social ecology. At the family level, violent discipline, domestic violence, poor communication, parental migration, economic hardship, and parental trauma increase vulnerability, while stable and cohesive family relationships remain strongly protective. At the school level, bullying, peer violence, staff violence, academic pressure, social comparison, and inconsistent inclusion of children with disabilities undermine well-being. At the community level, stigma, discrimination, child marriage, child labor, migration, and weak access to services compound the risk for already marginalized children. Digital environments have become an additional source of concern, with parents and children reporting cyberbullying, harmful content, unsafe online contact, fake accounts, digitally altered images, and online trends that can translate into real-world harm.

4. Service landscape and system gaps

MHPSS services for children and adolescents exist across health, education, and social protection systems as well as delivered through civil society organizations and the private sector, but they do not yet function as one coherent system. Families and young people experience the current landscape as fragmented, confusing and often unaffordable. There are multiple entry points, including schools, family medicine centers, Centers for Social Work, Non-Governmental organisations (NGO), private providers, and online spaces, but there is no visible, youth and family-friendly pathway that explains where to go, what support is available, how referrals work, and what follow-up can be expected.

In the health sector, child and adolescent mental health services remain highly centralized in the capital city – Prishtina. Public specialist capacity is very limited, with few child and adolescent psychiatrists and psychologists, and the only dedicated child and adolescent psychiatric service is located at the University Clinical Center in Prishtina. Primary health care has the potential to support early identification, especially through family medicine and the home visiting program, but adolescent mental health screening and brief intervention are not yet systematically integrated.

Families report long waiting times, transport barriers, limited privacy, high out-of-pocket costs, and frequent movement between public, private, and NGO services.

In the education sector, schools are the most accessible platform for mental health promotion and early identification, but coverage and quality vary widely. Where school psychologists are available, they provide counseling, group activities, prevention work, teacher consultation, and referrals. However, many schools have no psychologists, and many psychologists cover multiple schools. Their role is often stretched across counseling, crisis response, behavior management, prevention, documentation, and administrative tasks, without a standardized model of practice, supervision, or clear referral tools. In some schools, psychological support is still associated with discipline or punishment, which discourages voluntary help-seeking.

Centers for Social Work are legally mandated to support children and families in situations of vulnerability, but they are overburdened and under-resourced. Many centres have limited access to psychologists or specialized staff, and psychosocial work is often reduced to assessment, referral and crisis management. NGOs and private providers fill important gaps, especially for children with developmental needs, trauma-related concerns, and complex family vulnerabilities. However, NGO services remain project-dependent, and private services are unaffordable for many families, which creates interruptions in care and deepens inequity.

5. Legal and Policy Environment

Kosovo has a solid rights-based legal foundation for child and adolescent mental health. The Constitution and legal framework on health, education, child protection, social and family services, and early childhood education recognize children's rights to healthy development, safe environments, and psychosocial support. Administrative instructions define some roles for school psychologists and child protection mechanisms. The Early Childhood Intervention Strategic Document and Action Plan 2025 to 2030 is an important opportunity to strengthen early identification and family centered support for children age 0 to 6 years.

However, implementation remains weaker than the normative framework. Kosovo does not yet have a dedicated child and adolescent mental health strategy, a costed multi-year action plan, or clear budget lines for MHPSS across sectors. The Law on Mental Health does not sufficiently define the pathways for children and adolescents, school-based support, community prevention, or links to social protection and education. A revised draft Law on Mental Health is reported to be in the final stages of preparation by the Ministry of Health, offering an opportunity to address these gaps explicitly. The legally mandated child helpline has not yet been fully operationalized. These gaps mean that rights and policy commitments are not consistently translated into services that children and families can access.

6. Cross-sector system issues

The MHPSS landscape is shaped by five cross-cutting systemic issues. First, coordination and referral pathways are largely informal and rely on personal relationships among professionals rather than on shared protocols, time-bound feedback, and joint case management. Second, access remains inequitable, with rural families, low-income households, minority communities, and children with disabilities facing combined barriers of distance, cost, information, stigma, and lack of adapted services. Third, the system remains more crisis-oriented than preventive, with limited

investment in mental health literacy, early identification, school-based support, and primary care screening.

Fourth, workforce planning, licensing, and supervision are weak. School psychologists, social workers, clinical psychologists, NGO providers, and other frontline professionals often work with complex cases without structured supervision or sufficient access to evidence-based tools. Fifth, the existing data systems do not allow systematic monitoring of child and adolescent mental health needs, service use, referrals, waiting times, quality, or outcomes. Education, health, and social services information systems lack basic MHPSS indicators, and NGO and private sector data are not integrated into central level data monitoring system. Without these system functions, coverage, quality, and accountability cannot be managed at the population level.

7. Priority Package of MHPSS Actions

The report proposes a Priority Package of MHPSS Actions for Children and Adolescents in Kosovo. The package should be understood not only as a list of services but also as a phased agenda for system strengthening. It should start with foundational actions that create the conditions for effective service delivery through a central governance and coordination mechanism, a dedicated Child and Adolescent Mental Health (CAMH) strategy and costed action plan, sustainable financing, regulation and contracting of non-government providers, child-specific legal and procedural safeguards, workforce development and supervision, Kosovo-wide implementation support, and integrated data and monitoring.

The delivery service actions should be organized across three tiers. At Tier 1, universal promotion and prevention should include continuous mental health literacy and stigma reduction, establishment of the child helpline, a joint digital psychoeducation and self-help platform, gatekeeping and early identification in schools, and operationalization of Early Childhood Intervention (ECI) teams. At Tier 2, targeted and early intervention should include structured parenting support, school-based counseling and referral, evidence-based school interventions such as Helping Adolescents Thrive (HAT) initiative and Early Adolescent Skills for Emotions (EASE), adolescent mental health screening in primary care, social and family support through Centers of Social Work, and contracted NGOs bridging services for children with neurodevelopmental and complex psychosocial needs. At Tier 3, specialized and crisis responses should include school crisis pathways, specialist multidisciplinary assessment for complex cases, and a 24/7 youth crisis line and chat linked to local services, emergency response, and follow-up care.

These actions should be phased and budgeted. In the immediate term, Kosovo should establish the central level coordination mechanism, finalize the child helpline pathway, define referral and feedback tools, pilot school-based gatekeeping and primary care screening, and prepare the CAMH strategy and action plan. In the medium term, Kosovo should expand school psychology coverage, introduce structured supervision, contract core NGO services, strengthen Centers for Social Work, and operationalize ECI teams. Over the longer term, the priority package should be scaled Kosovo-wide with routine monitoring, quality assurance, and dedicated financing.

8. Overall implications

The mapping shows that Kosovo has the foundation needed for a stronger child and adolescent MHPSS system with committed professionals, active civil society, a growing policy window, relevant legal frameworks, and increasing public awareness. The core challenge is not the absence of effort.

It is the absence of a coherent, financed, and coordinated system that can bring these assets together and make support accessible, trusted, and continuous for children and families.

The current political attention to child and adolescent mental health creates an important opportunity. To make the most of this opportunity, Kosovo should move from fragmented, project-based initiatives to a central, tiered, and child-centered system anchored in schools, primary health care, social services, and community-based providers. This requires clear governance, predictable financing, a supervised workforce, shared referral pathways, better data, and meaningful participation of children, adolescents, and caregivers. Investing in child and adolescent mental health is, therefore, not a discretionary program. It is a core obligation for the protection of children's rights, human capital development, and the well-being of Kosovo's youngest generation.

Introduction

The mental health of children and adolescents is one of the most neglected health issues globally, which remains underprioritized. An estimated 10–20% of children and adolescents experience mental health issues, and about half of all adult mental health disorders begin by age 14[1]. Mental health conditions account for a substantial share of the global burden of disease among 10–19-year-olds, and suicide was among the top five causes of death in this age group before COVID-19.[2] In the latest WHO global suicide estimates, suicide was the third leading cause of death among 15–29-year-olds in 2021, while UNICEF reports that suicide is the fourth leading cause of death among adolescents aged 15–19 globally.[3] Although international agencies and governments, including those in the EU, increasingly recognize the importance of Mental Health and Psychosocial Support (MHPSS), systematic and comprehensive programs remain limited, particularly in less developed countries[4]. Around 90% of adolescents live in low- and middle-income countries[5],[6] where child and adolescent mental health services are often underfunded, fragmented, and hard to access, with stigma further discouraging help-seeking even when services exist[7].

Kosovo's population stands at 1.6 million, with over 423,000 children under 18, accounting for 26 percent of the total population. Despite the average age increasing by five years over the past decade, reaching 35, Kosovo still has the youngest population in Europe.[8] However, according to the Human Capital Index, a child born today in Kosovo will only reach 57 percent of their potential due to limited investment in education and healthcare.[9] As an upper-middle-income economy, Kosovo has seen robust growth in recent years. Yet, this growth has not translated into a significant reduction in unemployment, with 18 percent of the population still living below the poverty line.[10] While 40.7 percent of the total working-age population is active, the rate among women is significantly lower at just 24 percent. Additionally, one in three young people aged 15-24 (33 percent) are not in employment, education, or training.[11]

DEFINITION OF MENTAL HEALTH

Mental health is fundamental to the ability to think, feel, learn, work, build relationships, and contribute to society. It is more than the absence of mental disorders and is a core component of overall health and well-being[12].

Mental health and psychosocial well-being refer to a positive state in which children and adolescents are able to cope with emotions and everyday stressors, build relationships and develop social skills, learn, and maintain a positive sense of self and identity.[13]

Childhood and adolescence are periods of rapid developmental change, including a critical period of brain growth in which proximal social environments strongly shape mental health and well-being. During this stage, mental disorders may emerge, and many risk factors associated with poor mental health later in life also begin to develop.[14] Risks and protective factors across different levels of social ecology are therefore key determinants of mental health and developmental outcomes[15]. Poor mental health can have a profound impact on children's and adolescents' health, learning outcomes, social well-being, and participation, ultimately constraining their ability to realize their full potential. [16],[17],[18]

DEFINITION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mental Health and Psychosocial Support (MHPSS) refers to any support that children, adolescents, families, and caregivers receive to protect or promote their mental health and psychosocial well-being, or to treat mental health conditions. MHPSS includes various approaches, from promoting environments that support healthy development and well-being to providing specialized psychological and psychiatric care, including the provision of education and information on mental health.

Kosovo has made considerable efforts to address child and adolescent mental health, namely through several important initiatives, including: the deployment of school psychologists to support early identification and prevention of poor mental health; the establishment of the Child and Adolescent Psychiatric Service at the University Clinical Centre Prishtina (UCCP); the home visiting programme for pregnant women and children aged 0-3 operating in 34 out of 38 municipalities; the integration of mental health and psychosocial support within child protection and justice settings; and the approval of the Early Childhood Intervention (ECI) Strategic Document and Action Plan 2025-2030 (Government Decision Nr. 05/253, March 2025).

Despite these efforts and investments, access to quality and age-appropriate services remains limited, unevenly distributed, and far from universal. Mapping the available mental health services across sectors in Kosovo is critical to addressing existing gaps and ensuring coordinated, equitable, and sustainable MHPSS for children and adolescents.

To support the mental health and psychosocial well-being of children and adolescents in Kosovo, a holistic, tiered MHPSS approach is required, combining actions to:

- Promote and protect well-being for all children and adolescents;
- prevent poor mental health by addressing risks and strengthening protective factors, at family, school, and community levels; and
- ensure timely, quality, and accessible care for children and adolescents with mental health conditions, including clear referral pathways and continuity of support.

Achieving this requires coordinated, multi-sector engagement across health, education, justice, and social welfare services, together with active involvement of municipal authorities, schools, communities, parents and caregivers, service providers, and, particularly, children and adolescents themselves. Strengthened coordination mechanisms and budget allocations are essential to translate commitments into consistent service delivery across sectors.

This multisectoral, tiered approach aligns with UNICEF's Global Multisectoral Operational Framework for MHPSS of Children, Adolescents, and Caregivers Across Settings.

MHPSS Mapping

Aim and objectives

The aim of this mapping study is to support the further strengthening of MHPSS systems and services for children and adolescents in Kosovo. More specifically, the MHPSS mapping exercise aims to clarify what child and adolescent MHPSS services exist, where the main gaps and inequities lie, and which groups are least reached, in order to guide priority actions toward a more comprehensive, community-based and multisectoral MHPSS system, in line with UNICEF's Global Frameworks for a minimum package of services for Kosovo. Commissioned by UNICEF and conducted by the University of Prishtina, Institute of Psychology, the study adopted a participatory approach, engaging relevant stakeholders across the design, implementation, and validation of findings.

Methodology

This mapping used a mixed-method, participatory design, combining a secondary data review with primary data collection. Desk reviews synthesized available evidence, Kosovo reports, and research articles on child and adolescent mental health, and key policies and legal documents across the health, education, and social welfare sectors. Primary data collection consisted of consultations with policymakers, service providers, caregivers and adolescents.

- Drawing on UNICEF's Multisectoral Operational Framework for MHPSS[19] , which emphasizes a tiered continuum of services across the social-ecological model, the analysis was organized around four dimensions **Service alignment with the MHPSS tiered framework:** the extent to which existing services correspond to UNICEF's three-tiered model of mental health and psychosocial support, universal promotion and prevention, targeted and early intervention, and specialized clinical services.
- **Equity, inclusion and multisectoral integration:** attention to the most vulnerable children and adolescents, including children with disabilities, children in alternative care, children from Roma, Ashkali and Egyptian communities, and gender-diverse groups, and the degree of integration across health, education, social protection and justice sectors.
- **Community relevance and participation:** the extent to which services are community-driven and culturally appropriate, and the degree of meaningful participation of children, adolescents and families in service design and delivery.
- **Coordination, referral, monitoring and accountability:** the functioning of cross-sector referral and feedback mechanisms, and the use of indicators to track service quality, coverage and outcomes

Sampling and Data Collection: A purposive sampling strategy captured perspectives from key stakeholder groups involved in MHPSS policymaking, service delivery and service use, complemented by snowball sampling. 16 Key Informant Interviews were conducted with stakeholders at the central and local levels covering health, education, and social sectors, including civil society service providers (Annex 1: List of Key Informant Interviews). Additionally, 12 Focus Group Discussions were held with more than 90 participants, including children and adolescents (school grades 6–9 and 10–12) from urban and rural areas, children and adolescents from Roma, Ashkali and Egyptian communities, Serbian youth, parents and caregivers from urban and rural areas as well as non-majority communities (Serbian, Roma, Ashkali and Egyptian communities), CSO

representatives and MHPSS providers and school psychologists (Annex 2: List of Focus Group Discussions).

Analysis: Semi-structured Key Informant Interviews and Focus Group Discussions were conducted using interview templates and topic guides adapted from the UNICEF MHPSS Toolkit (Annex 3: Topic guides for individual interviews, focus groups and consent forms). Thematic analysis was used to identify patterns related to availability, access, quality, gaps, and implementation challenges. Content analysis of policy and strategic documents, reports, and consultation notes identified trends, convergences, divergences, and structural barriers. Comparative analysis across stakeholder groups, sectors, geographic areas and vulnerability categories supported interpretation, and triangulation across methods and sources underpinned integrated findings and recommendations.

Governance: A Technical Committee co-chaired by the Office of the Prime Minister/Office for Good Governance and UNICEF was established, comprising representatives from the Office of the President, the Office of Strategic Planning within the Office of Prime Minister, the Ministry of Health, the Ministry of Education and Science, the Ministry of Finance, Labour and Transfers, the Ministry of Justice, the Ministry of Youth, Culture and Sports, the Mental Health Centre for Children and Adolescents, the National Institute of Public Health, the Ombudsperson Institution, the Faculty of Education at the University of Prishtina, civil society organisations (KOMF, the Association of School Psychologists of Kosovo, the Kosovo Education Centre, and the Centre of Information and Social Improvement). The Committee reviewed and endorsed the methodology, provided guidance at key stages, and reviewed preliminary findings prior to finalization (Annex 3: Members of the Technical Committee).

