Educational psychology and recreation for children's mental health

INSTITUTO DARA
Saúde e Desenvolvimento Humano

HM DROTTNING SILVIAS STIFTELSE
CARE ABOUT THE CHILDREN

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Contents

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Foreword

A number of studies have indicated that investment in children 0-12 years of age – a stage during which much of the brain's architecture develops – can have positive or negative impact on human development and, as a result, on a country's future and on the future of humankind. Interventions and investments in children's physical, cognitive, linguistic, and socioemotional development have the potential to offset negative trends and improve outcomes in education, quality of learning, physical growth, health and consequently all social dimensions. Failure to develop these capacities can have long-term effects, which are often irreversible and entail significant costs to families and society.

The relationship between poverty and the multiple areas of child development underlines a need for strategic interventions so that inequalities and obstacles to a nations' development are not perpetuated. Investments in improving physical and mental health reduce dependence on health systems and the likelihood of engaging in high-risk behaviour, including criminal and violent activities (Lynch, 2005). In addition, mental health care in childhood is key to identifying possible impairment to child development and the need for early intervention, and strategic to strengthening individuals from their maturation stage to adulthood.

The Declaration of the Rights of the Child (UN, 1959) states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth". Article 29 of the Convention on the Rights of the Child (UN, 1990) makes it the duty and commitment of all nations to develop "the child's personality, talents and mental and physical abilities to their fullest potential".

Also from a rights perspective, Brazil's Child and Adolescent Statute, Law No. 8.069/90, declares:

> [...] children and adolescents enjoy all fundamental rights inherent to the human person, without detriment to the comprehensive protection extended by this law, and are assured, by this law or other means, all opportunities and facilities, in order to afford them physical, mental, moral, spiritual and social development in conditions of freedom and dignity (Art. 3) (Brazil, 1990).

The Law is designed to ensure that all children have the right to life and health, to a healthy and harmonious birth and development, and decent conditions of life.

Reality, however, is hard on most of the world's children. Helen Clark, co-chair of the commission of 40 experts convened by the United Nations Organization (UN) and the United Nations Fund for Childhood (Unicef) and the lead author of the report, A future for the world's children? (Clark et al., 2020), stated that: "new estimates, based on proxy measures of stunting and poverty, indicate that 250 million children younger than 5 years old in low and middle-income countries are at risk of not reaching their developmental potential" (Reis, 2020).

This concern is shared by the World Health Organisation (WHO) as well, especially in relation to mental health. To the WHO, depression and anxiety increased by more than 25% in the first year of the covid-19 pandemic alone[1], the main causes of depression being child sexual abuse and bullying. "In all countries, it is the poorest and most disadvantaged in society who are at greatest risk of mental ill-health and who are also the least likely to receive adequate services" (WHO, 2022).

WHO Director-General Tedros Adhanom Ghebreyesus explained:

> Everyone's life touches someone with a mental health condition. Good mental health translates to good physical health and this new report makes a compelling case for change. The inextricable links between mental health and public health, human rights and socioeconomic development mean that transforming policy and practice in mental health can deliver real, substantive benefits for individuals, communities and countries everywhere. Investment into mental health is an investment into a better life and future for all (WHO highlights [...], 2022).

1. On 30 January 2020, the WHO declared the new coronavirus outbreak constituted a Public Health Emergency of International Concern – the WHO's highest alert level, as provided for in the International Health Regulations. See: https://www.paho.org/pt/covid19/historico-da-pandemia-covid-19

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The WHO further finds that 75% of mental disorders start in childhood and adolescence and half occur before 14 years of age (WHO, 2022).

It is thus crucial to invest in child mental health. But what strategies can be pursued by social organisations that provide care for children and families? Certain theoreticians[2] and the Dara institute's 30-year experience in caring for families in situations of vulnerability give grounds for believing that through play and the language of playfulness, children can develop neural, cognitive, motor and social skills. Play activities, when included appropriately in the process of children's knowledge acquisition and skill development, will enable children to construct knowledge. That process will stimulate critical and reflective thinking, enabling the child to understand situations experienced in their day-to-day lives and to develop skills and abilities corresponding to their age group (Melo, 2016). Accordingly, play is a fundamental strategy for child development and a means to strengthening a child's mental health.

