Child psychiatry takes to the streets: A developmental partnership between a university institute and children and adolescents from the streets of Sao Paulo, Brazil

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Abstract

Objective: High levels of domestic violence, mental illness, and alienation from authorities are associated with high incidence of children/adolescents living on the streets in low and middle income countries. The Equilibrium Project (Programa Equilíbrio) was created to facilitate social reintegration through a virtual partnership between an academic psychiatric institute and highly vulnerable children and adolescents living on the streets, in group shelter with supervision, and in other high risk situations.

Methods: Descriptive presentation of qualitative data and analysis of preliminary empirical data collected over a 24-month period.

Results: Dialogue between academic professionals, street children, and city officials shaped The Equilibrium Project over the last 2 years. The program has progressively moved from a professional clinic setting to a community-based but protected activity center with recreational and professional services and an emphasis on linkage with social service agencies, city government and law enforcement officials in an academic research context. A total of 351 patients have been served of whom virtually all were neglected by their parents, 58.4% report physical or sexual abuse, 88.89% have been diagnosed with a psychiatric disorder, 40.4% drug use. After 2 years of operation, 63.5% (n = 223) successfully completed or continue in treatment and 34.8% (n = 122) were reunited with their families.

Conclusions and Practice implications: Program development guided by consumer input led to a successful program offering professional services in a protected community setting that facilitates social reintegration by providing “go between” services integrating relationships between alienated consumers and formal psychiatric, pediatric, social service, and criminal justice systems.

Introduction

Domestic violence, urban drug use, and homelessness among children and adolescents are global public health problems (Marwick, 1998; Ringwalt, Greene, Robertson, & McPheeters, 1998) whose seriousness has been highlighted by several stud-
ies conducted in developing countries in recent years (Koenig et al., 2003). In Brazil, violence against women (46%—lifetime prevalence) (da Silva, Falbo Neto, Figueiroa, & Cabral Filho, 2010) and the high prevalence of harsh physical punishment of children and adolescents (10.1%) are closely associated phenomena (Bordin, Paula, do Nascimento, & Duarte, 2006).

There is consistent evidence that multigenerational familial addiction and abuse are primary reasons for homelessness among children and adolescents (Martinez, 2006; Thrane, Hoyt, Whitbeck, & Yoder, 2006). Early exposure to domestic violence also increases the risk for internalizing and externalizing psychiatric problems (Moylan et al., 2010) and important impediments to the capacity for attachment and resultant vulnerability to repeated victimization (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008).

In a large US study, nearly half (47.9%) of the youths aged 2–14 years (N = 3,803) with completed child welfare investigations had clinically significant emotional or behavioral problems but only one quarter of such youths received any speciality mental health care during the previous year. Making services accessible and acceptable to clients is an imposing challenge (Bruns et al., 2004).

Academic understanding of the multiple factors that can affect the mental health status of children and adolescents is necessary but not sufficient for the development of novel treatment approaches needed to serve this population (Eisenberg & Belfer, 2009). In countries like Brazil in which models from more developed countries may not be compatible with high levels of urban crime, violence, and an organized drug trade, the development of effective services must also be guided by direct input from the potential users of those services even when, as is often the case, they are not organized in formal advocacy groups (Penna, Santos, & Souza, 2004).

The Brazilian Ministry of Health is committed to working on the implementation of a mental health policy for childhood and adolescence, based on the development of community-based services, such as the CAPS (Centers for Psychosocial Care) for children and adolescents (Caldas de Almeida & Horvitz-Lennon, 2010). But the establishment of integrated networks that include health, education, social service, child welfare, and criminal justice input can only take place with active dialogue and guidance from children, adolescents and families themselves.