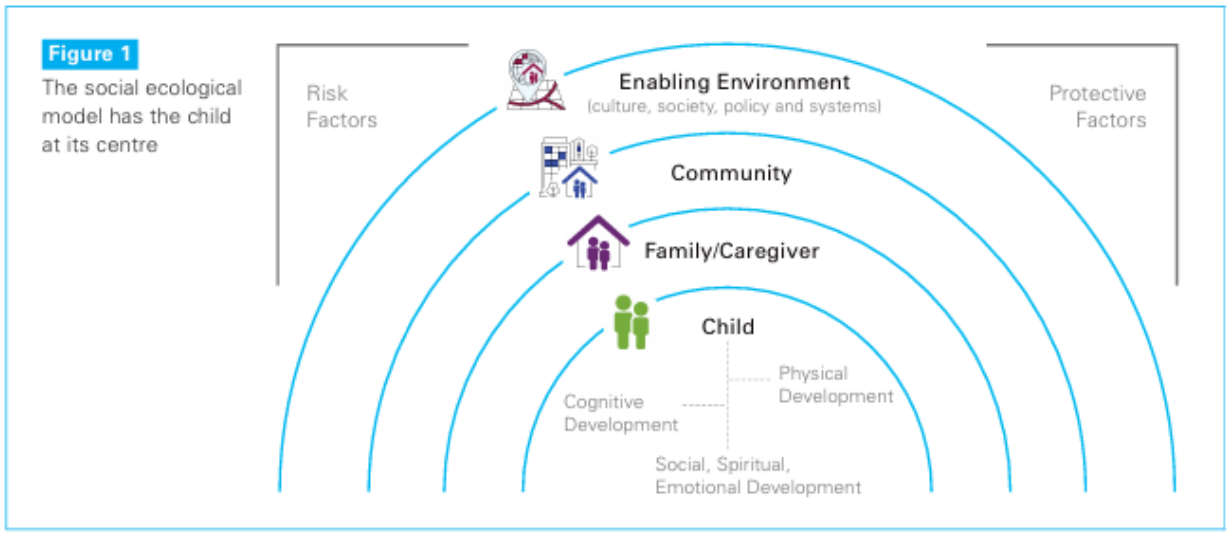
Ethical considerations: The study design and data collection followed UNICEF's Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis. During inception, the Institute of Psychology and UNICEF Kosovo completed UNICEF's Criteria for Ethical Review Checklist (UNICEF Criteria for Ethical Review Checklist), and the tools and report were ethically cleared by Health Media Lab (HML) Institutional Review Board. The participation was voluntary, and informed consent was obtained from all participants. Interviews and Focus Group Discussions were paused or stopped if distress was observed. Confidentiality and anonymity were ensured through coding and aggregated reporting, and all data were stored securely to prevent the identification of individual respondents.

Limitations: Several limitations should be considered when interpreting these findings. The study relied primarily on qualitative methods and a review of secondary data. The sample of key informants and focus group participants may not represent all stakeholder perspectives, particularly those of service users (children, adolescents, and families). The absence of systematic, disaggregated data on child and adolescent mental health limited quantitative analysis. The mapping captures a snapshot at a specific point in time, and the landscape may have evolved since the data were collected.

The Conceptual Framework for MHPSS for children and adolescents

The analysis is anchored in two complementary frameworks. The UNICEF Multisectoral Framework for MHPSS of Children and Adolescents (Figure 1) organizes understanding across the social-ecological levels of child, family, school, community, and enabling environment, while the IASC (Inter-Agency Standing Committee)[20] MHPSS pyramid structures the continuum of response across tiers, from universal promotion and prevention through to specialized clinical care. Together, drawing also on the WHO-UNICEF Helping Adolescents Thrive (HAT) guidelines[21], this integration ensures the mapping addressed both the determinants of mental health and the system's capacity to respond.

Figure 1: Socio-ecological model of the child environment



In the Kosovo context, this integrated framework is applied through four dimensions:

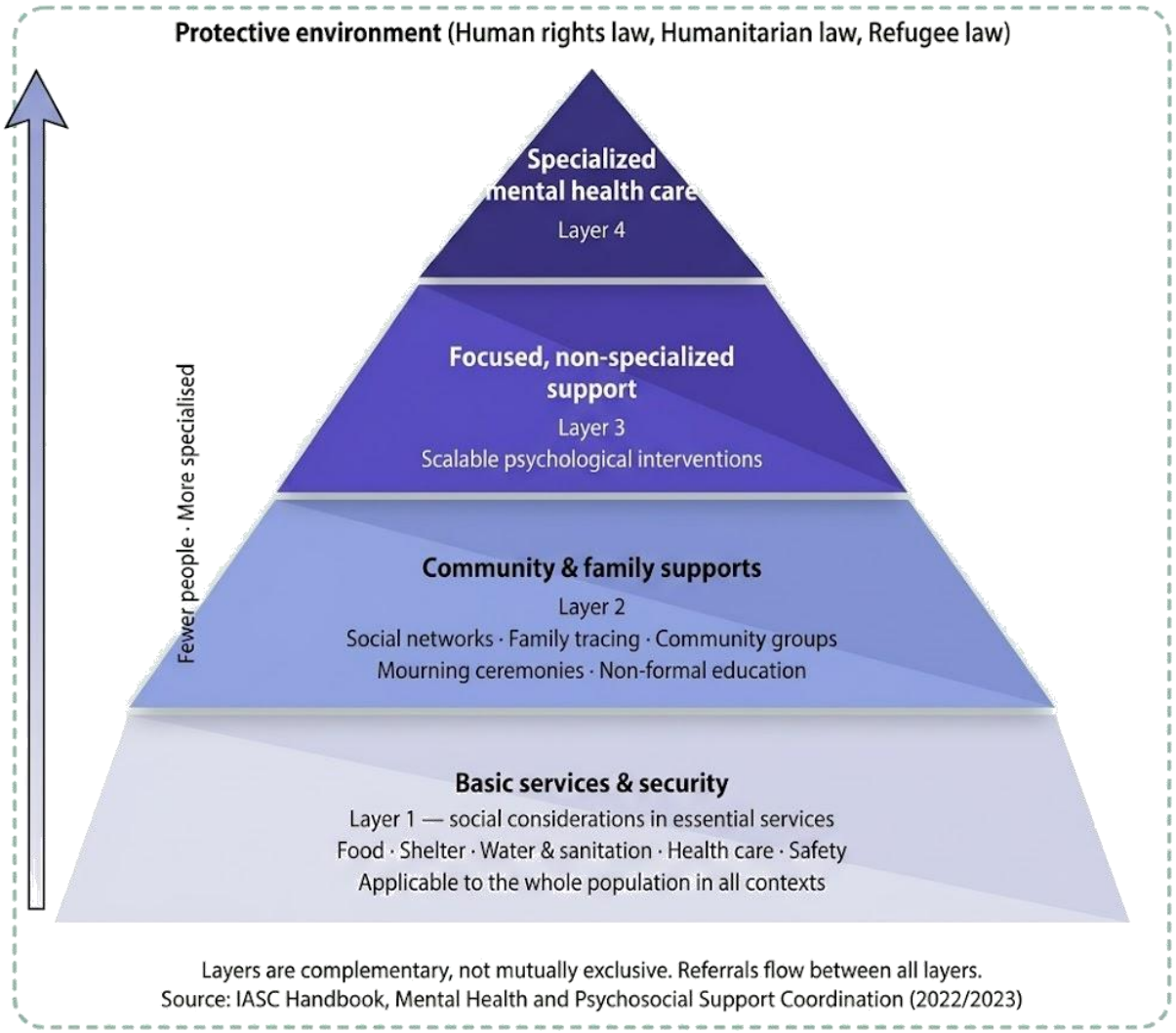
First, a tiered model of support (three levels) organizes the response (See Figure 2). *Universal promotion and prevention* refers to actions that strengthen well-being and reduce risk for all children and adolescents, across everyday settings. *Targeted psychosocial support* provides focused support for children and adolescents experiencing elevated distress or specific vulnerabilities. *Specialized clinical care* ensures accessible, quality services for children and adolescents with mental health conditions, including referral pathways and continuity of care.

Second, a multisectoral, settings-based lens examines MHPSS services and support delivered across key systems and settings relevant for Kosovo, including health services, education settings, social services/child protection and social welfare, and justice-related services, and the ways these connect at municipal and community levels through referral, coordination, and joint planning.

Third, equity, inclusion, and meaningful participation anchor the analysis in identifying who is least reached and why. Particular attention is given to groups prioritized in this mapping, including children with disabilities, children in alternative care, children from Serbian, Roma, Ashkali and Egyptian communities, and gender-diverse youth, as well as to the meaningful participation of children, adolescents, and caregivers in shaping MHPSS services.

Fourth, system functions that enable delivery are assessed beyond the mapping of available services. The framework explicitly assesses system functions that determine whether services work in practice, including coordination mechanisms and governance, referral pathways, monitoring, indicators, and accountability, and service quality and accessibility.

Figure 2: Mental Health and Psychosocial Support tiered model



Mental health and psychosocial well-being: The situation for children and adolescents in Kosovo

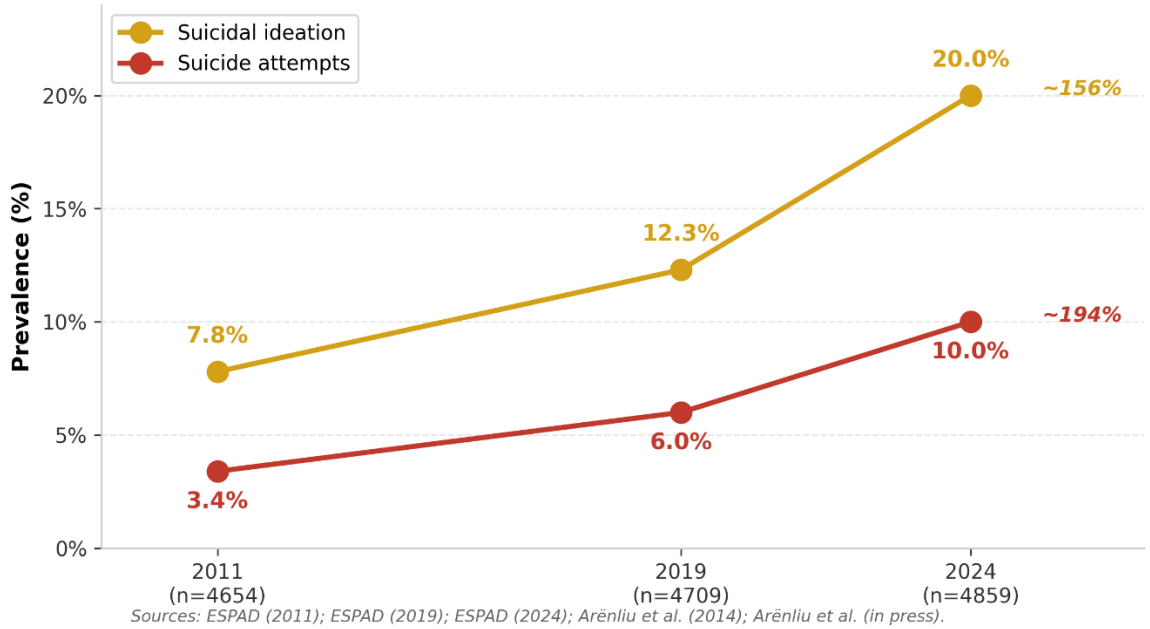
Mental health outcomes

Many children and adolescents in Kosovo experience significant stress, which is also linked to Kosovo's post-war context. Lack of data on mental health among children and adolescents is largely hindering the identification of the actual magnitude of mental health issues and needs of children. However, based on available data, intergenerational trauma has been widely documented, with studies showing that youth whose parents suffer from Post-Traumatic Stress Disorder (PTSD) are more likely to experience posttraumatic stress, anxiety, and depression themselves. Children of parents with PTSD display greater emotional and behavioral difficulties,[22] which is particularly concerning in a context where around 18% of the adult population meets criteria for PTSD.[23] Emerging biological evidence also suggests elevated cortisol levels and altered DNA methylation among children whose mothers experienced conflict-related trauma during pregnancy, further supporting the need for integrated psychosocial and health responses.[24]

In Kosovo, Internalizing issues such as anxiety, depression, and somatic complaints affect an estimated 25–40% of adolescents, with higher rates among girls aged 15–17.[25] Parents report similar patterns of emotional and behavioral difficulties, especially among adolescents, urban youth and those from socioeconomically disadvantaged families.[26] Developmental factors such as early or advanced pubertal timing are associated with increased emotional vulnerability.[27] Poor sleep quality, excessive electronic device use, bedtime fears and low self-esteem are also linked to higher psychological distress, with gender differences in presentation and risk.[28],[29],[30]

Suicide is closely related to poor mental health. Data from the European School Survey Project on Alcohol and Other Drugs (ESPAD) show a sharp and accelerating rise in both suicidal ideation and suicide attempts among 15–16-year-old students in Kosovo. Self-reported suicidal ideation increased from 7.8 percent in 2011 to 12.3 percent in 2019, then rose steeply to 20.0 percent in 2024, an overall increase of approximately 156 percent. Self-reported suicide attempts rose from 3.4 percent in 2011 to 6.0 percent in 2019 and to 10.0 percent in 2024 — nearly tripling over the same period. The steepest increases for both indicators occurred between 2019 and 2024, suggesting an acceleration in adolescent suicidal behavior in the post-pandemic period [31],[32],[33].

Figure 3: Trends in suicidal ideation and suicide attempts among 15-16-year-old students in Kosovo (2011-2024).



Sources: ESPAD (2011); ESPAD (2019); ESPAD (2024); Arënliu et al. (2014); Arënliu et al. (in press).

Reliable data on suicide deaths among adolescents in Kosovo remain scarce. Between 51 and 57 suicide deaths per year were recorded across all age groups in 2007-2008, with the post-war suicide rate estimated at 3.17 per 100,000. More recently, Kosovo Police data indicate 40 deaths and 101 attempts in 2020, and 41 deaths and 130 attempts in 2021, though these figures are not disaggregated by age. [34] However, Kosovo lacks a unified suicide registration system, with significant discrepancies between data sources. While official KAS statistics recorded approximately 400 suicides between 2010 and 2019, data from Kosovo Police figures for the same period report nearly twice that number[35]. Importantly, neither source provides age-disaggregated mortality data specifically for adolescents. Cases among those under 17 accounted for only 3.5 to 3.9 per cent of all recorded suicides, though underreporting due to stigma is likely[36]. The absence of routine, disaggregated suicide mortality surveillance represents a critical data gap that should be addressed as a priority.

Risks and determinants of mental health and psychosocial well-being

Childhood and adolescence are periods of rapid social and developmental change, during which the timing and nature of environmental exposures and immediate social contexts can strongly influence mental health and well-being. Risk and protective factors accumulate across the life course and often cluster together, with children exposed to multiple adverse childhood experiences, such as abuse, neglect, violence, or dysfunction within families, peer groups, or communities, facing the highest risk of poor mental health outcomes.[37] Mental health and well-being among children and adolescents is shaped by three interrelated spheres of influence: “the world of the child,” encompassing individual assets as well as parents, caregivers, and families, “the world around the child,” which includes safety, security, and healthy attachment within schools, communities, and

online environments, and "the world at large," referring to broader social determinants such as poverty, disaster, conflict, discrimination, and migration.[38]

The world of the child

Nurturing and responsive care are critical determinants of children's mental health and well-being and play a central role in enabling children to reach their full potential.[39],[40] However, MICS data indicate that fewer than half of mothers, 46 percent, engage in home-based activities with children aged 2–4 years, while engagement among fathers is notably lower, at only 10 percent.[41] Family dynamics also play a significant role: low family satisfaction, weak family cohesion, and parental unemployment are each associated with greater adolescent distress.[42] Similarly, positive family communication, characterized by openness, clarity, emotional support, cohesion, and effective stress management, is a significant predictor of adolescent psychological well-being.[43]

By contrast, **violence and neglect experienced within households and families** are significant risk factors for mental health conditions. Data from the 2020 MICS point to serious child protection concerns with direct implications for mental health, with 72 percent of children aged 1–14 reported to have experienced some form of violent disciplining at home, with even higher rates among children from Roma, Ashkali, and Egyptian communities at 80 percent.[44] The co-occurrence of domestic violence and violence against children further elevates the risk of mental health issues.[45]

Parental migration adds extra risk. Around 10% of children have at least one parent abroad, and they report higher psychological distress.[46] While migration itself does not directly predict depression, irregular remittances and rare contact are linked to poorer school performance and well-being, whereas strong family ties are protective.[47]

Data from the ESPAD from Kosovo [48],[49],[50] indicates a recent increase in **substance use** among 15-year-old children between 2011, 2019 and 2024. Daily smoking declined from 8.1 percent in 2011 to 7.8 percent in 2019 before increasing sharply to 14 percent in 2024. Alcohol use in the past 30 days increased gradually over the same period, from 10.4 percent in 2011 to 11.2 percent in 2019 and 13.9 percent in 2024. The non-medical use of tranquilizers also rose substantially, from 2.7 percent in 2011 to 4.3 percent in 2019 and 9.7 percent in 2024. While 30-day cannabis use and lifetime ecstasy use remained stable at 1.5 percent in both 2011 and 2019, both indicators notably increased in 2024, with cannabis use rising by more than double to 3.4 percent and lifetime ecstasy use to 2.1 percent.[51] Findings from 2024 ESPAD data indicate a further increase in the use of tranquilizers to 9.71 percent. In addition, other risky behaviors have increased over time, most notably gambling, which rose from 11 percent in 2011 to 24 percent in 2024[52]. Gender differences in substance use are notable in Kosovo. Boys report significantly higher rates of smoking than girls (47% vs 36% lifetime prevalence), with the widest early-onset gap across all ESPAD countries (boys 31% vs girls 16% starting before age 13). Boys also report higher e-cigarette use (25% vs 13%). For tranquillizer misuse and gambling, Kosovo-specific gender breakdowns are not reported separately in ESPAD, though across ESPAD countries pharmaceutical misuse is generally higher among girls and gambling for boys.

