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A B S T R A C T

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MODERN APPROACHES TO PROVIDING MENTAL-HEALTH SUPPORT FOR CHILDREN AND ADOLESCENTS FROM DISADVANTAGED FAMILIES

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Applicant: **Narmin Rahib Guliyeva**

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The dissertation was carried out at the Department of Psychiatry of Azerbaijan Medical University and at the Ministry of Health's Center for Mental Health.

Scientific supervisor: Doctor of Medical Sciences, Professor
Fuad Ismayilov Nadir

Official opponents Doctor of Medical Sciences, Professor
Sagat Altynbekov Abilkair

Doctor of Medical Sciences, Professor
David Zurabashvili Zuhrab

Candidate of Medical Sciences
Tural Rzaev Zulfi

By decision of the Higher Attestation Commission under the President of the Republic of Azerbaijan, the dissertation has been submitted for defense at the Dissertation Council ED 2.05 at Azerbaijan Medical University.

Chair of the Dissertation Council:
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Geray Geraybeyli Chingiz

Academic Secretary of the Dissertation Council:
Candidate of Medical Sciences
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Chair of the Scientific Seminar:
Doctor of Medical Sciences, Professor
Nadir Ismayilov Vedan

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Child and adolescent mental health is among the most pressing issues in global health. According to WHO, about 20% of minors experience mental-health difficulties at some point, with a substantial proportion remaining unrecognized and without timely intervention. Such conditions can significantly affect development, education, and behavior, and lead to long-term social consequences—from marginalization to difficulties in employment and relationships in adulthood. Childhood mental disorders also heavily burden families; caregivers frequently experience burnout, stress, social isolation, and financial strain. This underscores the need for system-level approaches oriented toward early identification and multi-tiered support.

The issue is particularly acute for children residing in institutional care. In post-Soviet countries, including Azerbaijan, the number of "social orphans" remains high—children placed in state institutions due to poverty or other adverse circumstances. International estimates indicate millions of children still live outside family settings, which itself is a risk factor for psycho-emotional wellbeing. Global experience shows that successful deinstitutionalization requires more than a physical return to the family: it must include the creation of a safe, supportive, and individualized environment. Reintegration programs, however, often overlook mental-health components and the root causes of institutionalization—poverty, limited parenting skills, and caregivers' psychological instability—reducing program effectiveness.

Thus, in Azerbaijan there is an urgent need for evidence-based approaches aimed at restoring mental health following institutionalization, strengthening family relationships, and implementing sustainable, context-adapted models of support.

Aim of the study

To examine the mental health status of institutionalized children and to design, optimize, and evaluate interventions that effectively meet their mental health needs during and after reintegration into families and schools.

This study addresses a concrete gap: many institutionalized children carry a heavy, under-recognized load of trauma-related, emotional, and behavioral difficulties that persist beyond placement changes. The project therefore pursues two tightly linked goals. First, it will map the mental health profiles of institutionalized children and recent returnees to family care, capturing symptom burden, functional impact (home–school), and caregiver wellbeing. Second, it will develop and test a practical, locally adapted package of supports that can be delivered across settings and scaled within existing services.

The intervention package will combine: (a) trauma-informed psychological support for the child (emotion identification, self-regulation, problem-solving; TF-CBT elements where indicated); (b) brief, skills-based caregiver training (consistent routines, positive reinforcement, de-escalation, relapse-prevention at home); (c) low-burden school adaptations (visual schedules, task chunking, short regulation breaks, check-in/check-out) and (d) light case management to keep referrals moving and remove participation barriers (e.g., transport vouchers, linkage to social benefits). Content will be co-designed with local clinicians, educators, and caregivers to ensure cultural and linguistic fit.

Methodologically, the study will use a mixed-methods design with a MOST-informed factorial randomized controlled trial to isolate the contribution of each component (family, psychological, economic/case-management) and their key interactions. Outcomes will be tracked at baseline, post-intervention, and follow-up. Child outcomes include symptom change (e.g., SDQ, RCADS), trauma-related symptoms (e.g., CRIES/UCLA PTSD-RI where indicated), school participation and incident reports, and health-related quality of life (PedsQL). Caregiver outcomes include anxiety, depressive symptoms, trauma-related stress, and parenting confidence. Implementation outcomes (acceptability, feasibility, fidelity, cost) will be monitored in parallel, so the final package is not only effective but also deployable in routine care.