In 2022, this context led HM Queen Silvia's Foundation – Care About the Children – and the Dara Institute to form a partnership to undertake a project in Rio de Janeiro to promote child mental health.

2. See DONGO-MONTOYA (2009) e WINNICOTT (1975).

In 2022, "Educational Psychology and Recreation for Children's Mental Health" provided care for 226 up to 12 years old in vulnerable situations by offering multi-sector services from psychologists, educators, doctors and nutritionists. The conditions of the children's lives and their emotional state were assessed through play activities developed and conducted by these professionals. When specific needs were identified – such as anxiety, food insecurity, depression, lack of interest in school or physical signs of mistreatment and so on –, the children either underwent a monitoring process at Dara or were referred for treatment with specialists who are part of Dara's expanded support network.

The project is now in its second year and this publication is intended to share the knowledge acquired to date with organisations, health and education personnel who are not necessarily specialists in child development. By offering technical and scientific information, concepts, indicators, signs of neurodevelopment and suggestions as to how to provide children with essential, timely stimulation, we are fulfilling our vision of what it is to participate in building a healthy, sustainable world in which all have the same opportunities and the same rights and thus can be the protagonists of their own development.

Care About the Children

HM Queen Silvia's Foundation – Care About the Children works for a world in which every child's most fundamental needs are fulfilled, as established in the United Nations Convention on Child Rights (UN, 1990). The foundation's mission is to contribute to projects that benefit the world's most vulnerable children directly, so that they receive support for education and can feel secure and happy during childhood.

Founded in 2013, the Care About the Children Foundation was gifted to the Queen for her 70th birthday after successful fundraising by Swedish executive, Olof Stenhammar. Since then, the foundation has been supporting vulnerable children in Sweden and around the world by collaborating with organisations with well-defined aid projects. Queen Silvia regards this as an additional opportunity to support children who have no say because they belong to the most vulnerable groups in society.

The Dara Institute

The Dara Institute, an independent civil society organisation and world pioneer in inter-sector work on the social determinants of health, has developed a social technology to combat extreme poverty. Its award-winning Family Action Plan is a methodology involving various different sectors to produce lasting outcomes in five key areas: health, income, education, housing and citizenship. In its more than 30-year trajectory, the Dara Institute has had impact on the lives of thousands of families in situations of extreme vulnerability and has inspired new projects and new public policies around the world. Formerly Saúde e Criança Renascer, the Dara Institute has gained more than 50 awards and tributes in Brazil and abroad, including being ranked in 2022 the best NGO in Latin America and 21st in the world, by thedotgood. Set up in 1991 by Dr Vera Cordeiro, a general practitioner, the Dara Institute works with governments and civil society to design solutions based on scientific and social knowledge.

The Family Action Plan

The Family Action Plan is the social methodology developed by the Dara Institute. It consists in the participatory construction of goals and integrated actions in the fields of health, housing, income, citizenship and education, all directed to building autonomy for socially vulnerable families and to their development. The gateway to serving the families has always been their children's physical and mental health. The Family Action Plan is recognised in Brazil and internationally for its innovative, inter-sector approach to combating poverty. In 2003, it gained the Banco do Brasil Foundation's social technology certification. Within the Family Action Plan, the aim of the Psychology sector, as an integral part of the Health area, is to minimise the level of emotional stress of whoever is responsible for the family, as measured by the Self-Reporting Questionnaire (SRQ), an instrument developed by the WHO to measure the level of likelihood of mental disorders (Beusenberg; Orley, 1994). The family, the family and social context, as well as the territory, must be taken into account when assessing the mental health of children and adolescents.

Photo: Daniel Alves

Social, political, economic and cultural context

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Children and adolescents represent one third of the population of Brazil. There are 68.6 million children and adolescents, ages 0 to 19 years, an estimate produced by Brazil's official bureau of statistics, the Instituto Brasileiro de Geografia e Estatística (IBGE, 2021). That is approximately seven times the population of Sweden and almost equal to the population of France or the United Kingdom.