Extensive social media use is an emerging area of concern for adolescent mental health. Adolescents spend substantial time on social platforms such as Snapchat, TikTok and Instagram, with documented risks including harmful content, cyberbullying, harassment and unsafe offline encounters.[53],[54],[55] A study conducted in Kosovo shows that 97.8 percent of high school students own a smartphone and 92.7 percent use it mainly to access social media, spending on average 183 minutes per day on Snapchat, 126 minutes on TikTok, and 120 minutes on Instagram.[56] International

evidence links frequent social media use to cyberbullying, reduced sleep and lower physical activity.[57] In Kosovo, 25 percent of children reported harmful online behavior in the past year, 6 percent online exclusion, and 3 percent online threats. Over 20 percent of 11–16-year-olds reported weekly exposure to sexual content, while 47 percent refused to answer questions on the topic. Among children who met online and created face-to-face contacts (19.2% per cent), 22 percent experienced hurtful comments, 2.1 percent sexual abuse, and 1.8 percent physical injury.[58] Additional research shows that 13.8 percent experienced online harassment or threats, 10.8 percent were targeted by online rumors, and 5.9 percent faced threats or embarrassment through the distribution of photos.[59] Nearly half of children, 46.5 percent, report being more digitally skilled than their parents, highlighting a generational gap in managing online risks and explaining parents' need for support in managing children's screen time and use of digital tools. Long hours spent online, exposure to age-inappropriate or harmful content, and the risk of cyberbullying were identified as key concerns among parents during focus group discussions. Parents also reported often lacking the practical tools and skills to effectively guide and support their children as they navigate the digital environment.

Children and adolescents living in poverty or social assistance beneficiary households show particularly high rates of severe distress, pointing to socio-economic hardship as one of the key family-level MHPSS risk factors.[60] Nearly half of new mothers experience postpartum depression, which is associated with low social support, younger age, and economic difficulties, with likely negative effects on early child development and attachment.[61]

Children and adolescents from non-majority communities are faced with multiple deprivations that may disproportionally affect their mental health and well-being. MICS data indicate inequities in outcomes for children and adolescents among Roma, Ashkali and Egyptian communities across health, education, and child protection areas.[62],[63] For children and adolescents from Serbian communities, parents emphasized safety anxieties, a shrinking peer context and reluctance to involve law enforcement, relying instead on school psychologists where available. This compounds broader vulnerability among adolescents who are not in education, employment or training (NEET), a group that accounts for one third (33 percent) of young people aged 15–24 in Kosovo, and who face heightened risks to their mental health and psychosocial well-being due to social isolation, limited opportunities and reduced access to structured support systems[64].

Children themselves often lack an adequate understanding of mental health. Across focus group discussions, children and adolescents demonstrated a basic but uneven level of mental health literacy, describing mental health in everyday terms such as sleep, eating, relationships, and “feeling good.” Most were able to identify anxiety, school-related stress, and sadness as common concerns. Younger children, in particular, relied heavily on school-based cues, such as “mediation” classes, which are not widely available, to make sense of mental health, suggesting that literacy is strongly shaped by what is explicitly modeled and named within the school environment. Overall, depth of understanding varied by age and context, limiting timely self-identification of mental health concerns and help-seeking, especially among younger children and those from more marginalized groups.

Parents' perspectives mirror and extend these concerns. Across all focus groups, urban Albanian, Serbian, and Roma, Ashkali and Egyptian parents described a consistent picture indicating children struggling with bullying (often psychological), heavy and unsupervised phone and social media use, social withdrawal, and academic pressure, while available services are fragmented, hard to navigate, and often short-term.

Parents also reported a growing awareness of children's mental health, though framed differently across communities. Urban Albanian parents stressed that *"children do not know how to talk about mental health; it is the parents' duty"*, linking current challenges to their own unaddressed post-war trauma. Roma, Ashkali, and Egyptian parents described a generational shift, noting that mental health was once "shameful" to discuss, but they now want to *"do better"* than their parents. Serbian parents highlighted experiencing a more restrictive environment recently, where perceived insecurity, including fear of reporting to the police, limits children's socialization and shapes how problems are managed.

Children also identify clear structural barriers to care. Specialized services are centralized in Prishtina, coordination between schools, health, and social services is inconsistent, and there is no institutionalized crisis helpline specifically for youth. Young people noted that even when a helpline exists, it is "good but not institutionalized" and felt that such support should be ensured by the state. Visibility in small communities, neighbors noticing frequent visits, was mentioned as another deterrent to regular attendance, especially of school psychologists. Despite these barriers, youth voices aligned closely with clinician and CSO perspectives on what is needed: they called for psychologists to be present from kindergarten onwards, for regular sessions at the class level in terms of information provision and preventive mental health, more structured spaces to talk about stress and anxiety, for addressing bullying and online harms, and clear, safe pathways to services. This convergence between children's experiences and provider priorities creates a strong basis for designing child-centered, school- and community-anchored MHPSS responses.

The world around the child

Schools are central platforms for MHPSS, but the evidence shows they are both a source of risk and a potential key protective environment. The data indicate that 77 percent of students experienced some form of victimization in the past month, typically verbal abuse and physical aggression.[65] Peer, psychological, cyber, physical, and sexual victimization are strong predictors of psychological distress.[66] More than a quarter of students report emotional or physical victimization by school staff.[67] School climate emerges as a critical leverage for MHPSS. Supportive teacher–student relationships, clear anti-violence policies, and meaningful student participation in school life are protective against victimization and distress, whereas weak teacher support and unsafe peer environments significantly increase emotional and behavioral problems. School climate indicators explain a substantial portion of variance in staff-perpetrated emotional victimization.[68]

School psychologists provide a critical first line of support for the promotion of mental health and referral to specialized services. According to MES, Kosovo's pre-university education system comprises 1,035 schools for the 2024–2025 school year, staffed by 22,620 teachers and serving approximately 300,000 students.[69] Within this system, 230[70] school psychologists are currently engaged, yielding a ratio of roughly one psychologist per 1,300 students, more than twice the National Association of School Psychologists' recommended ratio of 1:500 and well above the European average.[71] The current administrative instruction projects 1 school psychologist for every 1,000 schoolchildren.[72] Coverage is also uneven. A survey of 107 school psychologists conducted for this mapping found that 40 percent work across more than one school, 28 percent cover two, and 12 percent cover three, meaning the 230 psychologists cover an estimated 320–350 schools, or roughly one third of the school network. Where psychologists serve multiple schools, the time available for individual support, prevention, and collaboration is substantially reduced.[73] Despite these gaps, this existing cadre represents a strategic and under-utilized infrastructure. Targeted investments, expanding the workforce toward the 520 [74] positions foreseen under the Ministry of

Education and Science funding formula, standardizing roles and supervision, and integrating psychologists into a MHPSS referral pathway could serve as the most scalable entry point for delivering mental health promotion, early identification and psychosocial support to children and adolescents across Kosovo. However, school psychologists report that referral patterns indicate important gaps in how mental health needs are identified and addressed. Referrals by teachers are predominantly related to behavioral issues, 93.5 percent, and academic challenges, 71 percent, while parents most frequently refer children for academic, 71 percent, and behavioral concerns, 62.6 percent, with family-related issues rarely cited. In contrast, students' self-referrals are primarily driven by emotional difficulties, 86.9 percent, peer conflicts, 79.4 percent, and family concerns, 59.8 percent. This divergence points to a misalignment between students' self-perceived mental health needs and the concerns identified by teachers and parents.[75] For Roma, Ashkali and Egyptian children, the school environment is often perceived as harmful rather than protective. 51% of adult respondents from these communities believe schooling negatively affects development and wellbeing due to stigma and prejudices that children experience at schools, compared to 43% among non-Roma respondents.[76] Children from other vulnerable groups, such as children with disabilities, face exclusion from schools, which deprives them of benefiting from the MHPSS platform for social interaction, emotional development, and peer support, and increases their risk of psychological distress. Persistent stigma and social exclusion further restrict participation.[77]

Violence against children and young people in Kosovo remains pervasive across home, school, and community settings. According to the 2020 MICS, 72 percent of children aged 1 to 14 experience violent discipline, including psychological aggression and physical punishment, and cases often go unreported due to social acceptance and weak institutional responses.[78] In school settings, a Kosovo representative study of over 12,000 students in grades 6 through 9 found that 77 percent reported victimization in the past month, predominantly verbal abuse at 61 percent and physical aggression at 45 percent.[79] The study demonstrated a clear dose-response relationship with each additional type of violence experienced, associated with a 1.25-point increase on the Kessler Psychological Distress Scale, with cyberbullying and socio-emotional victimization emerging as the strongest predictors of harm. Additionally, despite progress with the adoption of the Juvenile Justice Code and the Law on Child Protection, the UNICEF-KOMF assessment found that practical implementation remains fragmented, essential services such as shelters for child victims and functional reporting lines are absent, and schools lack psychologists who could promote evidence-based prevention programs. These findings underscore the urgent need for both a stronger ethical research infrastructure and evidence-based prevention strategies embedded within schools, families, and communities[80].

Schools are important platforms for early identification and low-intensity support. Some students described positive experiences with school psychologists that helped them manage conflicts and emotions. Others reported that their schools had no psychologist, no structured activities, or that psychologists were framed as punitive ("you go there when you are in trouble"). Academic pressure, teacher behavior and school climate were consistently mentioned as major stressors. Urban–rural differences were also evident: rural youth valued close-knit communities but feared gossip and community scrutiny, which discouraged openness even among peers; urban youth felt more able to talk to friends but reported higher exposure to competition, anonymity and digital overload. In all areas, excessive social media use, cyberbullying, fake accounts, AI-altered images and online "trends" that escalate into offline conflict or self-harm were described as significant sources of stress and real-world harm. Parents also consider schools to be the most accessible entry point for mental health issues everywhere, but the quality and consistency of support differ markedly among schools and municipalities.

The world at large

At the community level, the evidence highlights risks related to migration, repatriation, marginalization and digital environments, all of which require community-based MHPSS analysis and interventions. Repatriated children, mainly from Western European countries, often experience social isolation, discrimination, and poor living conditions, which exacerbate mental health issues.[81] Additionally, Roma, Ashkali, and Egyptian communities continue to face discrimination and harmful practices such as child marriage and child labor,[82] although overall prevalence is declining.[83],[84] In the general population, 4 percent of women and 2 percent of men aged 20–24 were married before 18, compared with 33 percent of women and 10 percent of men in Roma, Ashkali, and Egyptian communities.[85] These patterns indicate the need for community-level MHPSS that integrates child protection, gender equality and social inclusion. Community-level economic stress remains a key MHPSS risk factor, with nearly 23 percent of Kosovo's children living in poverty and 7 percent in extreme poverty.[86] **At the level of the enabling environment,** cultural norms, policy choices, and resource allocation heavily condition the scope and effectiveness of MHPSS. Risky behaviors, including smoking, alcohol use, gambling, and weapon carrying, are widespread and likely linked to high stress levels, with 77 percent of youth reporting high stress.[87] Young Voices Kosovo 2024 data highlight both opportunity and gaps with 48.8 per cent of grade-9 adolescents wanting to have a say in issues affecting health and well-being, including mental health, yet 26 per cent do not know where to seek help for depression or sadness, 37 per cent do not know where to go after experiencing or witnessing violence and 33 per cent do not know how to report unfair treatment.[88] Findings from the Young Voices Kosovo 2024 report, conducted by the Institute of Psychology, show that youth in Kosovo are more inclined to seek help from family and friends, although around 50 percent expressed willingness to seek professional support.[89] This mismatch between willingness to engage and limited knowledge or access indicates the need for youth-friendly information, services, and participation mechanisms within MHPSS.

Stigma is a major structural barrier. Among youth, mental health awareness is moderate, but strong traditional family values and cultural stigma inhibit open discussion and help-seeking related to mental health issues. While there is a general belief that mental health issues can be treated and that individuals can recover, a proportion of young people in Kosovo still experience a degree of discomfort and show limited social acceptance and physical proximity toward individuals with mental health difficulties.[90] Only 20 percent feel their mental health needs are met, citing limited access to counseling.[91] Another study found that 52.9 percent of students reported needing help for mental health issues, but only 14.7 percent had received treatment, while perceived public stigma was higher than personal stigma.[92]

Gender norms shape both risk and resilience. Increasing support for gender equality among youth can be empowering for girls and young women, while traditional expectations among boys and young men can lead to stress and confusion. Education is seen as key to challenging stereotypes, and there is growing mobilization among youth and civil society through youth-led research, anti-stereotyping toolkits, and youth panels. Lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI+) young people report high levels of depression, anxiety, and stress driven by stigma and discrimination, indicating a need for inclusive and rights-based MHPSS[93].

Gaps in access to and awareness of available services. Across all focus group discussions, parents reported confusion about which services are available and how to access them. Some parents were not aware that there is a child and adolescent mental health center at the University Clinical Center (UCC), even when they had a child with developmental delays and no diagnosis,

illustrating weak referral pathways from schools and primary care. Parents reported that they would rather seek care at private clinics due to long waiting times and limited knowledge of services in the public health sector. However, private services such as psychologists, speech therapists, and assistants are seen as an option but are described as costly and difficult to sustain, so care is often interrupted after a few sessions. This issue was highlighted especially for children with neurodevelopmental disorders, who require lengthy, frequent, and intensive interventions. Parents described cost as one of the strongest determinants of whether children receive and continue to receive support, counseling, and therapies, which are widely perceived as a "luxury" that only better-off families can afford. CSO-run services are appreciated but are often project-based and end mid-process, undermining continuity of care. These project-based services are crucial, especially for minorities such as Roma, Ashkali, and Egyptians.

School psychologists are used inconsistently and inefficiently. In some Serbian schools, "a psychologist is perceived as a punishment", which discourages children from seeking help. Focus groups with parents and schoolchildren, and interviews with school psychologists, indicate that schools rely on school psychologists as general problem solvers, without any clear, standardized model of practice, referral procedures, or supervision, and with unclear guidelines for prevention, counseling, crisis response, and behavior management. This appears to be more of a structural gap than just a staffing issue, as their roles need to be institutionalized and better structured.

The budget allocation for mental health is low. Investment in mental health remains low in Kosovo, with funding estimated at around 1.5 percent of total health expenditure, well below the European average of 3.6 percent, and is poorly tracked. [94] This underinvestment limits the scale, quality, and sustainability of MHPSS services, even though the Ministry of Health has adopted the Health Sector Strategy for 2025-2030, there is no specific or targeted strategy for child and adolescent mental health.