While there have been some studies of services for children/adolescents living on the streets (Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006) the available services for children on the streets or in group shelter with supervision are frequently “inadequate, fragmented and poorly coordinated” (Pumariega & Winters, 2003). There is little interaction between social and health system, the social support is precarious and the health care follow-up is impeded by frequent changes in client residence and the impracticability of assertive community outreach because of lack of a guarantee of safety for community workers (Galehouse, Herrick, & Raphel, 2010). As a result, it is difficult to maintain a significant bond than can sustain the confidence and trust of children and adolescents in these situations. Long-term follow-up, lasting from the street to the point of family reintegration, is essential to countering further family disaffection (Pumariega & Winters, 2003), but can only be achieved through partnership between clients and professionals in program development so that the clients take a lead role in identifying methods of service delivery that are acceptable.

To the best of our knowledge, there has been no documented account of professionals from both the health area and other services, taking the lead from clients themselves to develop cooperative efforts for integrated community-oriented service delivery. The Equilibrium Project (TEP) was developed through partnerships with children and adolescents living on the streets and in group shelter with supervision residences, with the main goal of integrating the widely diverse services needed to meet the unique demands of this population in a safe accessible setting.

Much progress has been made in the recent years regarding the understanding of the mental disorders among children and adolescents in fields such as genetics or brain imaging. However this knowledge, however sophisticated, will not be useable unless basic alliances with consumers are developed in order to guarantee the access to networks of services, even when the consumers are not organized in coherent advocacy group (Eisenberg & Belfer, 2009; Patel, Flisher, Nikapota, & Malhotra, 2008).

The aim of this article is to describe the implementation of TEP through a community-academic partnership, to outline its current operation and some of the challenges and lessons learned during the first 2 years of program development.

Methods

Implementation of The Equilibrium Project

Through 2005, services were available for homeless children/adolescents, as for other children who needed psychiatric care, at the outpatient clinic of the Institute of Psychiatry of the University of Sao Paulo Faculty of Medicine (IPq-HC–FMUSP—tertiary referral center). However, the hospital clinic required scheduled appointments, offered primarily clinical services and was located several miles from the central city areas of Sao Paulo where homeless children and adolescents congregate. Not surprisingly, these clinics were not well suited to meet the needs of street children. Well aware of the inadequacy of this approach, psychiatric faculty (led by a professor in the Department of Psychiatry) began to visit central city areas to talk to street children and youth to better understand their needs and interests in obtaining what were then largely conceived as conventional psychiatric services. Surprisingly, many of these children recognized their need for pediatric care, help with substance abuse, and even psychiatric care. Many of these children eventually came to reside in group shelter with supervision programs, housing about 20 children each in residences supervised by a small number of staff and funded part by NGOs and in part by the city, but that were not formally linked to either health services nor to the school system, although
The elements of the program: an interdisciplinary model of intervention

Initial assessment. Children and adolescents are referred to TEP either by the group shelter staff or by the Children’s Court of Sao Paulo for which it offers a diversion alternative to jail. To avoid any experience of being “dumped” in an institution attendees are required to attend the first evaluation session with their current caregivers or families. A clinical evaluation is first conducted in order to identify organic problems that might hinder the further assessment process (for example, infectious diseases requiring isolation). Socio-demographic characteristics, prior and present stressors, family, and clinical history are assessed during the subsequent 4 week period—initially conceptualized as the “Diagnostic Phase.” Detailed assessments are completed by diverse professionals on an interdisciplinary team which includes psychiatrists, pediatricians, psychologists, neuropsychologists, speech therapists, psychopedagogists, physiotherapists, occupational therapists, social workers, art therapists, nurses, and family psychologists. As an academic center, informed written consent is obtained for all assessments so they can be used in research efforts to allow better understanding of the needs of the population and to document the effectiveness of the program for the municipal stakeholders who are responsible for its funding.

Psychiatric assessment is conducted through clinical interviews by certified child and adolescent psychiatrists. All diagnoses were reviewed and discussed with the psychiatrist coordinator of the program. The application of diagnostic assessment on this population was initially difficult since there are few formal psychiatric diagnostic instruments designed for the distinctive problems faced by these children and/or validated for use in a Portuguese speaking population.