At least 32 million boys and girls in Brazil live in poverty, in other words, 63% of all the country's children and adolescents. Here, poverty is taken to be multidimensional and to entail factors including income, diet, education, child labour, housing, water, sanitation and information, as pointed out by the Unicef study Multiple Dimensions of Child Poverty in Brazil (2023).Meanwhile, in 2020, the IBGE's continuous national household sample survey (Pesquisa Nacional por Amostra de Domicílios Contínua, Pnad Contínua) showed that 44% of children and adolescents, ages 0 to 14 years, were in the lower income bracket (IBGE, 2021).

Another aspect to be considered is the Human Development Index (HDI), which comprises three indicators: life expectancy, education and income. The HDI for Rio de Janeiro's metropolitan region is 0.761 (Atlas Brasil, 2022)[3]. Although considered high on the UN scale, social inequality is a daily presence in people's lives. IBGE figures for 2022 show that, in Brazil, more than 11 million women are solely responsible for the care of children and 63% of households headed by women are below the poverty line. In 2021, 10.9% of children born in the State are the sons and daughters of adolescent mothers under 19 years old (Observatório da Criança e do Adolescente, 2022, based on data from Brazil's live births information system (Sistema de Informações sobre Nascidos Vivos, Sinasc). Studies relate overwork of women

3. The HDI scale ranges from 0 to 1. The closer to 1, the greater the human development. The scale classifies countries into five ranges: very high HDI (0.800 to 1.000), high (0.700 to 0.799), medium (0.600 to 0.699), low (0.500 to 0.599) and very low (0 to 0.499).

in low-income countries with less engagement in sensory stimulation activities with their children. As a result, these children's neuro-psychomotor performance is lower than average (Braga, 2010).

It is no less important to consider the indices of violence that children and adolescents are exposed to in certain geographical regions, because, over and above police and legal considerations, violence is a public health issue, because it can lead to emotional illness and suffering. The many forms of violence to which children are victims, such as psychological, sexual or physical abuse, can be social – understood here as any action or omission by individuals, groups or classes that can cause physical, emotional, moral or spiritual harm to themselves or others (Brasil, 2005) – institutional or familial.

In 2021, during the covid-19 pandemic, for example, the Disque 100 complaints channel recorded some 35,000 cases of children's rights abuses. In 62% of the cases, the victim was a girl and 58% involved 0- to 6-year-olds, according to a survey by the Care Programme for Child and Adolescent Victims of Violence of the Rio de Janeiro Foundation for Childhood and Adolescence (Fundação para a Infância e Adolescência/RJ) (Raciunas; O'Kuinghttons, 2021).

Over and beyond the impacts of the covid-19 pandemic on children's physical and mental health, education – and thus their intellectual and cognitive development – was strongly affected (WHO, 2022; Unicef, 2023). According to Brazil's 2021 School Census (Brasil, 2022), by the Instituto de Pesquisas Anísio Teixeira (Inep), teaching activities were suspended on average 279 days during 2020, the first year of the pandemic. Even though, for purposes of international comparisons, large scale educational assessments are conducted in Brazil, the effects of educational actions reveal themselves in the long run and affect the most diverse aspects of human development. Such contextual factors are fundamental and must be taken into consideration when planning, executing and assessing social projects, especially with a view to reducing inequalities, as required by UN Sustainable Development Goal 10.

Indicators of child mental health

To the Dara Institute, understanding the social determinants is fundamental to promoting human health and development. Social determinants of health are social, economic, cultural, ethnic/racial, psychological, and behavioural factors that influence the occurrence of health problems and related risk factors in the population. Therefore, one must look beyond the disease and envisage all other, individual and collective, human dimensions. The first challenge is to broaden the spectrum of analysis from traditional clinical diagnosis; the second is to realise that there is not always a direct cause-and-effect relationship among the various factors that influence individual and population health. For example, to what extent do precarious public transport or labour relations influence the adult population's mental health and how is that reflected in child mental health? Accordingly, if the social determinants of health are taken as the basis for comprehensive development of the human person, it is imperative to find ways to address inequities and reduce social inequalities.