Current responses to the mental health needs of children and adolescents

Legal framework, strategies and policies

Kosovo's legal and policy framework recognizes child and adolescent mental health and psychosocial support. Core legal instruments, the Constitution, the Law on Child Protection, the Law on Pre-University Education, and the Law on Social and Family Services, set strong rights-based foundations for child and adolescent mental health, including healthy psychological development, school-based services, and psychosocial support through social welfare. Administrative instructions on school psychologists and child protection in schools translate some of these principles into operational roles at the school level. However, implementation is uneven due to staffing limitations, weak intersectoral coordination, and limited reach in rural and underserved areas. As a result, core rights and legal provisions are not consistently upheld, and service availability remains inadequate. While the Law on Mental Health establishes a general framework, it does not explicitly address child and adolescent mental health and fails to define critical pathways such as school-based support, community-level prevention, and child-specific procedures.In addition, the Law on Early Childhood Education (Law No. 08/L-153) is relevant to MHPSS, establishing the legal basis for early education and care services for children from birth to age six,

including provisions for early identification of developmental delays and coordination between education, health and social services.

At the strategic level, the Strategy for Youth 2024–2032 and the Health Sector Strategy 2025–2030 acknowledge the importance of youth mental health and prioritize support for certain infrastructure improvements. However, Kosovo lacks a dedicated, long-term vision for children and adolescents' mental health. Budgeting, service integration, and monitoring arrangements remain vague. The Kosovo Education Strategic Plan 2022–2026 refers broadly to student well-being and safe learning environments but does not set concrete mental health objectives, staffing plans or accountability measures. For the purposes of this mapping, these gaps help explain why service provision appears fragmented. Kosovo has a relatively strong normative basis to protect and promote mental health for children and adolescents. However, there is a lack of a dedicated, cohesive strategy or action plan, sustained financing, and effective coordination mechanisms for cross-sectoral implementation and addressing of mental health for children and adolescents. To bridge this gap, it is critical that legal provisions are linked with clear strategies and plans to address and strengthen cross-sectoral MHPSS services in health, education, and social protection. In this regard, the Ministry of Health's Strategic Plan for Mental Health includes a specific objective addressing the mental health of children and the strengthening of health promotion and education through dedicated promotive and educational activities. The gap identified here, therefore, concerns the absence of a dedicated, costed, and monitored cross-sectoral child and adolescent mental health plan, with clear accountability, rather than the absence of any policy commitment.

Table 1 Overview of legislation and Kosovo policies relevant to mental health and MHPSS in Kosovo.

Domain / sector	Summary of key child and mental health and MHPSS provisions, including main gaps and implications	Relevant legislation / policies
Health / Early Childhood	Establishes Kosovo's first integrated ECI framework for children aged 0-6 with developmental delays or disabilities. Mandates 48 transdisciplinary ECI teams (psychologist, speech therapist, physiotherapist/occupational therapist, social worker, educator) in PHC centres across all 38 municipalities. Services are free and family-centred. Coordinated across Ministries of Health, Education and Finance/Social Affairs. Directly relevant to MHPSS: psychologists in each team provide early identification of psychosocial needs in children aged 0-6. Total budget: EUR 18.9 million (2025-2027). The revised Primary Health Care Administrative Instruction required to unblock recruitment has since been approved and signed (Administrative Instruction MoH No. 01/2026); recruitment and deployment of ECI teams across municipalities remain to be realized.	ECI Strategic Document and Action Plan 2025-2030 (Government Decision Nr. 05/253, 21 March 2025); Administrative Instruction MoH No. 01/2026 amending Administrative Instruction (Health) No. 04/2020 on Primary Health Care
Cross-sectoral	Guarantees the right to health (Art. 51), child protection from psychological harm (Art. 50), non-discrimination (Art. 24)	Kosovo Constitution

	and the right to education (Art. 47). Gives direct effect to international human rights instruments, including the Convention on the Rights of the Child (Art. 22). Provides a strong rights-based foundation for child and adolescents mental health and MHPSS across sectors but remains high-level and requires translation into concrete service standards, financing and accountability mechanisms.	
Education / early childhood	Defines developmental goals that include emotional expression, identification of emotions, interpersonal skills, self-understanding and psychological development (Art. 3). Guarantees the right to pre-school education for all children, including those with behavioral and emotional difficulties, and foresees individualized support and specialized assistance (Art. 6). Creates a legal basis for early childhood psychosocial support and inclusion but does not spell out specific child and adolescents mental health service models or staffing norms. Implementation depends on education coverage and resources.	Law on Early Childhood Education (No. No. 08/L-153)
Education / school system	States that the education system aims at full mental, physical, and emotional development of pupils (Art. 1). The Kosovo Curriculum Framework (Art. 24) promotes learner-centered, inclusive education and holistic development, supporting school-based mental health promotion, life skills, and psychosocial support. Offers a clear mandate for integrating mental health in schools but lacks detailed provisions on school mental health services, minimum staffing or referral pathways, contributing to uneven practice across municipalities.	Law on Pre-University Education (No. 04/L-032)
Social welfare / child protection	Recognizes psychosocial needs as essential life needs (Art. 9). Prioritizes children affected by violence, neglect, trauma, substance abuse, disability or family dysfunction (Arts. 29–30) and mandates therapeutic counselling, psychosocial support and parenting education by licensed professionals. Requires individual care plans, including mental health support, in shelters and residential care. Provides a strong legal basis for psychosocial interventions within social services, but effective coverage is limited by shortages of social workers and psychologists and by weak coordination with health and education services.	Law No. 08/L-255 on Social and Family Services
Child rights / protection	Protects children's right to mental and emotional development (Art. 4), requires access to child-friendly psychological support for victims and witnesses, and mandates parenting skills plans that may include counselling and mental health treatment (Art. 32). Creates clear obligations to integrate CAMH into child protection responses, but implementation depends on inter-institutional coordination and availability of trained staff at the municipal level.	Law on Child Protection (No. 06/L-084)

Health / mental health system	Establishes the general framework for mental health care, including principles of community-based services and protection of the rights of persons with mental disorders. Does not contain child- and adolescent-specific provisions, omits school-based and community-preventive CAMH pathways, and has weak links to education, child protection, and juvenile justice, leaving a major normative gap for children's and adolescents' mental health.	Law on Mental Health (No. 05/L-025)
Child protection / media and online safety	Regulates harmful content in media and online platforms via age classification, warnings and restrictions. Article 18 foresees psychosocial support for children exposed to harmful content, linking protection from harmful media with children and adolescents' mental health needs. Supports the prevention of media-related harms and justifies psychosocial support for exposed children, but does not specify the roles of school psychologists or mental health professionals in implementation.	Administrative instruction (grk) no. 04/2022 on measures for the protection of children against websites with pornographic content and those that harm the health and life of the child
Education / implementation (school-based MHPSS workforce)	Defines the role and responsibilities of school psychologists in pre-university education, including early identification of difficulties, psychosocial assessment, coordination with teachers and parents, referrals and maintenance of individual case records. Recognizes psychologists as essential for school MHPSS, but application is constrained by staffing rules (one psychologist per 1,000 students) and limited posts, resulting in many schools without direct access to a psychologist.	Administrative Instruction on School Psychologists (UA 26/2014)
Education / child protection	Requires schools to priorities child protection in policies, development plans and curricula (Art. 7). Mandates that professional support staff (psychologists, pedagogues, doctors, speech therapists) provide awareness activities and direct support to children at risk of harm to their physical, emotional or psychological development (Art. 13). Provides an explicit entry point to integrate child and adolescents mental health within the education system, but effectiveness depends on the presence of professional staff, functioning referral mechanisms and sustained intersectoral collaboration.	Administrative Instruction (GRK) No. 05/2024 on Education on Child Protection
Cross-sector youth policy	Identifies mental health as a critical, under-addressed challenge, especially post-COVID-19, and highlights high stress levels and stigma. Foresees budgeted measures such as training for educators and psychologists, development of service protocols and expansion of online and in-person support. Signals strong political commitment to youth mental health, yet requires clearer links to primary care,	State Strategy for Youth 2024–2032

	sustainable financing and monitoring to ensure that planned measures translate into accessible MHPSS services.	
Health sector strategy	Acknowledges mental health as a growing public health concern and notes investments in child and adolescent psychiatry and integration across care levels. Lacks a dedicated CAMH strategy, specific budget lines and long-term planning for decentralized CAMH services beyond Prishtina; weak implementation tools (by-laws, operational plans) limit impact on actual service organization.	Health Sector Strategy 2025–2030
Education sector strategy	Refers to student well-being, inclusive education and safe learning environments, and promotes intersectoral collaboration and violence prevention in schools. Does not include explicit mental health objectives, staffing targets for school psychologists or CAMH-related indicators and budgets, leaving school-based MHPSS weakly defined and underprioritized.	Kosovo Education Strategic Plan 2022–2026
Health/child protection	Sets out the medical and psychological treatment pathway for children who are victims of abuse, to support their rehabilitation and reintegration into society. Provides an explicit child-specific clinical protocol within the health sector, but is not yet cross-referenced with school- and community-based referral pathways.	Administrative Instruction No. 04/2023 on the Medical and Psychological Treatment of Child Victims of Abuse
Health / substance abuse prevention	Establishes measures for the prevention of, and protection of children from, substance abuse. Provides a child-specific regulatory basis for substance-use prevention within the health sector, complementing school- and community-level prevention efforts.	Administrative Instruction No. 05/2023 on Measures for the Prevention and Protection of Children from Substance Abuse
Health / adolescent mental health promotion	Sets out promotive and preventive interventions specifically for adolescent mental health, and, together with related guidance on the treatment of substance-use disorders in adolescents (drawing on WHO and mhGAP recommendations), gives the health sector an adolescent-specific promotive and treatment framework. Implementation depends on dissemination and workforce training to translate the guidance into routine practice.	Guideline on Promotive and Preventive Interventions in Adolescent Mental Health; guidance on the treatment of substance-use disorders in adolescents
Health / clinical guidance	Comprises clinical guidelines approved and published by the Ministry of Health on depression, anxiety, suicidal behavior, trauma and post-traumatic stress disorder, schizophrenia, obsessive-compulsive disorder, and the use	Ministry of Health clinical guidelines (depression,

	of alcohol and other drugs, together with the guideline on the risk of overdose involving alcohol and other drugs published in 2026; all identify children and adolescents among their target populations. Provides a meaningful clinical guidance base, though uptake is not yet systematically monitored.	anxiety, suicidal behavior, PTSD, schizophrenia, OCD, alcohol and other drugs, overdose risk 2026)
Health / workplace mental health	Sets out guidance on mental health in the workplace. Relevant to MHPSS mainly as part of the Ministry's broader normative guidance base rather than through a direct child- or adolescent-specific pathway.	Guideline on Mental Health at Work
Health / mental health strategic planning	Sets out the Ministry of Health's strategic priorities for mental health, including a specific objective addressing the mental health of children and the strengthening of health promotion and education through dedicated promotive and educational activities. Requires a costed, monitored, cross-sectoral child and adolescent mental health plan to translate this commitment into practice.	Ministry of Health Strategic Plan for Mental Health
Health / financing and social contracting	Provides the legal basis for the Ministry of Health to finance NGOs delivering health promotion, disease prevention and public-awareness activities; used since 2018 to support NGO-delivered mental health promotion, including a March 2025 public call. Currently operates through periodic, largely single-year calls rather than sustained, multi-year financing dedicated to child and adolescent mental health.	Regulation MF No. 04/2017

Health

The capacity in the health system for children and adolescents' mental health is very limited. There are only seven child and adolescent psychiatrists in the public sector, two clinical psychologists, and ten psychology specialists who work in secondary and tertiary care, with very few focused on children and adolescents.[95] The only dedicated mental health care service for children and adolescents is the Child and Adolescent Psychiatric Service at the University Clinical Center in Prishtina (UCCP), which recently opened a seven-bed inpatient ward and provides outpatient psychiatric and psychological assessments, individual and group therapy, and consultations with parents and institutions. Pediatric services at UCCP are overstretched with one psychologist and two social workers serving more than 7,000 pediatric patients annually.[96] There is no specific service model for mental health for children and adolescents, a strategy, or a dedicated budget.

Child and adolescent mental health services within the health sector remain highly centralized in Prishtina, with limited specialist provision outside the capital. Regional public health provision is limited or nonexistent, largely depending on private and NGO providers; multidisciplinary care is rare, and families face long waits, geographical disparities, and high out-of-pocket costs when shifting between public and private services. Service quality is uneven and rarely monitored or

systematically assessed, with short consultation times, outdated or invalid assessment tools, limited professional supervision, and no 24/7 crisis line for children and adolescents.

Access and availability of child and adolescent mental health services in the health sector are identified as major concerns. Families reported barriers such as long waiting times, especially in public child and adolescent mental health centers, transport difficulties, and clinic hours that do not match school and work schedules. Child and adolescent-specific services and crisis care remain underdeveloped. The most common presentations include behavioral issues, bullying, anxiety, depression, attention deficit hyperactivity disorder (ADHD), and somatic complaints, alongside a substantial number of developmental and autism cases. Some young people are seen in adult psychiatric settings or through brief consultations, and even emergency cases such as self-harm or suicide attempts are handled through routine evaluations. The Child and Adolescent Mental Health Center in Prishtina provides diagnosis, therapy, and medication, but its capacity is insufficient to meet the demand.

Family medicine centers are often not child-friendly and offer limited privacy for adolescents, with typical consultations of “10 minutes”, which providers view as insufficient for meaningful engagement. However, an important milestone is that Family Medicine Centers now provide a structured home-visiting programme for pregnant women and children aged 0–3 years, in 34 out of 38 municipalities, bringing preventive care and parenting support directly to families’ homes, including those in rural areas, providing potential for early identification of mental health and developmental issues. Another important milestone has been the Ministry of Health's approval of the Strategy for Early Childhood Intervention (ECI), which focuses on providing integrated, family-centered services for children aged 0–6, particularly those with developmental delays or disabilities. The strategy promotes a coordinated approach that brings together health, education, and social services to support early identification, intervention, and inclusive development. Following the approval of the ECI strategy, the Ministry of Health allocated 1.8 million euros to recruit ECI teams at the municipal level. The revised Primary Health Care Administrative Instruction required to unblock recruitment has since been approved and signed (Administrative Instruction MoH No. 01/2026, amending Administrative Instruction (Health) No. 04/2020 on Primary Health Care), removing the principal regulatory obstacle. The actual recruitment and deployment of the ECI teams, and the monitoring of their roll-out across municipalities, nonetheless remain to be realized in practice.

Beyond these service initiatives, the Ministry of Health has developed a substantial body of normative and clinical guidance relevant to child and adolescent mental health. This includes guidance with a specific focus on young people, such as the Guideline on Promotive and Preventive Interventions in Adolescent Mental Health and guidance on the treatment of substance-use disorders in adolescents drawing on World Health Organization and mhGAP recommendations, as well as child-protection instruments such as Administrative Instruction No. 04/2023 on the medical and psychological treatment of child victims of abuse and Administrative Instruction No. 05/2023 on measures to prevent and protect children from substance abuse. The Ministry has also approved and published a series of clinical guidelines, including on depression, anxiety, suicidal behavior, trauma and post-traumatic stress disorder, schizophrenia, obsessive-compulsive disorder, and the use of alcohol and other drugs, and, most recently in 2026, the risk of overdose involving alcohol and other drugs, which identify children and adolescents among their target populations. The Ministry has also developed and published a separate guideline on mental health in the workplace. Taken together, these instruments represent a meaningful normative and clinical guidance base on which a more coherent system can be built. The mapping found, however, that their development and

approval have not yet been consistently matched by systematic dissemination, workforce training, or routine monitoring of their use, so the existence of this guidance does not yet translate reliably into changed practice at the service-delivery level. Establishing mechanisms to track the uptake and implementation of these instruments would be an important step in closing the gap between the normative framework and frontline care.