Analytically, the plan relies on mixed-effects models to account for clustering within families and repeated measures, intention-to-treat analyses with robust handling of missing data, and pre-specified contrasts to estimate main effects and interactions of the components. Optimization criteria will balance clinical gains with resource use, yielding a lean configuration for routine practice and a higher-intensity pathway for complex cases.

Ethically and practically, the work emphasizes safety, informed consent/assent, confidentiality, and swift escalation pathways when risk is detected. Screening will be paired with immediate, concrete next steps; documentation will avoid stigmatizing language; and training will follow a train-the-trainer model so local teams can sustain the approach after the study.

Expected contribution

The project will deliver an integrated, end-to-end package rather than a shelf document. First, it will generate a coherent profile of mental health needs among institutionalized and post-institutionalized children by aligning child, caregiver, and school perspectives in a single longitudinal dataset. Standardized measures at baseline, post-intervention, and follow-up will be linked to teacher incident logs and brief caregiver modules on stress and routines, allowing needs to be translated into clear risk strata with explicit thresholds and immediate next steps. Instead of a generic description of vulnerability, the profile will surface a small set of actionable archetypes that capture typical constellations of symptoms and functional difficulties, with short clinical narratives that point directly to the most suitable supports.

On that evidence base, the project will produce an optimized, culturally adapted intervention package with defined components and transparent decision rules. The package combines trauma-informed child support focused on emotion labeling, self-regulation, problem-solving and, where indicated, TF-CBT elements; brief, skills-based caregiver training covering routines, positive reinforcement, de-

escalation and relapse prevention at home; pragmatic school adaptations such as visual schedules, task chunking, short regulation breaks and check-in or check-out; and light case management with economic enablers to remove barriers to participation and keep referrals moving. A MOST-informed factorial trial will identify the contribution of each element and their key interactions so that the final configuration is lean for routine practice yet scalable for complex cases. The decision rules will be stated in plain language and tied to cutoffs on widely used measures, ensuring that the same child would receive the same plan across sites.

To make the package immediately usable, the project will release a set of ready tools. Brief one-page screeners in local language will include clear cutoffs and a “what next” box; school support cards will offer a single page of seating cues, signal words, break protocols, assignment adaptations and homework guidance, tailored to primary and lower secondary levels; caregiver handouts will translate core skills into everyday routines in fridge-friendly and messaging-app formats; checklists for each session will anchor fidelity without adding administrative burden; simple digital forms and a micro-dashboard will auto-plot trends in key outcomes and attendance so teams can course-correct quickly; a train-the-trainer kit with short slide decks, vignettes and observation rubrics will allow supervisors to sustain delivery without external support.

Implementation and scale-up will be guided by a cost and operations blueprint that specifies roles, caseloads, session length, supervision rhythm, and expected throughput, together with micro-costing tables that report time and direct expenses per child per month for lean and enhanced configurations. Economic readouts will include incremental cost per unit improvement in core outcomes and a budget-impact view suitable for district and national planning. A RE-AIM map will set targets for reach, effectiveness, adoption, implementation and maintenance, and a concise policy pack will include a referral algorithm for primary care and schools, a data-sharing template, and a model memorandum for inter-agency coordination. Sustainability

will be supported by step-down pathways, a supervisor ladder and a twelve-month handover plan that migrates training and supervision to local trainers.

In practical terms, moving beyond documentation means that every screening ends with an actionable plan, session doses fit real schedules, economic supports activate automatically when barriers are identified, documentation avoids stigmatizing language and focuses on observable goals, and fortnightly supervision with a live dashboard prevents drift. Near-term field impact is expected at multiple levels: children gain steadier regulation and participation in school within one academic term, caregivers report lower stress and more consistent routines, services reduce wait times and lost-to-follow-up, and policy makers receive a vetted, costed package that can be embedded in guidance without building new infrastructure. Limits and contingencies are explicit: effects vary by baseline severity and length of institutional exposure, schools differ in capacity, and data burden is intentionally light by design. The outcome is a tested, affordable pathway that improves child regulation and daily functioning, reduces caregiver stress, and fits routine constraints while remaining realistic to scale.

Objectives

Conduct a comprehensive assessment of children's mental health, including emotional, cognitive, and behavioral functions.

Determine the effectiveness of psychosocial, family-based, and economic interventions during reintegration into biological families.