Individualized intervention plan elaboration. After the initial assessment, an individualized intervention plan is established, according to the specific needs of each child or adolescent and their family. Among the prescribed activities are both clinical services such as psychiatric treatment, individual psychotherapy, group psychotherapy, art therapy, family psychotherapy, speech therapy, and recreational activities such as occupational therapy, theater, and sports activities, all integrated within a center which has more of the trappings of a sports club than a clinic.

Long-term supervised management of cases. As many of these children and adolescents have a history of family neglect and have frequently been shuttled between different foster centers, high levels of distrust and an elevated rate of treatment dropout were anticipated. To address this problem an assertive case management strategy was adopted in which a specific professional member of the team is chosen to be the point of reference for each child or adolescent. Case management of the type widely available in the US (Phillips et al., 2001) is often impossible in middle or low income countries like Brazil because of the lack of safety or even access to slums controlled by criminal elements.

Nevertheless the case manager’s primary responsibility, although based at the community center, is to form a therapeutic alliance with each child or adolescent and, where available, with their family, that can support sustained implementing of the formal treatment plan. Case managers organize and follow all the activities in which the child participates within the program, with outside agencies (e.g., attending hearings involving the Children’s Court and maintaining links with social service agencies, and establishing contact with medical specialists as needed). The case manager at TEP, while providing services similar to those of ACT providers in the US (Phillips et al., 2001), does so within the safe haven of the community center. At each step in the development of this model, the children and adolescents themselves guide
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Table 1
Socio-demographics characteristics, frequency of psychiatric disorders and early emotional stress situations of children/adolescents under social vulnerability attending to a multidisciplinary treatment program (n = 351).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-demographics</td>
<td></td>
</tr>
<tr>
<td>Gender (male, %)</td>
<td>68</td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>12.47 ± 3.47</td>
</tr>
<tr>
<td>Residence at the beginning of treatment</td>
<td></td>
</tr>
<tr>
<td>Group shelter with supervision</td>
<td>82%</td>
</tr>
<tr>
<td>Family</td>
<td>15.4%</td>
</tr>
<tr>
<td>Streets</td>
<td>2.3%</td>
</tr>
<tr>
<td>Delinquent institution</td>
<td>0.3%</td>
</tr>
<tr>
<td>Psychiatric disorders*</td>
<td></td>
</tr>
<tr>
<td>Any psychiatric disorder</td>
<td>88.8%</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>40.4%</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>35.3%</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>16.2%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>8.8%</td>
</tr>
<tr>
<td>Early emotional stress situations</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>100%</td>
</tr>
<tr>
<td>Physical or sexual abuse</td>
<td>58.4%</td>
</tr>
<tr>
<td>Institutional education*</td>
<td>44.3%</td>
</tr>
</tbody>
</table>

* Psychiatric disorders were assessed through clinical interview performed by child and adolescent psychiatrist, according to the criteria for Behavior and Mental Disorders in ICD-10.

b Institutional education refers to a situation where these children were separated from their parents in early childhood and they have been growing up in group shelters with supervision.

Focus on the communication skills. Since one of the main goals of the project is social reintegration beyond simple clinical treatment, new strategies have been needed to interact safely with the world outside the community center to allow clients to be exposed to positive roles in community (Pumariega & Winters, 2003). In TEP, strong emphasis is given to the development of basic communication skills, for example, the production of a monthly newspaper and a radio program. These formal communicational activities often provide a safe socialized opportunity to express and articulate their past traumatic experiences in a sheltered context within a world that has previously offered little experience of safety (Hyde, 2005).

Performance evaluation after the first 2 years. As an academically based clinic staffed by a university institute and funded with special municipal resources, formal evaluation has been a core activity of TEP from the outset. After 2 years, the first data from the Program were available allowing basic characterization of the problems and needs of the population served. Through the scientific evaluation of the program as a whole and of individual treatment modalities (such as speech therapy) staff aim to better serve individual clients as well as to provide data to support the expansion of the programs and the development of public policies, allowing the better use of public resources to improve the health, social situation, education and criminal justice rehabilitation of these clients.