Overall, several specific aspects of the Ministry of Health's normative and financing framework still need to be addressed to translate these commitments into practice. First, the child-specific objective in the Strategic Plan for Mental Health needs to be carried through into a costed, monitored child and adolescent mental health action plan, rather than remaining a strategic statement without dedicated budget lines or accountability mechanisms. Second, the guidelines, clinical guidelines and administrative instructions described above need systematic dissemination, workforce training and routine monitoring of their use so that their existence translates into changed frontline practice. Third, the social-contracting mechanism under Regulation MF No. 04/2017 needs to shift from periodic, largely single-year NGO calls to sustained, multi-year financing dedicated to child and adolescent mental health promotion, to provide community-based providers with greater continuity. Fourth, now that the revised Primary Health Care Administrative Instruction (AI MoH No. 01/2026) has been signed, the remaining regulatory obstacle to the Early Childhood Intervention strategy has been removed; what is still needed is the actual recruitment, deployment and monitoring of ECI teams across all 38 municipalities. Finally, the revised draft Law on Mental Health, reported to be in its final stages of preparation, offers an opportunity to close the normative gap identified above by explicitly incorporating child- and adolescent-specific provisions, and should be pursued to completion.

Affordability further constrains access and continuity of care. Private services and sometimes in NGOs are costly, and many families cannot afford repeated sessions, transport, or medication, particularly for children with learning difficulties or special needs who require longer-term support and rehabilitation. Public funding for preventive and school-linked services is limited, and there is no insurance coverage that reliably reduces out-of-pocket expenditure. Stakeholders and parents emphasized the need for sustainable financing arrangements, such as insurance schemes, municipal subsidies, or contracts with NGOs and private providers, to ensure more equitable access. One such mechanism already exists: under Regulation MF No. 04/2017, the Ministry of Health has since 2018 provided financial support to NGOs for health promotion, disease prevention, and public awareness, including a public call in March 2025 that covered the promotion of mental health and the empowerment of young people for healthy living.

Early identification of emotional, behavioral and developmental difficulties is often delayed until problems become visible in primary school. Frontline workers, including preschool educators, nurses, and family doctors, rarely receive training in screening or referral for child and adolescent mental health. There is a severe shortage of child psychiatrists, clinical psychologists, speech therapists, and other specialists, alongside limited supervision and continuing professional development. Many clinical psychologists are licensed or are working “without ever having supervision”, and high caseloads contribute to the risk of burnout and inconsistent care. Quality assurance is particularly weak in the private sector, where psychosocial services are sometimes provided in unlicensed settings and certification processes lack verification of content or adherence to standards. This is compounded by a blurred, poorly regulated boundary between private and NGO provision of mental health services for children and adolescents.

Cultural beliefs, stigma, and misinformation significantly influence help-seeking for child and adolescent mental health services. Families, according to some clinicians, on occasions turn also to religious or traditional healers and only later, when symptoms worsen, to mental health professionals, viewing psychologists as a "last resort". Misconceptions, for example, linking vaccination to autism, fuel mistrust and encourage unregulated therapies. Providers pointed to the need for coordinated public communication and media engagement to normalize help-seeking and counter pseudoscience. Adolescent mental health problems, especially anxiety, depression, and self-harm, appear to have increased after COVID-19, yet structured responses remain weak. Often, somatic complaints mask psychological distress, and there are no clear crisis protocols, suicide-prevention procedures, or widely available structured school-based supports.

Equity issues cut across all these challenges in health-related services. Children in rural areas often have their first contact with a professional only at school age, and minority communities face additional language barriers, with some families requiring interpreters in clinical encounters.

Despite these constraints, several strengths were identified. Professionals in both public and private sectors show high commitment despite heavy workloads, and there are pockets of capacity, particularly in better-resourced private clinics and among school and community actors who play a key role in early identification. Awareness of adolescent mental health risks and of system gaps is increasing in the general population, and there is momentum for improving data, referral and response systems.

Education

Mental health is not systematically integrated into school curricula or extracurricular activities. The few extracurricular initiatives that address mental health, directly or indirectly, are largely small-scale pilots without Kosovo-wide reach.[97] School psychologists are available and often shared between schools, with poorly defined roles that overlap with pedagogues and are often constrained by administrative tasks. There is no licensing or supervision system for school psychologists, and stigma among students, teachers, and parents remains a major barrier to help-seeking.

The Ministry of Education and Science formally promotes student mental health as part of a broader agenda for inclusive, holistic education. Well-being and life skills are embedded in curriculum areas such as "Education for Health, Sports and Physical Education," and child protection is increasingly reflected in school policies. However, implementation is uneven. Initiatives like the "Healthy Schools" forums support local action but are vulnerable to staff turnover and project-based funding. Coordination with external services, such as health, social welfare, and police, is often ad hoc, and there is no monitoring system of the services provided by the school psychologists.

School-level capacity for MHPSS varies substantially. School psychologists are unevenly distributed, with smaller municipalities sharing staff and many schools having no psychologist at all. In schools with psychologists, mental health support is more structured and integrated into school plans. In these cases, psychologists deliver individual and group interventions, run preventive activities on topics such as self-esteem, bullying, self-harm, and social skills, and coordinate with teachers and parents to manage classroom and individual concerns. School psychologists report limited access to training, increased workload, and complexity of cases, and no access to evidence-based manuals and tools for individual or group interventions. Students increasingly self-refer, particularly girls, indicating growing trust in psychological services, although high caseloads, limited time, and scarce materials constrain the depth of follow-up.

In schools without psychologists, directors, class teachers and occasionally pedagogues assume responsibility for psychosocial support. They provide informal counselling and manage crises, but lack formal training, tools and systematic documentation. Referrals to external services, such as centers for social welfare, police or child psychiatry, occur mainly for severe cases and can be delayed due to institutional workload and weak feedback mechanisms. In rural areas, where external services are also scarce, many problems are managed informally within the school. Overall, referral pathways depend heavily on local initiative and personal relationships, rather than on standardized procedures or digital tracking systems.

Help-seeking patterns reflect this mix of progress and persistent barriers: in schools with school psychologists, students, especially girls, are more likely to seek support proactively, while boys tend to mask stress or present with behavioral issues. engagement has improved, with more families accepting referrals and participating in psychoeducational meetings, yet it remains largely reactive rather than preventive. Stigma and misunderstanding still delay access as some parents resist referrals or engage only when problems become visible. Where psychologists are present, structured psychoeducation and parent–teacher meetings help build trust, but limited time and resources constrain reach. Some parents resist referrals or engage only when problems become visible. Where psychologists are present, structured psychoeducation and parent–teacher meetings help build trust, but limited time and resources constrain reach.

Across interviews and focus groups, several recurring issues emerged as central to students' mental health and psychosocial well-being. Bullying and peer violence, often amplified by social media such as fake accounts and harmful posts, remain among the most common challenges. Emotional and behavioral difficulties, such as anxiety, restlessness, aggression, crying during activities, and difficulty concentrating, are frequently reported in primary grades and often linked to family instability and stress. Academic pressure and social comparison, particularly via social media, contribute to low self-esteem, fatigue, and disengagement among adolescents. Self-harming behaviors are increasingly observed, sometimes linked to online "challenges" or cumulative school and family stress. Inclusion of children with disabilities inconsistent: while some schools have assistants or speech therapists (logopeds), many rely on short-term or donor-funded support, leaving gaps in sustained expertise and funding. Early screening for developmental difficulties is weak, and there is a long waiting time for municipal teams for pedagogical assessment of children with disabilities with inconsistent access to specialized support; parents are sometimes informed that an assistant has been approved, but support is not actually available when needed.

Family circumstances and the wider community environment play a crucial role in shaping how school-based mental health and psychosocial support is experienced and delivered. Directors and psychologists report that family conflict, divorce, and economic hardship are major drivers of emotional and behavioral difficulties in the classroom, and schools often absorb the emotional burden of these problems. In many cases, directors and teachers act as intermediaries between parents and children, working to maintain routines and stability. Schools also collaborate with community actors, such as school police units, centers for social welfare, and family medicine centers, particularly in cases of serious violence or neglect. These collaborations are valuable but remain highly dependent on individual relationships and local initiative rather than formalized inter-institutional agreements.

Despite systemic gaps, the education sector shows important strengths. There is a strong commitment from school staff, with many directors and psychologists taking proactive leadership on student well-being. Cultural attitudes toward psychological support are gradually changing, with

counseling normalized and accepted by students and parents. Well-being topics are integrated into curriculum and school life through life-skills sessions, awareness campaigns, and group discussions, and in some municipalities, schools participate in functioning local referral networks with police, social services, and health providers. These activities are, however, largely project-based and unevenly distributed, they depend on external funding, partnerships, or individual initiative, and are not implemented consistently across all schools, with many, particularly in rural areas, having limited or no access to them. Similarly, where schools cooperate with police, social services, and health providers, this collaboration is most often ad hoc rather than institutionalized, reflecting local relationships and specific projects rather than standardized, system-wide referral mechanisms.

Key challenges include unequal access to psychologists and other professional support, particularly in rural and underserved areas, and weak intersectoral coordination, leaving schools to manage complex cases largely on their own. Additionally, the lack of structured supervision and continuous professional development for school psychologists, and shortages of materials and infrastructure for preventive and therapeutic work, are critical bottlenecks to advancing MHPSS for children and adolescents. Gaps in monitoring systems are a critical structural barrier.

Education Management Information System (EMIS) contains no mental health module, making it impossible to systematically track student mental health needs, school psychologist caseloads or intervention outcomes. No unified framework exists for tracking referrals, waiting times or follow-up across sectors, and data on children accessing MHPSS services are rarely collected in a way that supports planning. Persistent stigma delays help-seeking, and family engagement in school-based MHPSS remains predominantly reactive and episodic rather than proactive and sustained.

Child protection services

Kosovo has established a comprehensive legal framework for child protection, aligned with international standards. However, weak implementation remains a major bottleneck, undermining the intended impact of this legal framework on children. Municipal Centers for Social Work (CSW) face structural and capacity constraints in supporting children's and adolescents' mental health. Many lack on-site psychologists and rely on referrals to NGOs or health services, which often lead to delays and out-of-pocket costs for families.[98] Across 38 centers, only 404 professionals are employed, most of them with a law education background, with critical shortages of social workers and psychologists, and no formal staffing norms linking workforce size to population or case complexity.[99] Assessments, reports and interviews consistently highlight the absence of mental health and psychosocial services in this sector, largely due to insufficient professional staff.[100],[101] Probation officers and juvenile justice staff are also overburdened, managing more than 100 cases each and having minimal capacity to provide mandated psychological services.[102]

CSW are mandated to deliver social and family services at the municipal level, but operate as overstretched, all-purpose providers with broad responsibilities across antisocial behavior, school violence, domestic abuse, trafficking, and street-involved children. This catch-all role, combined with limited staffing, insufficient funding, and a lack of clearly defined professional profiles, leads to high caseloads, role ambiguity, and a limited ability to go beyond basic assessment and referral. Although CSW is formally responsible for psychosocial “anamnesis” and expert opinions, its capacity to provide sustained interventions is restricted. The reintegration pathways for street-involved children or youth involved in violence are weak, and responses remain largely reactive rather than preventive or rehabilitative.

Service capacity is highly centralized in Prishtina. Urban areas benefit from greater service availability, while many rural municipalities rely on a single CSW office with minimal staff and no on-site psychologists. Critical profiles such as clinical psychologists, speech and occupational therapists, and pedagogues are absent in most municipalities, requiring referrals to Prishtina or other larger municipalities where services are overstretched, and many families cannot afford even the travel costs. Children enter the system through multiple pathways, including schools, school psychologists, probation services, courts, safe houses, and family self-referral, but sustained follow-up is difficult to nonexistent. NGOs such as SOS Children's Villages and Terre des Hommes provide counseling and outreach, helping fill gaps, yet their programs are largely donor-dependent and often end when project funding stops.

Workforce constraints are a central bottleneck. Many CSWs have no psychologist, leaving social workers to manage large, unspecialized caseloads spanning juvenile justice, disability, and child protection. Civil service reforms have weakened the professional status of social workers, contributing to low morale and retention, while training is irregular and rarely linked to structured supervision or real needs. Rising children and adolescent mental health needs further strain on this system. Informants reported increasing anxiety disorders across all ages, developmental and behavioral difficulties in younger children (e.g., enuresis, autism, learning problems), and more internalizing issues, substance use, and self-harm among adolescents, including cases influenced by online content. Yet service provision remains focused on crisis management and short-term containment, with limited emphasis on prevention, resilience-building or family-centered rehabilitation. Forensic and correctional institutions, including probation and juvenile facilities, lack staff trained in trauma-informed care or psychological assessment.[103] Early psychoeducational and stimulation-based services for children with developmental or behavioral conditions are not publicly available and are mostly purchased privately, reinforcing inequities.[104]

Coordination and referral pathways are inconsistent, as in other sectors. Although SOPs exist for child protection and domestic violence, cross-sector referrals between CSW, schools, police, courts, and psychiatry are unevenly applied, and formal feedback is rare. CSW staff report sending children to psychiatric services "without ever getting feedback on what happened," while data on service use and outcomes remain fragmented. Psychosocial data are not systematically tracked, and most information is recorded manually, making it impossible to routinely report how many cases involve mental health needs or to monitor waiting times and outcomes. Stigma and cultural norms continue to influence help-seeking and referral acceptance: some parents prefer neurologists over psychiatrists to avoid being "on record," and psychosocial problems are still sometimes framed as discipline issues rather than health and protection concerns.

Despite these constraints, the mapping identified several strengths. CSW functions as a recognized intake point for psychosocial and protection cases, with an established flow from initial assessment to NGO counseling and, when needed, Child and Adolescent Psychiatry. Multi-sector partnerships with NGOs, schools, probation services, and courts, though uneven, create a basic operational ecosystem, and staff often demonstrate strong motivation and flexibility in difficult conditions. Promising practices include NGO-supported home visits, school outreach on bullying and violence prevention, and donor-funded training on adolescent health and MHPSS, although most remain project-based and temporary.

Non-governmental and private sector services

NGOs play a crucial compensatory role within the MHPSS landscape. More than 50 NGOs provide free services, particularly for children with disabilities, trauma survivors, and at-risk youth, often operating without formal licensing due to legal ambiguities.[105] Despite their reach and expertise, NGOs are weakly integrated into the system. Organizations such as the Kosovo Center for the Rehabilitation of Torture Victims delivered trauma recovery programmes through municipal agreements but depend heavily on short-term funding.[106] The absence of a clear legal basis for formally recognizing NGO and private services as part of the child and adolescent mental health and MHPSS system undermines both sustainability and coordinated care.

Civil society organizations and private providers have expanded rapidly to fill gaps left by the public sector, moving from basic assessment to more comprehensive services such as individual therapy, family work, psychoeducation and multidisciplinary care, including speech and developmental therapies. Many began in Prishtina and later opened branches in other municipalities in direct response to unmet community needs. Some now provide youth-focused crisis support, including a suicide-prevention helpline, which functions as a safe space for adolescents in acute distress.

Providers in these sectors report a rising clinical burden, with increasing numbers of children and adolescents presenting with behavioral difficulties, bullying, anxiety, depression, ADHD and developmental delays, including autism spectrum conditions. Caseloads are increasingly long-term, requiring structured family plans and regular follow-up. At the same time, early identification remains weak. Developmental “red flags” are often normalized as something that “will pass.” Assistants assigned to support children with disabilities and development difficulties, such as autism spectrum disorders, intellectual disabilities or speech, language and learning difficulties, may be unavailable or untrained, and stimulation therapies, even when offered at symbolic fees, are unaffordable for many families over time. Schools frequently lack the capacity to respond effectively or to coordinate with external specialists, particularly in peripheral areas where specialized services are absent.

Access and equity barriers are pronounced for families of children with disabilities and developmental difficulties. Families face long waiting lists, sometimes for up to five months, high private costs, distance from services in rural areas, and limited awareness of what support exists. Many NGOs serving these children rely on parental contributions and short-term grants, leading to unstable financial models. Referrals from schools or pediatricians are typically informal and rarely accompanied by feedback. Documentation and reports vary widely among practitioners, and public and private providers often operate as “separate islands,” leaving parents to navigate fragmented pathways largely based on personal recommendations and word of mouth.