The determinants of health in the Family Action Plan

Based on that logic, the families of all participants in the project, "Educational Psychology and Recreation for Child Mental Health", are involved in Dara's Family Action Plan methodology. Families receive guidance in education, healthcare, their rights as citizens and home improvement. They also take part in income generation and entrepreneurship programmes, information on food security and nutrition for a healthy diet. In response to demands by families regarding their children, identified, the Dara team help manage relationships amongst the family members, to attenuate stress on the parents and contribute to understanding and managing the various different issues affecting their daily lives.

The various sectors of the Family Action Plan help strengthen the family and provide support to help families manage the challenges of their social reality:

- The health area, which includes nutrition, psychology and medical care, integrates the monitoring of the families, enhancing understanding of the family dynamics and offering guidance in response to whatever demands voiced by each family member and child.

The Housing area contributes to better understanding the dynamics of the home environment and its influence on the health of family members – especially the children's health. In addition, Dara seeks donations for home improvements that can attenuate environmental issues that affect health.

Income Generation works to organise, plan and increase the family budget, and stimulate sustainability and the autonomy of the family. It also helps Dara's understanding of the family dynamics, its possibilities and limitations.

Social Service works to guarantee civil, social and political rights, and underlines the civic duties of men and women. The team identifies, develops and strengthens family support networks, as well as promoting and exploring topics and activities that stimulate citizen participation and awareness.

The Education team supports the family in guaranteeing access to school for children and adolescents of school age, and encourages the family to participate directly in their sons' and daughters' school life. It also stimulates the adults' interest in opportunities for formal and non-formal education and cultural activities. Its work integrates with that of psychology, ensures the child's right to the public school system and intervenes in each child's development.

All these areas are interconnected and interact continuously in the Family Action Plan in real time. At the end of each day in which the families come to Dara, the different areas are in constant dialogue in order to consider what interventions are appropriate and possible. It is only through the integrated, multisector Family Action Plan that it is possible for each family to evolve and to monitor its progress, while guaranteeing best use of all the resources the Institute has to offer.

Photo: Daniel Alves

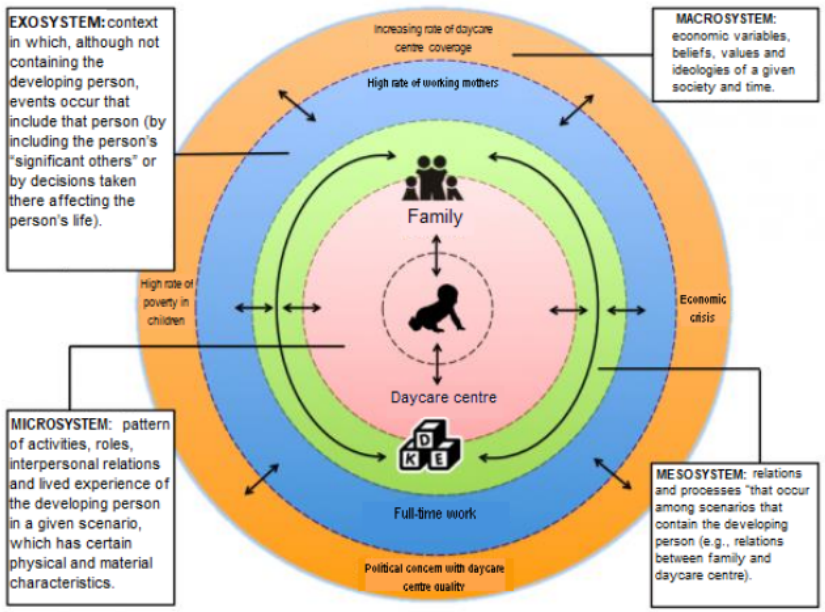
The concept of mental health

The WHO defines mental health as the ability to achieve and maintain good psychosocial functioning and state of wellbeing. The concept is directly related to each individuals' ability to adapt based on their understanding and interpretation of their surrounding environment. The WHO Comprehensive Mental Health Action Plan 2013-2030 (WHO,2021) out the conceptual bases and recommendation for the activities of personnel involved in providing mental health care. The Fiocruz adds, "75% of mental disorders start in childhood and adolescence and half occur before age 14. Adolescence is a critical time, but childhood plays a prominent role in such cases"[4]. The plan reasserts that it is fundamental to recognise mental suffering for children and adolescents to be properly cared for.