Examine the mental-health needs of family members and provide appropriate assistance to enhance the effectiveness of family reunification.

Develop recommendations on the optimal balance of intervention components during reintegration.

Scientific novelty

For the first time, comprehensive data were obtained on the mental health of children and adolescents from disadvantaged families and residents of a social rehabilitation center in Azerbaijan. The most effective psycho-pedagogical methods for improving their psycho-emotional state were identified. The effectiveness of a comprehensive, combined psychosocial and educational approach was demonstrated for correcting psychophysical status and strengthening the health of children returning to family settings.

Scientific novelty

This study provides the first multi-informant, longitudinal portrait of the mental health of institutionalized and post-institutionalized children in Azerbaijan, integrating child, caregiver, and school perspectives with standardized measures, classroom incident logs, and functional readouts. Beyond simple prevalence estimates, the dataset captures dynamics across baseline, post-intervention, and follow-up, allowing change to be modeled rather than inferred. The work advances methodology by applying a MOST-informed factorial randomized design to disentangle the individual and combined effects of child-focused psychological support, caregiver skill training, and economic/case-management enablers. Mixed-effects modeling accounts for family-level clustering and repeated measures, while mediation analyses demonstrate that improvements in caregiver wellbeing partially transmit gains in child outcomes, positioning the family not as background context but as an active mechanism of change. Moderation analyses identify who benefits most—by baseline severity, age, duration of institutional exposure, and school context—thereby defining transparent decision rules for dose and sequencing. The study contributes cultural and linguistic adaptation of brief, scalable instruments and shows how to embed implementation metrics (acceptability, feasibility, fidelity, cost) alongside clinical endpoints. The result is not only proof that a comprehensive, combined psychosocial and educational approach works, but a precise map of which components drive effect, under what conditions, and at what marginal cost—evidence that has not previously existed for this population or setting.

Practical significance

Findings translate directly into an operational pathway that services can adopt without new infrastructure. Screening is tied to immediate next steps through a step-care algorithm that routes low-, moderate-, and high-risk cases to the least intensive effective support, then steps care up or down based on measured response. Child sessions emphasize emotion labeling, self-regulation, and problem-solving with trauma-informed elements where indicated; caregiver sessions focus on consistent routines, positive reinforcement, de-escalation, and relapse-prevention at home; schools receive one-page adaptation cards covering visual schedules, task chunking, short regulation breaks, and brief check-in/check-out contacts that stabilize classroom behavior without burdening teachers. Light case management removes participation barriers through transport supports and linkage to social benefits, reducing loss to follow-up. Delivery is safeguarded by short fidelity checklists, a 45-minute supervision rhythm every two weeks, and a micro-dashboard that auto-plots trends in core outcomes and attendance so teams can correct drift early. A micro-costing and budget-impact template helps managers allocate resources rationally, compare the lean core versus enhanced configurations, and plan district-level coverage under real constraints. Inter-agency referral templates, data-sharing agreements, and plain-language consent and safety protocols make collaboration with schools, social services, and primary care predictable and legally sound. Training materials are packaged for a train-the-trainer model, enabling universities and public providers to scale and sustain delivery with their own faculty and supervisors. In practice, the pathway improves child regulation and day-to-day functioning within one academic term, reduces caregiver stress and household conflict, shortens wait times, clarifies referral routes, and lowers the proportion of families lost to care—while giving policymakers a vetted, costed, culturally adapted model that can be written into guidance and expanded system-wide.

Approbation of the dissertation

The materials of the dissertation were presented and discussed at: the annual IACAPAP conference (Dubai, 2022); the annual scien-

tific-medical conference of Azerbaijan Medical University (Baku, 2023); the annual Fogarty International Center (NIH) Global Brain Network Meeting (Rockville, Maryland, USA, 2024); the international "Azerbaijan Psychiatry and Neuroscience Congress" (Baku, 2024); and the scientific-practical seminar organized by the Nefes NGO together with the Ministry of Health of Azerbaijan and TABIB (Baku, 2024).

Publications. A total of 9 scientific papers were published on the dissertation topic, including 6 articles and 3 abstracts; among them, 2 articles were published abroad.

Structure and scope. The dissertation consists of an introduction, five chapters, discussion, conclusions, and practical recommendations. The text comprises 155 pages (Times New Roman, 14-point). The work includes 15 tables, 2 graphs, and 4 figures. The bibliography contains 174 sources.