Quality and safety gaps in assessment and diagnosis are a recurrent concern. Assessment tools are sometimes outdated, diagnoses may be made quickly and without the integrated and validated instruments, and formal clinical supervision is limited. Inclusion in education remains inconsistent, with some schools and preschools hesitant to enroll children with behavioral or developmental needs, and classroom assistants often insufficiently trained or supervised. As a result, families of children with disabilities or complex needs frequently turn to private providers or NGO-run programs for specialized services such as speech therapy, occupational therapy and behavioral support, services that are largely unavailable in the public system. This reliance on the private sector reinforces existing inequities, as only families who can afford out-of-pocket costs can access the

interventions their children need. Stigma remains significant, with some families still preferring religious or traditional help over clinical support.

Financing and governance arrangements are weak. Most services are funded through a mix of parent fees and ad-hoc donor grants, with no predictable state purchasing or long-term contracts in the NGO sector. A draft Administrative Instruction to enable public purchasing of NGO services has not yet been finalized. Licensing processes focus heavily on formal and legal requirements rather than clinical quality. There is no systematic monitoring of practice standards, and families lack an accessible mechanism for complaints and redress. Despite these constraints, NGOs demonstrate important strengths by offering community-anchored, youth-friendly services, innovating rapidly in response to unmet needs, providing training for frontline workers (teachers, police, nurses, social workers), building trust with families and young people, and playing an advocacy role by identifying gaps and proposing minimum service packages and decentralization models.

Figure 4. Child and adolescent MHPSS system in Kosovo: key actors, capacities and services by sector

HEALTH SECTOR (CAMH-RELEVANT)	EDUCATION SECTOR
Human Resources and Coverage **7 child psychiatrists** (vs 45 adult); ~2 clinical psychologists + ~10 psych specialists; 1 psychologist + 2 social workers in pediatrics (7,000+ patients/year). **Infrastructure** 1 Child & Adolescent Psychiatric Service (Prishtina) with ~7 beds; early-development/autism services mostly private. **Services** Psychiatric assessment, medication, limited psychotherapy, basic non-standardized psychosocial support; **no 24/7 youth crisis line.**	**Human Resources and Coverage** ~1,044 schools; **148 school psychologists + 77 pedagogues** → ~1 psychosocial professional per ~1,400 students; many schools share or lack a psychologist. The School Psychology Association of Kosovo reports **230 school psychologists** across public and private schools. **Systems / Data** EMIS without mental-health indicators. No licensing or supervision system for school psychologists. **Services** Individual/group counselling where psychologists exist; class sessions on bullying/self-esteem in some schools; informal crisis handling by staff; mostly informal referrals to psychiatry, QPS, NGOs.

Children / Youth

SOCIAL PROTECTION / CHILD PROTECTION (QPS)

Human Resources and Coverage

38 QPS (one per municipality); ~404 staff (mostly lawyers), typically 0–1 psychologist + a few social workers per center. Probation officers manage **100+ cases, each** with minimal capacity for psychological services.

Mandate

Domestic violence, neglect, juvenile justice, street-involved children, disability, and family conflict.

Services

Intake, limited psychosocial assessment, case management, guardianship/custody, safety planning with police/courts/shelters, limited counselling, referrals to CAP/NGOs/schools (feedback weak). Forensic and correctional institutions lack staff trained in trauma-informed care.

CIVIL SOCIETY / NGOS & PRIVATE

Coverage and Actors

>50 NGOs with MHPSS-related work; several developmental/autism centers; many small private practices in Prishtina + a few cities; at least one suicide-prevention helpline.

Services

Individual psychotherapy/counseling, family counselling, trauma programs; autism/ND services (speech/OT/stimulation/assistant training); hotlines; youth groups; school/community psychoeducation; outreach, home visits, case accompaniment, parent training. Early psychoeducational and stimulation-based services for children with developmental needs are mostly purchased privately, reinforcing inequities. **All project-based and donor-dependent.**

Cross-sector convergences and systemic gaps in child and adolescent MHPSS

The mapping across health, education, child protection, non-governmental, private, families, and young people reveals a shared pattern – services operate in parallel, with important strengths in each sector but without a coherent, integrated MHPSS system for children and adolescents. The following synthesis highlights the main convergences and systemic gaps that cut across sectors.

Fragmented coordination and unclear referral pathways. Across all sectors, coordination and referral are largely informal and depend on individual initiative rather than clear structures. Health providers, schools, CSW and NGOs rely on personal contacts, ad-hoc phone calls or letters, with limited feedback and no shared case-management tools. Families and young people experience this as confusion, “not knowing where to go” with schools not being an exception, which are often left to navigate parallel systems on their own.

Shared barriers to access and equity. Access and equity challenges are common to all actors. Health, education and NGO operate as statutory services with constrained but relatively stable public budgets. NGOs and private providers rely on projects and parental fees, allowing for flexible, tailored interventions but with uncertain continuity. For families, this creates a clear divide between “official but limited” and “helpful but expensive/temporary” services. Specialist child and adolescent mental health care is centralized in Prishtina, while schools, CSW, and NGOs in other municipalities operate with limited staff and uneven coverage. Rural areas, minority communities and low-income families face combined barriers of distance, transport, user fees and lack of information. Civil society providers extend access beyond the capital but are constrained by project-based funding and parental contributions. Parents in different communities describe mental health

care as a “luxury” that cannot be sustained over time, and adolescents remain highly dependent on parents for transport and payment.

Crisis-oriented responses and weak prevention/early identification. Across services and sectors, responses are more crisis-focused than preventive. Health and CSW typically see children once problems have escalated, e.g., self-harm, acute anxiety, violence, and street involvement. Schools with psychologists offer more preventive and developmental activities, but in schools without psychologists, support is mainly reactive to incidents. NGOs run groups, awareness activities, and school workshops, but coverage is patchy and often time-limited and project-based. Early identification in primary health care, preschool settings and community services is weak, and both adults and young people report that help is usually sought only when difficulties become visible or severe. Education and NGOs are more engaged in preventive and developmental work where capacity exists (life skills, psychoeducation, group activities), while health and CSW are largely oriented toward crisis, diagnosis and risk management. Families and youth experience this as brief, episodic contact with “systems” rather than continuous, stepped-care support.

System-wide absence of clinical supervision. Across all sectors, structured clinical supervision and Continuing Professional Development (CPD) are virtually absent. School psychologists operate without any formal supervisory framework; CSW staff manage complex caseloads without psychological supervision; and health sector psychologists report working without ever having received supervision. This gap contributes directly to burnout risk, skill stagnation and inconsistent quality of care, and represents one of the most urgent structural deficits in the current MHPSS system.

Stigma, cultural norms and informal help-seeking. Although cultural attitudes are gradually changing with counseling increasingly normalized, and discussions on mental health more common, stigma and cultural norms continue to shape help-seeking across communities and sectors. Families, children, and providers describe shame, fear of gossip, and fear of being “on record” as major deterrents to using formal services. In some schools, psychologists are still perceived as a punitive resource, and in many communities’ families turn to the religious or traditional helpers first. Young people often rely more on peers and the internet than on professionals, while NGOs deliberately use youth-friendly, confidential approaches to normalize help-seeking and reduce stigma.

Data, monitoring and governance gaps across sectors. Data and governance gaps affect all parts of the system across all sectors. Health lacks a comprehensive Health Information System, and the available health services data are not disaggregated by child- and adolescent-related indicators. In education, the Education Management Information System is outdated and capture mental health–related indicators. The CSW relies on manual and non-standardized records, and comprehensive data on child and adolescent mental health-related information is limited. Families, on occasion, perceive a lack of transparency and follow-up, which reinforces mistrust and limits accountability. In addition, data generated by NGOs and private sector service providers are not integrated into information systems. While administrative data on child and adolescent mental health remains largely insufficient, Kosovo also lacks institutional -level survey data on child and adolescent mental health, limiting the availability of reliable prevalence estimates and evidence to inform policy development, resource allocation, and system strengthening. CSW and justice-linked services are primarily concerned with legal risk and protection obligations; health focuses on clinical risk and diagnosis; education emphasizes behavior and school performance; NGOs focus on engagement, rehabilitation, and perceived impact; families and youth focus on safety, confidentiality, and being

listened to. These perspectives drive different (and often unaligned) expectations about documentation, follow-up and "what counts" as success.

Multiple "front doors" and no clear entry point for MHPSS. Institutions tend to view FMC or CSW as formal entry points, whereas schools and NGOs describe themselves as practical first points of contact. Families prefer simple, local gateways (schools, FMC-based psychologists), and young people often see peers, NGOs, and online spaces as their real front door. These differing perceptions make it harder to design a single, visible access pathway.

Finally, expectations about the "front door" into the system differ across actors. Health services and CSW see primary health care and statutory protection mechanisms as entry points. In the education sector, schools point of contact for many issues faced by children. NGOs are de facto entry points for some groups of adolescents, especially minorities, and families express a clear preference for simple, local gateways such as schools and primary health care-based psychologists. For children and caregivers, the system is not visible as a coherent whole, and pathways remain unclear.

These converging issues underscore the need for a more coherent and integrated multisectoral MHPSS system, with clearly defined pathways, shared standards, and a visible, youth- and family-friendly entry point. A concise overview of these cross-sectoral patterns is presented in Annex 5: Intersectoral Findings, which summarizes the key coordination, access, workforce, stigma, data, and entry-point challenges identified in this section.

Cross-sector divergences in child and adolescent MHPSS

While sectors share many problems, they differ in how they see their role, organize services and interact with children and families. Key divergences include:

1. Public statutory vs. project-based services. Health, education and CSW have stable mandates but limited capacity. NGOs and private providers are more flexible and often better at reaching families but depend on donor funding and fees. Children with complex, long-term needs fall into the gap between the two.

2. Different perceptions of the front door. Health and CSW see family medicine centres and statutory mechanisms as the entry point. Schools are the first point of contact for most children. NGOs are the real gateway for adolescents and minority communities. Young people themselves turn first to peers and the internet. These divergent perceptions make it structurally impossible to design a single coherent access pathway.

3. Different views on risk and accountability. CSW focuses on legal risk, health on clinical diagnosis, education on behavior, NGOs on engagement and wellbeing. Because sectors define success differently, they track different outcomes, use incompatible recording systems, and rarely generate data meaningful to other actors.

4. Prevention vs. crisis orientation. Education and NGOs invest in preventive and psychosocial work where capacity exists. Health and CSW engage predominantly at the point of acute crisis. The sectors most able to reach children early are the least resourced and least integrated into the formal system.

5. Relationship with families and young people. NGOs and schools build ongoing, trust-based relationships. Health and CSW interactions are typically episodic and transactional. Young people

clearly prefer settings where they feel safe over those associated with official record-keeping or judgment.

6. Workforce profile and professional identity. School psychologists are generalists covering multiple roles. CSW workers have predominantly legal backgrounds. Health professionals are clinically trained but unsupervised. NGO workers are often the most practically trained but have the least institutional status. These differences make genuine multidisciplinary collaboration rare in practice.

A Priority Package of MHPSS actions

Building on the situation analysis and service mapping, a priority package of MHPSS actions for children and adolescents is proposed to provide Kosovo with a practical, affordable framework to advance a multisectoral approach to MHPSS for children and adolescents. The package aims to support central and local authorities, together with civil society actors, in moving from fragmented, project-based initiatives toward a coordinated and sustainable national system of care. It draws on international evidence and guidance, particularly UNICEF's Global Multisectoral Operational Framework, contextualized to the realities of Kosovo identified through this mapping exercise. Emphasis is placed on decentralized, community-based, and intersectoral approaches to ensure timely, appropriate, and need-based support for children and adolescents.

The package consolidates key priority interventions, including policy-level actions that can be implemented using existing capacities while laying the foundation for longer-term system strengthening. It combines universal promotion, prevention, and early-intervention measures across schools, primary health care, and social services, supported by digital tools and community partnerships. Core design principles include stepped care and task-sharing; rights-based, inclusive, and developmentally appropriate services; meaningful participation of children, adolescents, and caregivers; systematic attention to financial and geographic barriers; investment in a sustainable and supervised frontline workforce; and the establishment of basic monitoring and quality-improvement systems. Together, these elements aim to mainstream MHPSS as a routine and reliable component of core services for children and families across Kosovo, reflecting the priorities, gaps, and practical recommendations raised by stakeholders through interviews and focus-group discussions conducted during this mapping exercise.

To advance the MHPSS agenda for children and adolescents in Kosovo, a set of foundational system-strengthening actions is proposed to enhance the multisectoral MHPSS system in line with international standards and in response to the emerging needs of children. These actions encompass priority measures across policy, service delivery, and system enablers, including a three-tiered approach to delivering a minimum package of services to build a strong and resilient MHPSS system for children and adolescents. This approach is designed to respond to growing mental health needs while contributing to Kosovo's broader human capital development and long-term social and economic prosperity.

Create a single national governance "home" for child and adolescent MHPSS and establish a Multistakeholder Coordination Mechanism. Mandate one lead national body, with clear authority and membership across sectors to set priorities, resolve mandate overlap, and ensure systematic coordination, information sharing, and joint action for advancing MHPSS programs and services for children and adolescents.

Adopt a Minimum Package of MHPSS services and develop a National Multisectoral Action Plan. Approve the package as the national baseline and integrate it into core sector plans and municipal planning requirements, so implementation is not optional or purely project-driven. Endorse a multisectoral action plan to provide a clear framework with defined priorities, responsibilities, and timelines for implementing and monitoring MHPSS programmes and services.

Clarify mandates, decision rights and accountability across sectors and levels. Issue an inter-ministerial implementing act or joint administrative guidance that defines who is responsible for what at the national and municipal levels, as well as at the sectoral level, including minimum coordination and escalation pathways when cases stall.

Establish a sustainable financing architecture. Cost the Minimum Package and translate it into multi-year budget lines across responsible institutions, including predictable municipal allocations, with clear rules for co-financing and coverage of priority services, reducing reliance on short-term donor cycles.

Standardize national contracting and regulation of non-public providers. Introduce a simple national framework for commissioning CSOs and private sector providers where public provision is limited, including eligibility criteria, safeguarding requirements, reporting expectations and contract templates to ensure continuity and accountability.

Strengthen the legal and procedural safeguards specific to children and adolescents. Align and clarify rules on consent/assent, confidentiality, information sharing across institutions, and duty-of-care responsibilities in child cases, so that frontline staff can act decisively without legal uncertainty.

Create national implementation support to reduce municipal inequities. Set up a light national support function, technical assistance and periodic reviews, to help municipalities operationalize policies consistently, especially where capacity is weakest, and to prevent the current pattern of uneven access by geography.

Enhance the generation of reliable and internationally comparable data on mental health to inform policy decisions and budgeting. Increase the capacities of the Kosovo Agency of Statistics and academia to integrate global data-collection tools, such as "Measuring Mental Health Among Adolescents at the Population Level (MMAPP)," into national data plans, enabling the production of robust, internationally comparable survey-based mental health estimates. Simultaneously, increase the capacities of relevant sector ministries to maintain mental health-related data collection within administrative data by defining clear indicators and integrating them into relevant management information systems.

Mainstream MHPSS-related interventions in national strategies and policies. Effectively integrate and budget MHPSS services into national strategies and policies to ensure sustainable financing and long-term MHPSS service delivery for children and adolescents. This should include both sectoral and cross-sectoral strategies.

A three-tiered approach to delivering a minimum context-specific package of services for children and adolescents in Kosovo includes: **A tiered framework for action: from universal prevention to specialized care.** The below section outlines recommendations according to the IASC intervention pyramid which structures MHPSS as a connected continuum rather than separate services. **Tier 1**: **Universal promotion and prevention** addresses population-wide actions that help build mental health literacy and reduce risk for all children and adolescents. **Tier 2: Focused, non-specialized support** addresses children showing early distress or elevated risk through structured group and family intervention in the community, with options delivered by trained non-specialists. **Tier 3: Specialized clinical care** provides individualized treatment for children with diagnosed conditions or complex needs, delivered primarily by mental health professionals. These tiers are

interdependent where strong universal promotion reduces demand in two other tiers, while functioning referral pathways allow children to move between tiers as their needs change. A child also receives support at more than one tier at the same time, for example, a universal school program in conjunction with specialized treatment for those in need or identified through the universal program.