The Bioecological model of Bronfrenbrenner is an important point of reference for the WHO in thinking about development. That is, the person has to be understood in process, in context and in time.

4. Fundação Oswaldo Cruz, 2022. See https://portaldeboaspraticas.iff.fiocruz.br/atencao-crianca/principais-questoes-sobre-saude-mental-de-criancas-sinais-de-alerta-para-aps/.

Figure 1 – Bioecological Model



Source: Bronfenbrenner (1979), in Peixoto et al. (2014, p. 2).

Because individuals are social beings, all systems in which they are involved affect their development. If the precariousness of their family environment, their territorial and social relations affects physical and mental health, then it is also true that preventive actions and interventions that alleviate suffering should also take place in all those spheres of interaction with society.

The Unicef report The State of the World's Children 2021 – On My Mind: Promoting, protecting and caring for children's mental health (Unicef, 2021) explains that:

> [...] a mix of genetics, experience and environmental factors from the earliest days, including parenting, schooling, quality of relationships, exposure to violence or abuse, discrimination, poverty, humanitarian crises, and health emergencies such as COVID-19, all shape and affect children's mental health throughout their lifetime.[5]

The report notes that protective factors, loving caregivers, safe school environments, and positive peer relationships can help reduce the risk of mental disorders.

The research presented in the report found that an inter-sector approach was needed for interventions in the field of child mental health. This included, for example, preparing parents, relatives, caregivers and educators (Unicef, 2021). In 2022, the Pan American Health Organisation (PAHO) set up a High-level Commission on Mental Health and COVID-19, made up of mental health experts. The PAHO report noted worsening mental health in the population, especially among children and adolescents. Epsy Campbell Barr, chair of the Commission, wrote "We must remember that the mental health burden is not a private struggle but a public health crisis that warrants urgent and immediate action"[6]. The report, A New Agenda for Mental Health in the Region of the Americas (PAHO, 2023) shows that childhood behavioural disorders can become repeat of severe behaviour in adolescence, such as hyperactivity and lack of attention (for example, the Attention Deficit/Hyperactivity Disorder) or destructive behaviour.

5. https://www.unicef.org/press-releases/impact-covid-19-poor-mental-health-children-and-young-people-tip-iceberg.
6. See Saúde [...], 2023. Available at: https://www.paho.org/en/news/9-6-2023-mental-health-must-be-top-political-agenda-post-covid-19-paho-report-says. Accessed on: 13 Nov. 2023.

Photo: Daniel Alves

Brazil's National preschool education curricular guidelines reflect this perspective:

> Children are subjects of history and rights who, in the interactions, relations and practices they experience in daily life, build their personal and collective identity, play, imagine, fantasise, desire, learn, observe, experiment, narrate, question and construct meanings for nature and society, thus producing culture (Brasil, 2010).

A child's first thousand days of life (from conception to age 2 years) are considered crucial to both its metabolic, immunological and microbiological health and its neurological development. It is at this stage that that the most dynamic formation and biochemical shaping of brain tissues takes place. Neuro-psychomotor development, as already mentioned, is influenced by the quality of social bonds and environmental and genetic factors.

Child development can be divided into sensory-motor, cognitive, language (communicational) and emotional (psychosocial). In the first three years of life, it is very important to stimulate the senses and psychomotricity with colours, smells, sounds, tastes and touch. Rolling, sitting, crawling, standing, babbling, humming, and manipulating objects are competences that should be stimulated at this stage. From three years on, the more words, the greater the number and variety of words a child hears, the richer will be the way it expresses itself in language as an adult (Brazil, 2023).

Play is a powerful instrument for stimulating development and learning. It allows the child to know and recognize shapes, activates memory, make associations, direct attention, find focus, organize, experiment, imagine and develop curiosity, boundaries, and socio-emotional skills.