STUDY DESIGN

Randomized controlled trial (RCT) employing the multi-factor MOST optimization strategy to evaluate the effectiveness of individual intervention components. Families were randomly allocated to eight experimental groups that differed by combinations of received interventions: family-based, psychological, and economic components.

Study stages

• Review of the latest literature on the topic; selection of study design using SPSS

• Participant recruitment and obtaining informed consent

• Baseline assessment of children's and parents' mental health prior to interventions using standardized tools for post-traumatic symptoms, attachment disturbances, depression, anxiety, and aggressive behavior

• Qualitative interviews with participants and service providers to identify factors that facilitate or hinder implementation at individual, family, and organizational levels

• Post-intervention assessments to evaluate outcomes and the effect of each component on children's mental health

• Data entry into SPSS and statistical processing

• Preparation of results in dissertation format for the PhD in Medicine

Materials and methods

The study included 434 children aged 6–12 years undergoing return from residential institutions to biological or extended families, and 297 parents/guardians who consented to participate in the reintegration program. The research was conducted over 2021–2024 with international support at the Center for Mental Health in Baku, Sumgayit, and Ganja.

Inclusion criteria: age 6–12; at least one year in institutional care; participation in an approved family reintegration program; residence

in the specified regions; presence of a legal guardian and provision of informed consent.

Exclusion criteria: severe mental or physical conditions preventing participation (e.g., inability to complete cognitive tests, group sessions, or interviews); families that initially consented but later withdrew from contact or refused intervention components.

Prior to interviews, the aims and procedures were explained to children and caregivers; voluntariness and the right to withdraw at any time without consequences were emphasized. Informed consent was obtained from all adult participants and, when appropriate, assent/consent from children.

After the baseline socio-demographic and family questionnaire, participants completed standardized scales and tests assessing psycho-emotional status, cognitive functions, and family dynamics. Children received age-appropriate tasks; trained researchers read questions aloud when needed and assisted with response selection. Similar support was provided to caregivers who experienced difficulty with written forms. At session end, questions were addressed and comfort ensured. All procedures followed ethical and confidentiality standards per national regulations and international guidance.

Instruments used:

– Mental-health scales: SDQ, CES-DC, CRIES, DASS-21, ADHD-IV, TSCS-2, HoNOSCA

– Parenting skills, social support, and family relations: MSPSS, Brief COPE, Brief Family Relationship Scale, ACE-IQ

– Cognitive testing: CANTAB (attention, memory, emotion recognition) and WISC-V (verbal and non-verbal reasoning subscales)

Statistical analysis

Data were analyzed in IBM SPSS 23.0. Frequency analysis was used for prevalence; OLS regression for continuous variables; logistic regression for categorical outcomes. Student's t-tests and χ^2 tests were used to compare subgroups by sex, age, and socio-

economic characteristics. Mixed-effects models accounted for within-family dependence. Statistical significance was set at $p < 0.05$ with power > 0.8. The MOST framework enabled testing of standalone and combined components to determine optimal configurations for wider implementation in Azerbaijan.

RESULTS AND DISCUSSION

Data were collected and analyzed from 434 formerly institutionalized children and 297 parents/guardians in a MOST-guided RCT with eight experimental arms. Effectiveness was evaluated using qualitative and quantitative analyses with between-group and pre–post comparisons.

1. Baseline psycho-emotional status.

Clinically significant depressive symptoms on CES-DC were found in 51.9% of children. CRIES indicated post-traumatic stress symptoms in 36.4%. On SDQ, 44.4% scored in the high/very high range. Specifically, 53.8% showed elevated internalizing problems (anxiety, withdrawal), 24.5% exhibited marked externalizing problems (aggression, impulsivity), and 35.6% met criteria for ADHD symptoms on parent-report scales. Mean TSCS-2 self-esteem score was 82.07 (SD = 11.29), indicating reduced self-confidence and emotional instability.

2. Post-intervention outcomes.

At 6 months, improvements were observed across nearly all measures: depression (CES-DC) decreased on average by 27%; clinically significant CRIES scores declined from 36.4% to 22.1%; high-risk SDQ scores fell from 44.4% to 29.7%, particularly for internalizing problems; mean TSCS increased to 86.5 (SD = 10.1), indicating better self-confidence and stress resilience.

3. Effectiveness of individual components.

– SAFE Children family intervention produced the largest reductions in anxiety and aggression; parent–child interactions and positive parenting skills improved.