Tier 1 – Universal promotion and prevention

Awareness-raising and stigma reduction related to mental health

Regular, age-appropriate communication on mental health should run across schools, primary health care, social services, youth centres and digital platforms. Core aims are to build basic mental-health literacy, normalize help-seeking, reduce "shame" and discrimination, and address key risks such as bullying, online harms, substance use and self-harm, with inclusive messages for children with disabilities, non-majority communities and gender-diverse youth. Such actions can be grounded in the Law on Health, and the respective sectoral strategies for Health and Youth, which recognizes promotion and prevention as state obligations. Over time, mental health promotion can be formalized in annual health and education calendars, with health, education, youth, municipal authorities, and civil society jointly planning campaigns and co-creating child- and adolescent-friendly materials.

Establishment of the National Child Helpline

The Law on Child Protection (No. 06/L-084) explicitly mandates the establishment of a national child helpline, yet Kosovo has not operationalized this service, a gap repeatedly noted in EU Progress Reports. The child helpline should be established as a priority action, providing free, confidential, 24/7 telephone and chat support operated by trained counselors. It should serve as the primary first-line contact for children experiencing distress, abuse, violence, or mental health difficulties, with clear referral pathways to social services, health, and emergency services. The helpline must be widely publicized and accessible to all children, including minority communities and children with disabilities.

Digital psychoeducation and low-intensity self-help

A joint education and health digital platform (web and app) would provide age-appropriate modules on stress, anxiety, low mood, bullying, self-esteem, and emotional regulation, combining psychoeducation, guided self-help, and simple coping tools. Anonymous self-checks can flag distress early and signpost children and adolescents to in-person support in schools, primary health care, centers for social welfare, or trusted NGOs. Anchored in existing digital education, health, and mental health strategies that recognize the right to information and preventive services. Future administrative guidance can formalize digital MHPSS tools as standard preventive services, with education, health, municipalities, NGOs, and information and technology-related partners jointly responsible for safe content, privacy, accessibility, and referral links. In addition, the platform could serve as a practical orientation point for parents, children, adolescents and youth, clearly indicating where and how they can seek timely support for mental health concerns.

Gatekeeping and early identification in schools

The network of school psychologists provides a strong entry point for scaling up first-line mental health promotion and support for children and adolescents. Realizing this potential requires both expanding the network of schools that have access to school psychologists, by progressively improving the coverage ratio, and investment in continuous professional development as there are limited training opportunities for school psychologists as findings indicate. With adequate numbers, supervised training school psychologists, can lead gatekeeping, screening and early interventions. . In schools without psychologists, trained gatekeepers should be equipped to recognize early signs of distress, provide brief supportive responses, and activate clear referral pathways using simple "traffic-light" triage tools. Schools should also conduct regular health and mental health screenings using digital tools such as brief questionnaires involving parents, enabling school teams to identify emerging needs and design appropriate interventions. These practices should be integrated into school policies, teacher Continuing Professional Development and child-protection procedures, grounded in existing legal frameworks that already require safe school environments and timely protection responses. Administrative instructions can define minimum gatekeeper coverage, standard triage and referral procedures, supervision and data protection requirements, with education leading the design and the health and social sectors validating risk criteria and pathways.

Operationalization of Early Childhood Intervention (ECI) Teams

The ECI Strategic Document and Action Plan 2025–2030, approved by the Kosovo Institutions on 21 March 2025 (Government Decision No. 05/253), establishes a national framework for early childhood intervention targeting children aged 0–6 with developmental delays, disabilities or high developmental risk. Led by the Ministry of Health in coordination with the Ministry of Education and Science and the Ministry of Family, Labour and War Veterans, the plan foresees 48 transdisciplinary ECI teams embedded within Primary Health Care centers across all municipalities, each comprising a psychologist, speech therapist, physiotherapist/occupational therapist, social worker, and educator. The document estimates the total implementation cost at EUR 18.9 million and identifies EUR 7.9 million in additional budgetary costs for 2025–2027, mainly related to the recruitment of 240 additional local-level professionals, including psychologists, speech therapists/logopedists, physiotherapists, social workers, and educators. The ECI framework is directly relevant to MHPSS, where the psychologists on every team provide the first systematic platform for the early identification of psychosocial needs in young children, a capability currently almost entirely absent from formal MHPSS services. Priority actions include training ECI psychologists in validated psychosocial screening tools, establishing referral pathways to school psychologists, child and adolescent mental health services and Centres for Social Work, building on the now-approved revised PHC Administrative Instruction (AI MoH No. 01/2026) to complete the recruitment and deployment of ECI teams, integrating ECI data into MHPSS monitoring, and extending outreach to Roma, Ashkali and Egyptian communities and other underserved groups.

Tier 2 – Targeted and early-intervention MHPSS

Family-based parenting support programmes

Structured parenting groups and brief support should be provided to caregivers, especially in vulnerable families, to strengthen positive parenting, communication, non-violent discipline, and

early recognition of emotional and behavioral difficulties. Programmes should be available in Albanian, Serbian, Turkish and Romani and adapted for families facing poverty, disability and minority-related barriers. Anchored in social and family services, health promotion, and child protection provisions that recognize families' central role in child wellbeing. Guidance can clarify how health, education, and social sectors jointly support family-based child and adolescent mental health interventions and set minimum inclusion and quality standards, with line ministries, municipalities, and NGOs collaborating on design and delivery.

School-based counselling and referral services

Brief, structured counseling by school psychologists should be available for students with emerging psychosocial difficulties, with clear thresholds and procedures for warm referral to health and social services when needed. Simple referral and feedback tools and cluster-based supervision can help manage caseloads and ensure consistent links to family medicine, child and adolescents mental health and CSW, including in rural areas. Regulated through administrative instructions under the Law on Pre-University Education, the Law on Social and Family Services, and the Law on Early Childhood Education (No. 08/L-153), clarifying collaboration and referral between schools, health, and social services. Over time, bylaws can set basic norms on caseloads, decreasing the norm from 1 school psychologist per 1000 students to 500, to supervision and referral standards, with education, health, social sectors and municipalities jointly supporting implementation.

Evidence-based school MHPSS interventions

Schools should routinely provide brief, structured, evidence-based interventions, individual and in group, for students with stress, anxiety, low mood, behavioral difficulties, and ADHD-related problems, using simple screening and outcome tools where feasible. Validated programmes such as Helping Adolescents Thrive (HAT)[107] Validated programmes such as Helping Adolescents Thrive (HAT)[108] or Early Adolescent Skills for Emotions (EASE),[109] a group intervention for adolescents experiencing anxiety and depression, offer ready-made, evidence-based frameworks that can be adapted to the Kosovo context. Both can be adapted and linked to whole-school life-skills promotion, violence prevention, inclusion and child protection. Other evidence-based Cognitive-Behavioral Therapy (CBT) interventions can be adapted and implemented by school personnel. These programmes can be anchored in education legislation, the Education Strategy and the Administrative Instruction on school psychological and pedagogical services. Future bylaw revisions should formalize standardization of school MHPSS protocols and assessment tools, with education providing direction and training, schools implementing interventions, and health, social sectors, municipalities, developmental partners, academia and NGOs supporting alignment, capacity-building and monitoring.

Primary care-based adolescent mental health screening

Primary health care teams should use brief, standardized tools to screen adolescents (12–18) for depressive and anxiety symptoms and psychosocial difficulties, provide basic advice and refer more complex cases to clinical psychologists, Child and Adolescent Mental Health Center (CAMHC), school-based services or CSW. A gradual scale-up from pilots to national coverage will embed psychosocial screening into routine adolescent contacts, especially where school/NGO services are scarce. Grounded in the Law on Health and the Law on Mental Health, the primary health care provisions should foresee mental health as part of primary care. Hence, employment of clinical

psychologists within primary health care teams should be clearly foreseen and encouraged in the law and bylaws, so that psychological assessment and brief interventions are available at the primary care level. This would require initial regulation of screening and referral by the Ministry of Health through guidelines and administrative instructions and later formalization of periodic psychosocial screening in law and bylaws, working with education, social sectors and municipalities to ensure functional referral and follow-up.

Social and family support and stabilization services

CSW should provide structured services for children flagged with moderate or high protection and mental-health concerns, focusing on rapid contact, a child-centered safety plan, and brief, goal-oriented family work, coordinated with schools, the primary health care, and Child and Adolescent Mental Health Center (CAMHC), as well as the justice actors where needed. Simple tools and basic tracking can be integrated into the shared referral and feedback system. Grounded in legislation on child and social protection, domestic violence, mental health, and education, which mandate state response and intersectoral cooperation for children at risk. Guidance can define minimum CSW response standards, safety plan requirements, joint case management and data protection protocols, with CSW leading and education, health, justice, municipalities, and NGOs contributing within their mandates.

CSOs-bridging MHPSS services

Civil society organizations can provide “bridging” support for children and adolescents with neurodevelopmental conditions (including autism spectrum conditions, Down syndrome, cerebral palsy, intellectual disabilities, and other developmental disorders), complex psychosocial needs, or multiple overlapping vulnerabilities and persistent psychosocial needs, offering multidisciplinary assessment, individual and group work, parent training and practical support such as accompaniment, translation, benefit navigation. Priority should be given to reducing waiting times, ensuring long-term follow-up, and reaching rural, low-income, and minority families with inclusive, bilingual materials. Anchored in legislation and policies on health, mental health, social and family services, child protection and pre-university education that recognize specialized support and the role of non-state actors. Administrative guidance can clarify CSOs scopes of work, safeguarding, minimum datasets and collaboration expectations, with health, education, social sectors and municipalities providing direction and quality assurance while accredited CSOs deliver bridging packages and report on outcomes.

Tier 3 – Specialized / clinical and crisis services

School crisis response pathways

A standard crisis pathway should guide schools in managing acute situations such as suicidal risk, self-harm, severe panic, violence, abuse disclosures through rapid triage, immediate safety planning, Psychological First Aid, and warm handover to school psychologists, primary health care, Child and Adolescent Mental Health Center (CAMHC), emergency services and CSW. Simple tools, such as checklists, phone lists, scripts and basic drills should be embedded in school policies and Continuing Professional Development and linked to follow-up and return-to-learn support. Grounded in laws and policies on education, child protection, social and family services, and mental

health that require safe school environments and timely responses. Administrative guidance can formalize mandatory crisis SOPs, minimum coverage, post-crisis procedures, and information-sharing safeguards, with education leading pathway design and health, social, municipal, and CSO partners supporting risk standards, training, and implementation.

Specialist multidisciplinary assessment (MDT) for complex cases

A specialist MDT should provide coordinated assessment and shared care planning for children and adolescents with moderate to high needs referred by schools, primary health care, CSW or Child and Adolescent Mental Health (CAMH). MDTs bring together relevant professionals from education, health, social protection, Special Educational Needs (SEN), Speech and Language Therapy/Occupational Therapy (SLT/OT) as needed, to produce one integrated assessment and joint care plan with the child and family, using bilingual, disability-inclusive tools adapted for Roma, Ashkali and Egyptian communities. Anchored in existing health, education, social and child-protection legislation that foresee intersectoral cooperation and specialist support. Guidance should define triggers for MDT assessment, the minimum team composition, and standards for documentation, information sharing, and safeguarding, with health leading clinical standards and education, social sectors, municipalities, and NGOs ensuring the school, family, and follow-up dimensions.

24/7 youth crisis line and chat

A national 24/7 youth crisis line and chat would provide immediate, confidential support for children and adolescents in acute distress, including self-harm/suicidal thoughts, violence and other crises. Via toll-free phone and digital channels, trained counsellors offer Psychological First Aid, brief stabilization, basic risk triage, safety planning and structured referrals (warm handovers: direct, supported transitions where the referring worker contacts the receiving service and personally introduces the child/family)to school psychologists, primary health care Child and Adolescent Mental Health Center (CAMHC), CSW and emergency services, with bilingual and disability-accessible options and adaptations for non-majority communities. Grounded in legislation and strategies on child protection, mental health, social and family services, education, domestic violence and digital/tele-services that guarantee protection and timely assistance. Administrative guidance can define duty-of-care, mandatory reporting, data protection and information-sharing with core sectors, with health leading clinical governance, education and social sectors supporting promotion and follow-up, and municipalities, emergency services, NGOs and IT partners contributing to operations and safe infrastructure.

Cross-cutting system enablers

To enable a coherent and whole system multisectoral MHPSS response, key cross-cutting enablers are required to ensure the system functions effectively and responds holistically to the diverse mental health needs of children and adolescents.

Shared referral and feedback mechanisms across sectors

A shared, time-bound referral and feedback mechanism is required to standardize what information is sent, who acts, by when, and how feedback returns between schools, CSW, primary health, and Child and Adolescent Mental Health Center (CAMHC). A single template, unique case identifiers and

simple tracking (paper or electronic) can ensure that referrals are acknowledged, acted on and closed with clear information to referrers and families. Grounded in frameworks on education, child and social protection, mental health and digital governance that foresee inter-institutional cooperation and data protection. Administrative guidance should formalize the template, minimum dataset, basic service-level expectations and safeguards, with education leading integration into school practice and health, social sectors, municipalities, and CSO partners jointly applying and reviewing the system.

Trauma-informed care and psychological support training for social services

Social workers and psychologists in CSW should receive structured capacity building in trauma-informed practice and basic evidence-based interventions for children and adolescents, with practical tools, clear referral pathways and regular supervision. This will help ensure safe, child-centered responses, reduce re-traumatization, and expand the capacity for brief psychosocial support within social protection, including in underserved municipalities. Anchored in the Law on Social and Family Services and related child-protection regulations that define duties around children's psychosocial needs. Guidance should set minimum competencies and embed ongoing training and supervision into professional development, with the Ministry of Labor, Family, and Liberation War Value leading design and coordination, and health, education, municipalities, developmental partners, academia, and CSOs aligning content with national mental health standards and supporting national roll-out.

Conclusions and Strategic Priorities

Children and adolescents in Kosovo face a rising burden of mental health challenges driven by poverty, inequality, violence at home and in schools, digital harms, stigma, and the long-term effects of conflict-related trauma. At the same time, protective assets, supportive family environments, committed teachers and educators, youth engagement, and strong community identity remain underused. This mapping confirms that mental health and psychosocial support services exist across health, education, social services, the NGO sector, and private providers, but they operate as disconnected islands rather than a coherent system. Access is deeply unequal across municipalities, with services concentrated in Prishtina. Prevention and early identification are weak, referral pathways remain informal and person-dependent, and data systems do not track needs, service use or outcomes in a way that enables planning or accountability.

Kosovo has a solid rights-based legal foundation and a growing political commitment signaling child and adolescent mental health as a national priority. This momentum is significant and must be seized. The core challenge is not the absence of activity, but the absence of a coherent, funded and coordinated system. Moving from the current crisis-driven, project-based landscape toward a functioning, tiered and child-centered system is both necessary and achievable. It requires sustained action across seven interconnected strategic priorities.

1. Establish national governance and coordination architecture.

Kosovo lacks designated coordination authority for child and adolescent mental health. A national CAMH coordination mechanism should be established with a clear institutional anchor and a mandate to align action across health, education, social services and justice. This mechanism should set the national agenda, harmonize referral and feedback protocols, prevent duplication between state and non-state providers, and convene a standing technical working group to update standards, tools and training over time. Without coordination architecture, all other reforms will remain fragmented.

2. Develop a dedicated national CAMH strategy and action plan.

While existing legislation provides a strong foundation, Kosovo has no dedicated national CAMH strategy or multi-year action plan. A dedicated strategy should be developed in alignment with the Early Childhood Intervention Strategy 2025–2030, the Law on Child Protection, the Law on Mental Health and the broader health and education sector strategies. It should define service standards and minimum packages, establish coordination responsibilities across sectors, set measurable targets for coverage, quality and equity, and include a costed implementation roadmap with clear accountability at national and municipal levels.

3. Implement the Priority Package of MHPSS Actions in a phased, scalable approach.

The tiered Priority Package of MHPSS actions detailed above should be implemented in a phased approach, beginning with pilot municipalities and scaling nationally. Implementation should be guided by shared referral and feedback protocols, enabled by digital tools, and supported by

structured supervision at every level, with clear roles for health, education, social protection, municipalities and civil society so that no single sector bears the burden alone.