As of Brazil's 1988 Constitution, it became the duty of the State to provide for the education of children from 0 to 6 years of age (Brasil, 2016), while the 1996 Guidelines and Bases Law (Lei de Diretrizes e Bases) included preschool education as part of basic education (through to upper secondary level) (Brasil, 1996). Article 9 of the national curricular guidelines for preschool education (Diretrizes Curriculares Nacionais da Education Infantil, DCNEI), states that educational practice in preschool education is built around interactions and play (Brasil, 2010). Interactions and play among children and between children and adults reveal expressions of affection, frustrations, mediation and resolution of conflicts and regulation of emotions. The National Common Curriculum (Base Nacional Comum Curricular, BNCC) stipulates that child's rights to learning and development in preschool education are:

“**Sharing** with other children and adults, in small and large groups, using various different languages, extending knowledge of themselves and others, respect for culture and differences between people.

Playing daily in various ways, in different places and at different times, with different partners (children and adults), extending and diversifying their access to cultural productions, their knowledge, their imagination, their creativity, their emotional, body, sensorial, expressive, cognitive, social and relational experiences.

Participating actively, with adults and other children, both in planning management of the school and of activities proposed by the educator and in carrying out the activities of everyday life, such as choosing what to play, materials and environments, developing different languages and elaborating knowledge, making decision, and taking stands.

Exploring movements, gestures, sounds, shapes, textures, colours, words, emotions, changes, relationships, stories, objects, elements of nature, in school and outside it, extending their knowledge of the diverse modalities of culture: the arts, writing, science and technology.

Expressing their needs, emotions, feelings, discoveries, opinions and questions, by means of different languages as creative, sensitive, dialogical subjects.

Photo: acervo Instituto Dara

Knowing themselves and building their personal, social and cultural identities, building a positive image of themselves and the groups they belong to, in all diversity of experiences of care, interactions, play and languages experienced in the school institution and in the context of their families and communities.”

(BRAZIL, 2018).

It is from this perspective, and on the basis of the ideas and concepts described above, that the project “Educational Psychology and Recreation for Children” is operated by the Dara Institute’s multidisciplinary teams.

Project stages

Overall aim: Monitor the mental health of children 0 to 12 years of age.

Specific aim 1: conduct play activities that enable them to express the conditions of their lives and their emotional state naturally.

Related activities:

1. Recruiting participants

2. Conducting age-specific educational activities.

3. Identify behaviour, during the individual and group activities, that may affect the children's overall development based on a checklist developed by the technical staff of the Dara Institute.

4. Maintaining a field journal after each activity, describing any important observations.

5. Making referrals to the Psychology and/or Education sectors, based on the field journals and/or demands from the team and family.

Specific aim 2: to monitor each case and, when necessary, refer specific cases identified by the multidisciplinary team to the partner support network outside of Dara.

Related activities:

1. Initial assessment of the child by the Psychology sector.

2. Individual appointments for children with special needs that should be monitored.

3. Implement an effective, personalised action plan based on needs identified by the multidisciplinary team and the participant's family.

4. Monitor the children's progress over time and perform interventions as necessary.

5. Prepare a plan for decision making and planning of future actions based on data and information obtained from the monitoring system.

6. Referral to network of partners, as necessary, to ensure appropriate support.

7. Discharge from psychological care when appropriate.

8. Proper recording and documentation of cases discharged, including reasons, outcomes achieved and plans for post-discharge follow-up.

The Mental Health Project is structured in three stages: identification, diagnosis, treatment and/or referral. Psychologists, educators, interns and trained volunteers conduct play activities and games with the children in the recreation setting. A checklist and daily journal are the observation tools that help in identifying each child's development and specific support needs. A multidisciplinary team of the Dara Institute monitors the children and, when necessary, conducts an assessment, individual psychological care or referral to professional help at clinics near the children's homes. We work closely with the families, sharing the knowledge we produce and learn on our knowledge platform, in seminars, workshops and through the Early Childhood Education and Infancy Parliamentary Group (Frente Parlamentar da Primeira Infancia).

The work is structured into the following stages:

In the first stage, the children are observed playing, either in group or individually, and the observations are recorded in the field journal. It is then possible to identify any need for an initial psychological assessment by the child psychology team. The demand for child psychology arises, in most cases, in the recreation space. However, the sector also receives demand from the multiprofessional team that monitors the family monthly and from the family itself.

