

Challenges in Developing a Community-Based Program for Maltreated Children and Adolescents in Brazil

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This column describes the planning and development of The Equilibrium Program (TEP) for multiply traumatized and neglected children and adolescents with mental and general medical problems in São Paulo, Brazil. The program is a partnership between university faculty, various service providers, the courts, and the city government. In the first step, child psychiatry faculty from the University of São Paulo visited central-city areas and group shelters to talk to street youths to better understand their needs. A nearby community sports center building was chosen to be a center where youths could access services and engage in recreational activities and where the work of family integration could be facilitated. A multidisciplinary team conducts an in-depth assessment and creates an intervention plan, overseen by a case manager. Challenges to implementing such programs are discussed. (*Psychiatric Services* 65:138–140, 2014; doi: 10.1176/appi.ps.201300439)

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Child traumatization and maltreatment are global problems (1) that affect high-, low-, and middle-income countries (2) in Latin America and elsewhere and are widely recognized to be risk factors for subsequent social disadvantage and psychiatric disorders (3). Studies have specifically demonstrated a high prevalence of child maltreatment in Brazil (4,5), and there has been considerable interest in both identifying maltreated children and treating them with evidence-based practices (6–9).

Although many children are victims of multiple forms of maltreatment (10,11), especially street children in low- and middle-income countries, research and program development have focused on one or another single type of abuse, and there have been no detailed studies of programs working with children in low- and middle-income countries who have experienced multiple forms of trauma and maltreatment. In addition, few studies have demonstrated a capacity for monitoring the outcomes of such programs as they operate in real-world settings. All published outcome studies of child trauma treatment have been from U.S. researchers studying children exposed to sexual abuse (8,9).

The development of service models for multiply traumatized children in low- and middle-income countries such as Brazil should be based primarily on direct input from the potential users of those services—even when, as is often the case, service users are not

organized in formal advocacy groups (12). In addition, mental health services for multiply traumatized children and adolescents must be linked with general health care programs, schools, social services, child welfare programs, and the criminal justice system. However, in most locations, resources are limited, there is little interaction between the relevant agencies or providers, and service delivery is precarious because children frequently change their residences (13). The assertive community outreach approach, widely used in developed countries, is impractical in deeply impoverished urban neighborhoods (called *favelas* in Brazil and “shanty towns” elsewhere) in low- and middle-income countries because the safety of community workers cannot be guaranteed. To build a safe integrated program, active dialogue is needed with children, adolescents, and their families and with diverse health and social service agencies.

Developing a multidisciplinary treatment program in Brazil

In this column, we describe the planning and maturation of a program called The Equilibrium Program (TEP) for multiply traumatized and neglected children and adolescents with both mental and general medical problems in São Paulo, Brazil. In the first step of TEP development, which occurred in 2006, child psychiatry faculty from the University of São Paulo began to visit central-city areas to talk to street

children and adolescents to better understand their needs. Surprisingly, many youths recognized their need for pediatric care and help with substance abuse. Some eventually came to reside in a series of group shelters with limited supervision programs that housed about 20 children each in residences funded in part by nongovernmental organizations and in part by the city of São Paulo. In 2007, on the basis of the clinical needs as perceived by the children, health professionals, and other agencies, the basic structure of a program was outlined that would provide services in a safe and effective manner.

Consensus was reached in regard to the development of a protected place in the community, near but not in a *favela*—a place where children and adolescents could enjoy safe access to both clinical and social services and that would also be favorably located for recreation and facilitation of social and family reintegration. On the basis of this proposal, the São Paulo municipality offered the use of a community sports center located near many of the shelters and also close to downtown. The center was also open to the local community, which served to facilitate the social reintegration process among children and their families and could be made safe and secure. Three key features of TEP are offering intensive professional services that are accessibly located within the community in a context primarily associated with recreational activities, providing services in a safe environment away from adverse elements in the community, and ensuring that services are accessible to relevant service providers located elsewhere in the city.