4. Build a sustainable and supervised CAMH workforce.

Kosovo currently has no CAMH workforce plan, no staffing norms that link professionals to population size or case complexity, and no structured supervision or licensing system for school psychologists or social workers who provide psychosocial services. A national CAMH workforce strategy should define required professional profiles and minimum staffing standards, create pre-service and in-service training pathways, including training in trauma-informed care and evidence-based interventions, and institute regular clinical supervision across all sectors. Task-sharing models should define clearly what non-specialists, such as teachers, community workers, and NGO staff, can safely do, and when and how to escalate.

5. Establish a shared data and monitoring system.

No sector currently tracks child and adolescent mental health needs, service utilization, or outcomes in a systematic way. A small, agreed set of national MHPSS indicators should be defined and integrated into existing information systems, the health information system, EMIS, and social services case management, to enable routine monitoring of prevalence, access, referral completion, waiting times, and outcomes. A shared referral and feedback mechanism with unique identifiers should link sectors and enable continuity of care. A national representative survey on children and young people's mental health would establish the population-level baselines and targets that the system currently lacks. Without this data infrastructure, planning, accountability and quality improvement remain structurally impossible.

6. Secure dedicated, predictable and multi-year financing.

CAMH services in Kosovo are overwhelmingly dependent on short-term, donor-funded projects that end when funding cycles close, driving fragmentation and discontinuity. Sustainable progress requires dedicated budget lines for CAMH within health, education, and social services budgets at both the central and municipal levels, alongside stable mechanisms for purchasing services from NGOs and private providers through multi-year arrangements rather than ad hoc grants. Financing should be linked to the phased implementation plan, with ring-fenced allocations for workforce, supervision, infrastructure and digital enablement. Without predictable financing, the minimum package will remain a pilot rather than a system.

7. Institutionalize the meaningful participation of children, adolescents and families.

Children, adolescents, and caregivers must be recognized not only as service recipients but as active participants in the design, delivery, and monitoring of CAMH services. Participation mechanisms, including feedback channels, peer support models, advisory roles in school-level planning and involvement in national strategy development, should be embedded across all levels of the system. Sustained, institutionalized awareness and stigma-reduction efforts, including the use of digital tools to provide low-threshold entry points for young people, should be treated as a core system function rather than a communication add-on.

Taken together, these seven priorities represent a realistic and evidence-based pathway from the current fragmented landscape toward a unified national system, one that children and families can find, trust and use. Building on existing systems and mechanisms, the next phase of efforts should focus on strengthening institutional architecture, sustainable financing, and cross-sectoral collaboration to transform the current landscape into a coherent, integrated, and child-centered MHPSS system. Investing in child and adolescent mental health is not a discretionary programme, it is a foundational obligation to Kosovo's youngest and most vulnerable citizens.

Annexes

Annex 1: List of Institutions and Representatives Interviewed through Key Informant Interviews

The following table presents the institutions and individual representatives who participated in key informant interviews conducted as part of this mapping exercise.

Sector	Institution / Role	Name
Health sector		
Health	Family Medicine Centre (FMC), Prishtina (Deputy Director)	Mr. Rrezart Halili
Health	Mental Health Centre for Children and Adolescents (Director)	Dr. Adelina Ahmeti
Health	Mental Health Centre for Children and Adolescents	Ms. Vjollca Berisha
Health	Ministry of Health	Ms. Merita Vuthaj
Health	Child and adolescent psychiatrist, private sector	Prof. Fitim Uka
Health	Child and adolescent psychiatrist, private sector	Ms. Aferdita Goci
Health	Child and adolescent psychiatrist, private sector	Mr. Visar Sadiku
Health	Child and adolescent psychiatrist, public sector	Ms. Henrijeta Pula
Health	Psychiatrist / Mental health expert	Mr. Naim Fanaj
Education sector		
Education	Ministry of Education and Science	Ms. Merita Jonuzi
Education	Ministry of Education and Science	Ms. Leonora Shala
Education	Practicing school psychologist	Ms. Erona Mjekiqi
Education	Practicing school psychologist	Ms. Erblina Vrbroci
Education	Practicing school psychologist	Ms. Nora Shehu
Education	School director (school with psychologist) — SHFMU	Mr. Zekria Rexha
Education	School director (school with psychologist)	Mr. Pleurat Rudi
Education	School director (school without psychologist) — SHFMU “Bajram Curri”	Mr. Fidan Hasani
Social protection and justice sector		
Justice	Ministry of Justice, Department for Social and Family Services Policies	Ms. Adile Shaqiri
Justice	Ministry of Justice, Department for Social and Family Services Policies	Mr. Blerim Shabani

Sector	Institution / Role	Name
Social protection	Centre for Social Work (Director)	Mr. Bajram Shala
Social protection	Centre for Social Work (Psychologist)	Ms. Filloreta Bokshi
Civil society		
Civil society	Linja e Jetës (Life Line)	Ms. Yllza Nikqi
Civil society	Linja e Jetës (Life Line) / QIPS	Mr. Bind Skeja

Annex 2: Focus Group Discussions Conducted

The following table presents the focus group discussions conducted as part of this mapping exercise, including the participant group, facilitator and date of completion.

No.	Focus Group
Children and adolescents	
1	Children grades 6–9 (urban)
2	Children grades 6–9 (rural)
3	Children grades 10–12 (urban)
4	Children grades 10–12 (rural)
5	Children from Roma, Ashkali and Egyptian communities
6	Serbian youth
Parents and caregivers	
7	Parents (urban)
8	Parents (rural)
9	Serbian parents and NGOs
10	Roma, Ashkali and Egyptian parents and NGOs
Professionals	
11	MHPSS service providers
12	School psychologists

Note: All focus group discussions were completed. A total of 12 focus groups were conducted between July and October 2025, facilitated by researchers from the University of Prishtina.

Annex 3: Technical Committee Members

The Technical Committee for the MHPSS Mapping exercise was co-chaired by the Office of the Prime Minister/Office for Good Governance and UNICEF Kosovo. The Committee provided strategic guidance, reviewed and endorsed the methodology, and validated findings throughout the research process.

Name	Institution
Government institutions	
Mr. Habit Hajredini	Office for Good Governance/Office of Prime Minister
Ms. Djellza Mujaj	Office of the President
Ms. Kaltrina Ajeti	Office of the President
Ms. Armenda Berani	Office of Strategic Planning/ Office of Prime Minister
Ms. Laura Shehu	Ministry of Health
Ms. Leonora Shala	Ministry of Education and Science
Ms. Luljeta Ibishi	Ministry of Local Governance Administration
Ms. Qendresa Ibra Zariqi	Office of Good Governance, Office of Prime Minister
Ms. Naime Rexhepi	Kosovo Agency of Statistics
Public health and mental health institutions	
Dr. Adelina Ahmeti	Mental Health Centre for Children and Adolescents
Ms. Kaltrina Ajeti	National Institute of Public Health
Academia	
Ms. Diadora Cërmjani	Faculty of Education, University of Prishtina
Mr. Aliriza Arënliu	Faculty of Education, University of Prishtina
Ms. Kaltrina Kelmendi	Faculty of Education, University of Prishtina
Civil society and independent institutions	
Ms. Donjeta Kelmendi	Coalition of NGOs for Child Protection (KOMF)
Ms. Arbnore Shehu	Association of School Psychologists of Kosovo
Mr. Petrit Tahiri	Kosovo Education Centre (KEC) Peer-to-Peer Mediation Clubs
Mr. Bind Skeja	Centre of Information and Social Improvement (QIPS)
UNICEF Kosovo	
Mr. Benjamin Samuel Fisher	UNICEF Kosovo
Ms. Teuta Halimi	UNICEF Kosovo
Mr. Laurat Raca	UNICEF Kosovo
Ms. Hane Ilazi	UNICEF Kosovo
Ms. Arjeta Gjikolli	UNICEF Kosovo

Annex 4: Key risk and protective factors for child and adolescent mental health in Kosovo, by social-ecological level — based on the literature review

Ecological level	Type	Factor	Brief description	Key sources
Child / Individual	Risk	Intergenerational trauma	Children of parents with PTSD have a higher risk of anxiety, depression and PTSD.	Schick et al., 2023; Duraku et al., 2023
Child / Individual	Risk	Biological transmission	Elevated cortisol and DNA methylation changes among children whose mothers experienced war-related trauma in pregnancy.	Muench et al., 2022
Child / Individual	Risk	Internalizing problems	Around 25–40% of adolescents show clinical levels of emotional and behavioural problems; girls are more affected.	Shahini et al., 2015
Child / Individual	Risk	Early / advanced puberty	Advanced pubertal development is linked to higher anxiety, depression and somatic complaints.	Krasniqi, Vazsonyi, & Cakirpaloglu, 2024
Child / Individual	Risk	Psychological/behavioural correlates	Poor sleep, bedtime fears, excessive electronic use and low self-esteem associated with greater psychological distress.	Hyseni Duraku et al., 2018; Fanaj & Melonashi, 2014; Fanaj & Shkëmbi, 2024

Child / Individual	Risk	Substance use – trends	Stable daily smoking and alcohol use, but increasing non-medical use of tranquilizers among 15-year-olds. ESPAD data for Kosovo (2019, 2024) among 15-16 year-old students show: Lifetime alcohol use 29% in 2024 (lowest in Europe; boys 37%, girls 23%); current alcohol use 14%; early smoking initiation before age 13 at 23% (among highest in Europe); lifetime cannabis use among lowest (1.4% current use in 2019); lifetime inhalants 1.3% (lowest); harmful gambling 22% (highest in all ESPAD countries); prevention programme participation among lowest (31% any event, 18% alcohol events, 9.4% gambling/gaming events). [Sources: ESPAD Group (2020). ESPAD Report 2019; ESPAD Group (2025). ESPAD Report 2024.]	Arënliu et al., 2025
Child / Individual	Risk	Substance use – high-risk patterns	Higher daily smoking, harmful alcohol use and illegal drug use, especially among boys; linked to poorer academic outcomes.	Tahiraj et al., 2016
Child / Individual	Risk	Social media and online risks	Cyberbullying, online harassment, harmful content exposure and unsafe offline meetings following online contact.	Saliu et al., 2021; Arënliu et al., 2020; Tovërlani & Muhaxheri, 2024
Family / Caregiver	Risk	Parental PTSD	Parental PTSD associated with higher emotional and behavioural problems in children.	Schick et al., 2023
Family / Caregiver	Risk	Adverse family environment	Low family satisfaction and difficult family environments linked to higher adolescent distress.	Shahini et al., 2015

Family / Caregiver	Risk	Maternal unemployment	Maternal unemployment associated with increased psychological distress among adolescents.	Shahini et al., 2015
Family / Caregiver	Risk	Poverty and social assistance	Youth in households on social assistance show particularly high levels of severe psychological distress.	Arënliu et al., 2024
Family / Caregiver	Risk	Parental migration (strain)	Limited contact and irregular remittances linked to school difficulties and higher distress among children of migrant parents.	Arënliu et al., 2018; Arënliu et al., 2023
Family / Caregiver	Risk	Postpartum depression	Nearly half of new mothers experience postpartum depression, with potential negative impact on early child development.	Jemini Gashi et al., 2025
Family / Caregiver	Risk	Violent disciplining and poly-victimization	Around 72% of children are exposed to violent discipline at home; many experience multiple forms of violence.	UNICEF–MICS, 2020; Kelmendi et al., 2019
Family / Caregiver	Protective	Family support and communication	Higher family satisfaction, cohesion and open communication associated with lower psychological distress among adolescents.	Arënliu et al., 2025
School	Risk	Peer victimization	About 77% of students report victimization (mainly verbal and physical); this strongly predicts psychological distress.	Kelmendi et al., 2023; Arënliu et al., 2025
School	Risk	Staff victimization	More than one quarter of students report emotional or physical victimization by school staff.	Arënliu, Benbenishty, Astor, et al., 2022

School	Protective	Positive school climate	Teacher support, clear anti-violence rules and student participation protect against victimization and distress.	Kelmendi et al., 2023
Community	Risk	Repatriated children	Repatriated children face social isolation, discrimination and poor living conditions, increasing mental health risks.	Kienzler et al., 2018
Community	Risk	Sexual and gender minority status	Sexual and gender minority youth report elevated depression, anxiety and stress due to stigma and discrimination.	Llullaku, Selimi, Roest, & Van Der Helm, 2023
Community	Risk	Marginalization and child marriage	Child marriage remains highly prevalent among Roma, Ashkali and Egyptian girls despite overall declines.	UNICEF, 2023; MICS, 2020; CRPM, 2024
Community	Risk	Negative perception of education	In marginalized communities, schooling is often perceived as hindering rather than supporting children's development.	Terre des Hommes, 2022
Community	Risk	Limited information and stigma	Many children do not know where to seek help for depression or after distressing events; stigma around mental health and help-seeking is high.	Save the Children, 2024; Hyseni-Duraku et al., 2025; Shkëmbi et al., 2025
Community	Risk	Traditional gender norms	Strong traditional gender norms and roles restrict opportunities and contribute to gendered exposure to risk.	UNDP, 2022; UNWomen, 2023

Enabling environment	Risk	Suicidal trends	Suicidal ideation increased from 8% (2011) to 20% (2024); suicide attempts have more than doubled in the same period.	Arënliu et al., 2014; ESPAD, 2019; Haskuka et al., 2024
Enabling environment	Risk	Risk behaviours	High prevalence of smoking (71%), alcohol use (20%), gambling (12%) and weapon carrying (15%) among youth.	UNDP, 2021
Enabling environment	Risk	Low mental health investment	Mental health receives less than 1.5% of the health budget (vs. 3.6% in WHO European Region), contributing to service gaps.	Arënliu et al., 2024; WHO, 2023
Enabling environment	Protective	Positive national identity	Strong collective national identity associated with higher well-being and life satisfaction among youth.	Dimitrova et al., 2017

Annex 5: Intersectoral Findings

Sector / Group	**Coordination & referral**	**Access & equity**	**Prevention vs crisis / early ID**	**Workforce & supervision**	**Stigma & help-seeking**	**Data & governance**	**Front door / role perception**
Health	Informal, relationship-based; no standard protocols	Centralized in Prishtina/QKUK; rural & minority gaps	Mostly crisis-oriented; early identification in primary care weak	Severe shortage (child psychiatrists, psychologists, speech therapists); no supervision	Families delay care; alternative healers; myths (e.g. vaccines & autism)	No disaggregated CAMH indicators; weak primary-care reporting	Family medicine & CAP expected, but pathway unclear to families

Education	Ad hoc with CSW/health; schools often manage alone	Unequal psychologist coverage; shared/no posts in many areas	Prevention where psychologists exist; otherwise reactive to incidents	Uneven distribution of psychologists; no structured supervision/CPD; heavy caseloads	Openness improving; in some schools psychologist = punishment	SMIA lacks MH indicators; limited use of data for planning	De facto first contact point for many child problems
Child protection / CSW	Weak feedback with CAP, schools, NGOs; SOPs unevenly applied	One CSW per municipality; minimal specialists; urban–rural gaps	Predominantly reactive; short-term containment, not prevention	Social workers overloaded; few psychologists; low professional status	Families fear being recorded; prefer neurologists to psychiatry	Manual data; psychosocial cases not clearly tracked	Legal intake for protection, but limited therapeutic capacity
Civil society / private	Informal referrals; rare feedback; sectors as "separate islands"	Extend beyond Prishtina but constrained by fees & project scope	Run groups, awareness, school workshops; coverage patchy	High caseloads; variable training; limited supervision	More youth-friendly; work to normalize help-seeking	Own records; not linked to national systems	Accessible for some youth; not universal entry point
Families & caregivers	Experience pathways as confusing; referral roles unclear	Cost, transport, information gaps; care seen as "luxury"	Help sought mainly at crisis point; little proactive support	Perceive turnover and inconsistent providers; trust easily eroded	Shame/*mare*; fear gossip and labelling; reliance on religious help	Perceive lack of transparency & follow-up	Want simple, local entry points (school, QKMF-based psychologists)
Children & adolescents	Experience services as fragmented; "don't know where to go"	Centralized specialist care; dependence on parents/transport	Some mediation classes/NGO groups; otherwise late identification	Value good psychologists; complain when absent or unavailable	"Going to psychologist = mad"; prefer peers & internet	System not visible to them as such	Use peers, internet, some NGOs more than formal services

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