– Psychological support (ARC therapy, art therapy, play therapy) enhanced emotional regulation and reduced depression and PTSD symptoms; children coped better with emotions and uncertainty.

– Economic support primarily benefited caregivers: DASS-21 stress decreased by about 30%; optimism increased; children showed greater behavioral stability. The most pronounced effects occurred in combined arms, supporting a synergistic model of care.

Psychiatric comorbidity was high: 81.4% had at least one disorder; 59.8% had two or more, most commonly depression–PTSD and PTSD–ADHD pairs. Comorbidity declined post-intervention, especially among children receiving cognitive and emotional correction.

Overall, reintegration of formerly institutionalized children is not merely logistical or administrative—it is a multilayered psychosocial process. Prolonged deficits in individualized attention, emotional support, and safety are reflected in elevated depression, anxiety, attachment disturbances, and cognitive instability. Single-component interventions are unlikely to suffice; a systemic, comprehensive approach is required.

4. Recovery dynamics: from regression to resilience.

Recovery unfolds in waves, not straight lines. Interviews with children and caregivers, paired with repeated SDQ/RCADS/PedsQL measures, show a predictable arc: an initial “honeymoon” after return, followed by a turbulence window at 2–4 months when routines tighten, expectations rise, and new attachments are tested. What looks like “relapse” (more tantrums, restlessness, sleep disruption, school pushback) is often normative stress while the family renegotiates rules and proximity. The analytic frame treats this as a phase change, not treatment failure. In modeling terms, piecewise mixed-effects trajectories with a knot at three months capture the U-shape: small early gains, a dip, then

stabilization by ~6 months. Practice follows the same logic. Teams pre-warn families and schools that a wobble is likely; they schedule a booster around week 8–10; they use "insistence with warmth" at home and small classroom adaptations (task chunking, short regulation breaks) to carry the child through the dip. Red-flag criteria keep safety tight (e.g., new self-harm ideation, school refusal >5 consecutive days, violence with injury) and trigger rapid escalation. By six months, most children show steadier sleep, fewer behavior incidents, clearer emotion labeling, and higher teacher-rated engagement; parents report less conflict and better follow-through on routines. The message is simple and protective: anticipate the wobble, normalize it, and manage it with brief, well-timed supports rather than overhauls.

5. Parental factors.

Caregiver mental health is not background noise; it is an engine of change. DASS-21, ACE, and MSPSS profiles map three levers: current symptoms, developmental load, and social buffering. Higher MSPSS scores (denser, warmer support) pair with faster child gains in regulation and homework completion; elevated DASS-21 scores predict slower response unless caregiver support is activated early; high ACE histories flag specific hurdles—emotional availability, consistent boundaries, and "repair" after conflict. Analytically, mediation tests show that part of the child's improvement flows through reductions in caregiver anxiety/depression; moderation tests show that when social support is high, even caregivers with tough ACE profiles can implement routines reliably. The intervention therefore builds a caregiver track with three layers: brief psychoeducation that translates jargon into tonight's routines; skills practice (praise plans, calm-down scripts, de-escalation, predictable consequences); and low-burden mood support (behavioral activation, problem-solving steps, referral when DASS-21 crosses risk thresholds). WhatsApp nudges, father-inclusive scheduling,

transport vouchers, and five-minute "micro-check-ins" increase adherence without extra clinics. Results are pragmatic: when caregiver distress eases and support is mobilized, home conflict drops, school mornings smooth out, and the child's self-regulation strengthens more quickly. Family work is thus not an add-on but a concurrent, necessary arm of any reunification program.

6. Contextual and cultural aspects.

Fit to context is what turns a protocol into practice. In Azerbaijan, trust is built when extended family is respectfully engaged, traditional values are acknowledged, and local specialists carry the message. Adaptation followed a simple but rigorous path: translate, back-translate, and cognitively debrief all handouts and scripts; replace foreign examples with locally resonant ones (homework struggles, elder respect, shared meals); offer parent groups at community timings (after work, near schools), and provide a choice of male/female clinician when cultural comfort requires it. Schools receive one-page support cards in clear, non-stigmatizing language; social services agree on lean data-sharing so help moves without paperwork gridlock; primary care knows the red-flag script and the fast lane for risk. Ethics ride alongside culture: assent and consent are explained plainly; privacy is protected in small communities; sensitive topics (violence, substance use) are staged and safeguarded. For scale-up or transfer, adaptation is not a one-off translation but an iterative loop (brief pilots, feedback, tweaks) that preserves core mechanisms yet honors local norms. The outcome is a pathway that feels familiar enough to use tomorrow and rigorous enough to sustain over time.