Initial assessment and individualized intervention plan

Children and adolescents less than 19 years old are referred to TEP either by shelter staff or by the Children's Court of São Paulo. Court referrals are made either to protect youths from abusive situations or to curtail their criminal activities. Whenever possible, primary caregivers, whether shelter staff or family members, are actively involved in the initial evaluation. Sociodemographic characteristics, prior and present stressors, and family and clinical history are all formally evaluated.

During the initial four-week diagnostic phase, a detailed assessment is completed with structured psychometrically sound assessment tools, whenever possible, by a multidisciplinary team, including psychiatrists, pediatricians, psychologists, neuropsychologists, speech therapists, psychopedagogists, physiotherapists, occupational therapists, social workers, art therapists, nurses, and family psychologists. For example, psychiatric diagnoses are made by child and adolescent psychiatrists using the Schedule for Affective Disorders and Schizophrenia for School-Age Children (14).

After the initial assessment, an individualized intervention plan is developed to meet each child's needs, which may include psychiatric consultation, individual or group psychotherapy, occupational therapy, speech therapy, educational supports, physiotherapy, social work intervention, family therapy, physical activities, or art therapy. In addition to these therapeutic interventions, participants are encouraged to participate in ongoing social and recreational activities.

The lifetime prevalence of psychiatric disorders among the children and adolescents evaluated in TEP is approximately 86% (4,15). Even children who are not given a diagnosis of a mental disorder at their initial assessment are offered psychosocial therapeutic interventions because virtually all the children and adolescents have a history of serious maltreatment of multiple types, and many have had to be separated from their parents by the courts. These children may also be referred to group speech therapy to improve their communication skills, educational support to improve their learning abilities, occupational therapy to develop new prevocational skills, or group psychotherapy targeted at improving their self-esteem.

Case management and continuous program evaluation

To ensure continuity of care from the initial outreach contact in the group shelter to the point of full family and social reintegration—with involvement of the family or the criminal justice system personnel—a case manager is assigned to each client and is identified as the focal point of service coordination.

Because systematic assessment and evaluation have been part of the program from its inception, the case manager is also responsible for assessing each child's status every three months with the Children's Global Assessment Scale (C-GAS) (16) and for coordinating a multidisciplinary reevaluation of each child's needs and modification of the treatment plan as needed. The case manager works with all other providers and agencies to promote school, family, and social reintegration, and when appropriate, the case manager maintains active links with the Children's Court. Attention to the family's needs apart from those of the child or adolescent is also offered whenever possible. Developing the child's alliance with the case manager is a central strategy for preventing dropout. When a participant is absent, the case manager makes assertive efforts to renew contact and clinical engagement. The team thus works actively with other partner organizations and natural supports to provide continuous care.

Implementation challenges

Four main challenges were noted in the development and implementation of this community-based program. These challenges are likely to be relevant to similar efforts elsewhere in Latin America and in low- and middle-income countries more generally. The first was the articulation of a multidisciplinary service plan to be implemented in a safe community setting close to client residences and accessible by relevant service providers. The second challenge was the development of a partnership between university faculty, other service providers, and city government to address needs for both suitable space and funding for staff. Third, once the foundations were in place, it took almost two years (from 2006 to 2008) to work through the details necessary to implement the program in concert with other service providers, including not only diverse health providers but also social service, educational, justice, and child welfare agencies. It was also very important to promote activities to the surrounding community through health promotion meetings, special events, and even parties promoted by program users.

Finally, program evaluation and research have been a core activity of TEP from the outset both because it was founded by academics from the University of São Paulo for whom research is a priority and also, more importantly, to provide data to support sustained operation of the program. At the beginning of the program, a computerized data collection system was developed, and all staff are required to document client assessment data, basic information on service delivery, and quarterly outcome assessments with the C-GAS. A recent analysis of C-GAS data showed significant improvements at both three and six months after program entry (17). These evaluation data have been used to support the expansion of the program and the continued provision of health and social services, education, and criminal justice rehabilitation for these clients.

Conclusions

TEP was specifically developed to provide comprehensive services to traumatized and neglected children and adolescents from impoverished, and often isolated and violent, communities in São Paulo. The project has demonstrated the feasibility of developing and implementing such specially tailored service programs and of supporting their continuation with the collection of systematic program evaluation data.

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