In the second stage, from the demands identified, initial child psychology assessments are conducted. A situational diagnosis of the demand is then performed and the direction of care is outlined, if necessary.

The third stage consists in individual psychological care and/or no referral to the psychosocial care network.

Photo: Daniel Alves

Photo: acervo Instituto Dara

Stage 1: Identification

The family's first meeting with the multiprofessional team responsible for the child's care will be in the reception group. The purpose of the reception group, which meets with new-entrant families every month, is to introduce them to the personnel and provide them with the most important information about the Dara Institute. Each sector presents its field and briefly explains its role. At that point, the Education and Psychology sectors ask the families to observe any issues that may harm their children's emotional development and to approach the sector teams if they see any need.

Each individual family then begins monthly care sessions. At the meeting, each specialist sets out his or her area's goals in the Family Action Plan and the main activities that can be offered to the family, guided by the following directions and focus of intervention: health, education, citizenship, income and housing. Each specialist then seeks detailed information on aspects of the family's life that may influence its vulnerability and, jointly with the family, draws up the goal and activities of their Family Action Plan.

The multidisciplinary team is instructed to be attentive, during their care sessions or daily conversation groups, for possible demands for psychological care in order to refer the children to child psychology, if necessary.

One of the activities at the Dara Institute is known as Comforting, which comprises daily conversation groups with the families in care, building on topics considered important by the team and/or the families. Awareness of child mental health is one of the subjects addressed over the year to highlight its importance and remind the families to observe their children and to seek help when necessary. If any demands arise during the conversation group, the child is referred to child psychology.

Lastly, the identification stage actually takes place in Recreation, a place where the families can leave their children on days when the parents are involved in other activities at Dara, if they have no one to leave them with at home. The team working at recreation, as already mentioned, is made up of psychologists, educators, interns and volunteers who offer age-appropriate play activities to observe and identify possible impairment to child development. The volunteers and interns are trained, and have the sensitivity, to observe behaviour that may signal impairment to the

course of a child's healthy development. That awareness is developed by guidance by the project technical staff, an information checklist and a list of activities to be conducted by each child's age group. These observations are recorded in the recreation field journal, which is analysed by the team weekly.

The information checklist of activities that are conducted by the volunteers and/or interns who work in recreation gives step by step instructions on what is to be done and what behaviour should be noted in the children. It is important to stress that the checklist has been, and continues to be, developed specifically for use with the public served at the Dara Institute and their characteristics and needs.

By observing interactions and play among the children and between them and the adults, it is possible to identify, for example, expressions of affection, frustrations, mediation and resolution of conflict, and control of emotions.

Activities offered in which it is possible to observe the child's level of development

In conducting the age-appropriate activities, our basis is the theory of development described by Piaget (1999), who considered that human development goes through four stages:

Photo: acervo Instituto Dara

0 to 2 years

Play using the body; sensory mat; rattles; musical toys; teethers; sensory PET bottles; self-image in mirror; cubes to put together and take apart; hammering toys; spontaneous doodles; blocks; toy cars; toy trains; stacking, sorting and plugging toys; toys to put together and take apart; stimuli for crawling or walking; welcome and introduction to the objects in recreation, interspersed with the mother's presence when requested by the child.

During this initial stage of development, babies are expected to:

- Acquire knowledge through sensory experiences, acquire the ability to handle objects, learn basic reflexes, develop sensory and motor responses;

- Learn to crawl and walk;

- L learning about the language of the people they interact with;

- Start to develop an understanding that objects continue to exist even when they cannot be seen – which also entails the child's developing a sense of security when away from its mother, knowing she will return;

- Learn that objects are separate, distinct entities with existences of their own independent of individual perception, and begin to be able to attribute names and words to objects; and

- Begin to develop a perception of self-image.

2 to 7 years

Play that stimulates symbolic thinking, as well as use of words and images to represent an object: child's kitchen; medical kit; Chinese whispers; modelling clay; doll's house with furniture; dead-alive; paper folding; storytelling; memory game; statue game; rope skipping; hopscotch; hula hoop; dancing.