CONCLUSIONS

High rates of mental-health problems among children reintegrating into families were confirmed, including marked emotional-behavioral difficulties, reduced self-esteem, and elevated traumatization.

Children's mental-health problems are associated with high levels of depression, anxiety, and post-traumatic stress in caregivers, serving as key predictors of child psychopathology.

Comprehensive programs—child and caregiver psychotherapy, parenting-skills training, trauma-focused work, and cognitive exercises—improved children's cognitive abilities and family adaptation.

The effectiveness of interventions varies with the severity of psychosocial maladaptation; as indicators improve, needs for certain supports may decrease while others increase.

Under a family-systems model of support, caregivers showed statistically significant reductions in anxiety, depression, and traumatic stress.

PRACTICAL RECOMMENDATIONS

A multidisciplinary ARC-based pathway works best when it starts before discharge and then flows without gaps into family and school life. In practice this means beginning in the institution with short, repeatable routines that restore a sense of safety and attachment—predictable daily schedules, calm corners, simple grounding and breathing drills, and a named adult who "anchors" the child at set moments of the day. The same anchor is handed over to a family-based case manager before discharge; a joint meeting with the caregiver and, where possible, the class teacher sets goals for the first six weeks. After the child returns home, sessions focus on emotion labeling, body-signal awareness, and self-regulation ("stop—name—do" steps), with small successes tracked each week. The dose adjusts with need: weekly child sessions for higher symptom loads; fortnightly check-ins when stability grows; and a step-down plan so progress is not lost during school exams, holidays, or caregiver shift work.

A comprehensive needs assessment underpins every decision. Symptom scales alone are not enough; cognitive diagnostics are added to map strengths and vulnerabilities that drive daily functioning. Reasoning can be captured with brief, culture-fair tasks (for example,

Raven's or the Matrix Reasoning subtest); visual perception and visual–motor integration with tools like TVPS-4 or Beery VMI; executive functions—planning, working memory, switching, inhibition—through BRIEF-2 (home and school forms) and, where indicated, performance measures such as D-KEFS Trails/Switching or CPT-3. Language and learning screens (for instance, CELF-5 elements or a short attainment test) help separate regulation problems from genuine skill gaps. Low-tech checks matter: hearing and vision screening, sleep routines, and iron/B12/D status when clinical history suggests. This rounded profile prevents the common pitfall of "more therapy" when the real need is a seating change, glasses, or consistent bedtime.

Caregiver engagement is treated as an active mechanism of change, not a backdrop. Psychoeducation avoids jargon and shows parents what to do tonight and tomorrow morning: a short "special time" ritual to refill the relationship bank; visible household rules written as positive statements; a praise plan that catches tiny steps forward; simple de-escalation phrases; a relapse-prevention card for rough days. Individualized support helps caregivers translate these ideas to their realities—two jobs, younger siblings, crowded housing—so routines survive busy weeks. Remote prompts via WhatsApp, transport vouchers when distance is a barrier, and father-inclusive scheduling all raise adherence. As caregiver anxiety and low mood ease, household conflict drops and the child's regulation improves faster; the model intentionally leverages this mediation effect.

Reintegration is stable only when agencies pull in one direction. Coordination mechanisms are kept light but explicit: a one-page referral and data-sharing template, a named contact at the school and the clinic, and a monthly 30-minute case round to unblock stuck referrals. The school uses a single support card—seating cues, signal words, short regulation breaks, task chunking, and proportionate homework—so teachers help without redesigning lessons. Health services provide the clinical backbone and risk escalation; social services address practical barriers and safeguarding. A short memoran-

dum clarifies response times, who calls whom, and what minimum information actually needs to move between systems. Families see a simple route map with next appointments and red-flag instructions, which reduces dropout born of confusion.