Ethics. IRB approval for this study was obtained from the Hospital das Clinicas research ethics committee, from University of Sao Paulo Faculty of Medicine. All participants and their legal guardians signed an informed consent.

Preliminary results. From September 2007 to September 2009, a total of 351 children/adolescents were served. The socio-demographics characteristics of the sample, the frequency of early emotional stress situations, such as neglect or physical abuse, and the high prevalence of psychiatric disorders, according to the criteria for Behavior and Mental Disorders in ICD-10 (Silva, Cunha & Scivoletto, 2010) are presented in Table 1. These data shows that the treatment staff must have specific training in dealing with domestic and civil violence and its consequences.

After 2 years of operation, 63.5% (n = 223) of participants had successfully completed or were continuing in the program and 34.8% (n = 122) had been reunited with their families. Of those, 68.3% (n = 84) were stable, attending to school, without drug use or any behavior problems and had been living with their families for more than 6 months.

Among the participants who dropped out, 74.2% (n = 95) did not specify a reason to the staff and most had probably not articulated it to themselves either. However, it was possible to get information from 25.8% (n = 33) of the participants among whom 30.3% (n = 10) were referred to other treatment centers, 30.3% (n = 10) were reintegrated into their families and these moved elsewhere, 24.2% (n = 8) left because of distance, 6% (n = 2) were discharged because of breaking program rules, and 6% (n = 2) were placed into a Witness Protection Program. One 15 year-old drug dependent girl committed suicide after 9 months of follow-up.
Discussion

TEP was developed and implemented based mainly on the direct input and indirect cues from individual children themselves, since no advocacy organization represented them, but also on the basis of scientific data gained during assessments and follow-up. Our use of both sources of information reflect the frame work of community-based participatory research in which academic experts join in an alliance with community agencies to provide assistance with community programs (Minkler & Wallerstein, 2002). One of the unique feature of TEP is that in the absence of a community organization representing street children in Sao Paulo, guiding partnerships were established with individual clients. Some additional lessons learned are presented below.

During the “Diagnostic Phase,” it was noted that the intensity of many symptoms suggestive of psychiatric pathologies decreased after a period living in a context more favorable for psychiatric-emotional development. Many of these children do not present with endogenous psychopathology but rather have developed inappropriate behavior in response to the raw settings in which they were living in. Their “inappropriate behavior,” such as secretiveness, hostility, and mistrust, were usefully adaptive for survival while living on the streets (Scivoletto, Stivanin, Ribeiro, & Oliveira, 2009). Characteristics of the context in which they were living need to be considered in the initial assessment and diagnostic evaluation and conclusions about underlying psychopathology should only be arrived at after longer periods of adaptation in safer and more supportive environments. When TEP started, the “Diagnosis Phase” was limited to 4 weeks but now has no time limit since it depends on the extended observation of each child in an optimal adaptive context.

Another important lesson is that street children need a global assessment of their problems, and that paying attention to their more obvious substance use disorders can lead to underestimation of other mental health problems (Silva et al., 2010). A continuous effort is thus needed to improve psychiatric assessment, and distinct approaches, like dimensional and categorical measures, should be considered (Rutter, 2003).

In this population, broken families are common, so a “family” composition unit may vary to include not only parents, but godparents, and others beyond the nuclear family. Of our 351 cases, there were a total of 301 “families” in which siblings were actively engaged. By information obtained through family interviews or through the Family Court data, it became clear that in 62.1% (n = 187) of families, at least 1 of the parents had a psychiatric disorder—drug and/or alcohol problems were reported by parents in 56.1% (n = 169) of cases. The report of domestic violence in childhood was also frequent among parents: 36.5% (n = 110) had been physically abused, 11.96% (n = 36) had been sexually abused, and 24.25% (n = 73) had both types of violations. If no intervention is made to interrupt this cycle of “unfavorable environment with psychically unstructured violence,” it tends to repeat through the following generations, probably with higher intensity, and more serious consequences (Stover, 2005). There is no other way to promote family reintegration if the children/adolescents’ relatives do not receive adequate treatment. Hence a general psychiatrist for adults was included on the team to guarantee appropriate treatment of all relevant family members in need.