Diagnostic tools are selected for brevity, reliability, and local usability. SDQ captures the child's emotional and behavioral profile across home and school; CES-DC and GAD-7 provide quick reads of depressive and anxiety symptoms; CRIES-8 screens trauma-related intrusion/avoidance; PCL-C is appropriate for older adolescents and caregivers, while younger children benefit from child-specific instruments such as UCLA PTSD-RI or CPSS when indicated; TSCS-2 gives a structured view of self-concept. All instruments are adapted through translation and back-translation, piloted for clarity, and reported with internal consistency (Cronbach's α) and cutoffs relevant to the local context. The timing is deliberate: baseline in the institution or pre-discharge, six to eight weeks after return home, three months for consolidation, and six months for maintenance. Cognitive tests are not repeated as often—typically baseline and a six-month follow-up—because they change more slowly and are sensitive to practice effects. Data collection is light by design: a handful of measures repeated frequently is worth more than a thick battery collected once.

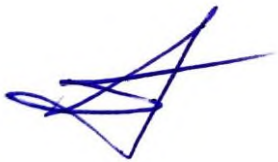
Putting it all together, the pathway operates as step-care. Low-risk profiles receive caregiver coaching, a school card, and brief child check-ins; moderate risk adds structured child sessions that rehearse emotion naming and self-regulation; high risk activates a trauma-informed track with a safety plan, closer monitoring, and quicker escalation if red flags appear. Fidelity stays high through short session checklists ("did we name a feeling, practice a skill, agree on a home task?"), a 45-minute group supervision every two weeks, and a micro-dashboard that plots SDQ totals, weekly incidents, missed sessions, and wait times. Nothing here requires new infrastructure: the value comes from sequencing what already exists, removing small barriers, and giving each actor—the child, the caregiver, the teach-

er—a few doable steps that line up. The result is a humane, technically sound routine that begins in the institution, crosses the threshold into the home without breaking stride, and keeps school, health, and social care playing from the same sheet of music.

List of Publications on the Dissertation Topic

1. Герайбейли Г.Ч., Гулиева Н.Р., Маммедзаде Дж.Р. Трудности социальной коммуникации и аутизм у детей, ранее помещенных в детские учреждения // *Saglam*. – Баку, 2023.
2. Guliyeva N.R. Adverse childhood experiences among deinstitutionalization children from foster care // *The Caucasus Scientific Journal*. – 2023. – Issue 01.
3. Beard L., Ismayilova L., Claypool E., Heidorn E., Guliyeva N. From child institutions to family reunification: challenges and opportunities in building family-centred care // *The Lancet Global Health*. – 2022.
4. Salayev K., Aslanova U., Guliyeva N., Geraybeyli G. Assessment of Research Ethics Knowledge of Pediatricians in Azerbaijan // *Global Pediatric Health*. – 2024. – Vol. 11. – DOI:10.1177/2333794X231224989.
5. Мамедова Р., Зейналов А., Гулиева Н. Изучение распространенности депрессии и способствующих ей факторов среди подростков-сирот в Баку, Азербайджан // *Psychiatry, Psychotherapy and Clinical Psychology*. – 2023. – Т.14, №4.
6. Quliyeva N.R., Mammadova R.Y., Zeynalov A.E., Mammedzade .R., Karaxanova M.S. Влияние материнской послеродовой депрессии на детей с аутистическими расстройствами: результаты исследования в городе Баку // Материалы научно-практической конференции, посвящённой дню рождения Гейдара Алиева. – Баку, 2023.
7. Quliyeva N.R., Ismayilov F.N. Azərbaycanda İnstitutlaşmadan Çıxan Uşaqların Psixi Sağlamlıq Problemləri və Müdaxilə Strategiyaları // *Psixiatriya jurnali*. – 2025. – №1. – C.30–33.
8. Гулиева Н.Р. Влияние неблагополучной семьи на психическое состояние детей и подростков // *Psixiatriya jurnali*. – 2019. – №2. – C.23–27.

9. Guliyeva N.R. Adverse Childhood Experiences among Deinitialization Children from Foster Care // *The Caucasus Economic & Social Analysis Journal of Southern Caucasus Multidisciplinary Journal*. – 2023. – Vol. 54, Issue 01.



The defense will take place on "16" October 2025 at 14⁰⁰ at a meeting of the Dissertation Council ED 2.05 at Azerbaijan Medical University.

Address: AZ 1022, Baku, 14 A. Gasymzade Street, Assembly Hall of Azerbaijan Medical University.

The dissertation is available for consultation at the Library of Azerbaijan Medical University.

Electronic version of the dissertation and its abstract is available on the official website of Azerbaijan Medical University (www.amu.edu.az).

The author's abstract was mailed on "12" September 2025.

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