After some months of TEP’s operation, some of the children and adolescents became resistant to the idea of coming to the program because they did not consider themselves to be patients and had heard that the community center was a “health center.” It thus became crucial to identify which interventions were best accepted. The speech therapist interventions were among the most important to the children, many of whom were aware of their complicated communication and behavior problems including serious hearing impairments, possibly related to previously untreated ear infections. As children/adolescents came to feel that TEP was their space and that their individual needs were respected, they began to have increased respect for each other. Drug and violent behavior became recognized within the community of youth as destructive tools and not a way to achieve success. Children/adolescents were increasingly engaged in group activities, like the radio program and the newspaper, both conducted with the supervision and support of TEP professionals in a normalizing social environment. In the case of the newspaper, the authors sign each article which offers a completely new identity for these long deprived children whose primary identify was as being unwanted. One child reported that prior to attending TEP he was unaware that familial love even existed.

One of the main practical challenges was obtaining access to the community center by families and children living far away. Since mobile case management of the type developed in the US is not feasible in Sao Paulo, TEP’s staff was able to manage this problem by offering transport-vouchers funded by the municipal government. Some group shelters also had difficulty bringing children/adolescents to the program. Again, the support from the local government was crucial as a van was supplied to facilitate transportation from distant group shelters. This initiative had a direct impact in the reducing missed appointments. However, these efforts are not sufficient to guarantee universal treatment access on a local basis because Sao Paulo is a large city of 11 million people. It will thus be necessary to extend, and create other similar services in different locations across the city affiliated with other academic and community institutions.

Despite the community based orientation of TEP, the integration with more complex centers of health care and social services is essential to guarantee effective and emergency intervention for severe conditions, whether medical, psychiatric or social in nature. Unlike ACT programs in the US, which strive to provide comprehensive services themselves (Phillips et al., 2001) TEP must rely on a wide network of agencies and providers to service its clients with the safe haven of the community center as its hub.

The integration of the service network was based on assessment of all the clients’ needs which included not only health service needs, but also social service supports, supported housing, job training, transportation vouchers, child welfare ser-
vices, justice system intervention, and linkage with educational institutions and with any other partners that could help with the individual needs of families and children/adolescents.

The program is supported by the city government, with which the main author (Dr. Scivoletto) maintains close relationships and who provided frequent progress reports. Interest has been expressed in expanding the program in Sao Paulo, which would represent a first experience of transferability within Brazil. It is premature to speculate about applications outside of Sao Paulo or Brazil at this time. TEP deserves comparison with similar efforts such as that of Covenant House which began in New York city. It will also be important as the program evaluation capacity matures to evaluate its cost-effectiveness both to support development of more effective treatment program but also to justify health policies for the marginalized youth, such as those living on the streets, shelters, and in poverty regions elsewhere, that can be embraced by government authorities as well as NGOs.

Conclusion

The Equilibrium Project is a distinct effort to provide comprehensive services to formerly homeless street children through a program whose development has been guided by individual children themselves allowing adaptation to the distinct circumstances of Brazilian cities. It offers the safety of a Community Center within which medical and non-medical services can be provided both directly and through community linkages and that fosters trust through individual case management, as well as recreational activities and opportunities for natural socialization. In addition to this rich array of services TEP has made a firm commitment to research and evaluation to provide information on which further innovation and advocacy can be based on behalf of street children subject to extreme adverse life events and with serious health and social disadvantages.

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