At this stage, it is expected that:

- Children are starting to think symbolically and learning to use words and images to represent objects; and

- While the foundations of language development may have been laid during the previous stage, it is at this stage that children establish their grasp of language.

7 to 11 years

Activities: board games; dominoes; races; gymkhanas; hot potato; riddles; soccer; skittles; twister; theatre.

At this stage, it is expected that the children are developing:

- rational thinking and are more skilled at using logic.

- the ability to understand and accept agreed limits, as well as thinking, perceiving differences and opinions different from their own; and

- an understanding of their feelings, thoughts and emotions.

12 years

Activities: creation of comic strips; music and rhyming; conversation groups; theatre; drawing.

At this stage, it is expected that the children are developing:

- abstract thinking;

- an ability to plan and think about their future; and

- an ability to think rationally about hypothetical situations.

Photo: Eurivaldo Bezerra

Remember, this division is organised didactically, but each child has its own context which will make for greater or lesser compatibility between its age and the abilities described above.

Stage 2: Diagnosis

Photo: acervo Instituto Dara

In the diagnosis stage, families whose children present specific needs are called in for an initial assessment by the child psychology team. The assessment is intended to learn more about the situation that has arisen and decide whether it is a more minor issue that may be solved by conversations with the parents or whether the child needs to be monitored or more continuous care and support. The diagnosis is carried out with only the person responsible for the child.

Note that, in more severe situations, as in the case of child that is the victim of sexual abuse, after an initial assessment, the psychologist may refer the child directly to a specialised service.

At this point, it is decided what the main complaints are that need for psychological attention, considering the history of the occurrences, including: the child's present context, which involves family, school and social contexts; its development history from the mother's pregnancy; the child's routine, behaviour, previously existing diagnoses, and any other issues that may arise and be pertinent to the process.

In the initial assessment, a child wellbeing questionnaire is also applied. It is used at the start and the end of the project to evaluate what aspects of the child's life have improved during the period it was receiving care in the programme.

When necessary, the monitoring of the children in the program will occur monthly or fortnightly and will continue according to the demand.

Child wellbeing questionnaire

The child wellbeing questionnaire was developed by the project team to help evaluate the quality of the child's wellbeing and mental health at the start of the programme and at the end of the process. It evaluates aspects including: spontaneity, quality and security in bonds of affection, ability to put him or herself in others' place, creativity, curiosity and learning in school. These factors are indicative of child mental health yet always taking the child's present family and social life contexts and life history into consideration.

The child wellbeing questionnaire, applied by

whoever is responsible for the child's psychological care, comprises 12 questions, the possible responses to each of which are: 0, 1, 2 and 3, where 0 is the lowest and 3 the highest. Once the questions have been answered, the scores are added. Scores of less than 24 are considered to indicate a low level of wellbeing. While the questions are being answered, it is also possible to learn more of the perceptions of the person responsible for the child. Information in addition to whatever was discussed in the initial assessment may also arise in this process.

In addition to the child wellbeing questionnaire, those responsible for the child and occasionally the child are asked to give their opinions during and at the end of the psychological care. This is part of the closure of the process and based on an individual elaboration of what the psychological support represented during the period. The statements also are part of the perception of the child's mental health condition at the end of care.

Photo: Eurivaldo Bezerra

Foto: acervo Instituto Dara

Stage 3: Treatment and/or referral

In this stage, the child begins to be monitored and, in the course of the process, if necessary, will be referred to specialised care.

Psychological monitoring is carried out at monthly or fortnightly meetings. The interval will depend on the need of each case and on whether the family is in a position – because of distance and/or other factors – to bring the child in for monitoring. The meetings involve conversation and play resources – games, toys, and drawings – as this is the way the child will express itself.

Winnicott (1975), an English paediatrician and psychoanalyst influential in psychological development theory, argued that play activity, of whatever kind, is fundamental to child development, because it is in playing that the child's main forms of expression are to be found. By way of games and play, it can express both feelings of pleasure and feelings related to fears and frustrations. That is why playing is considered such a rich tool for working with child psychological monitoring.

Through play, the child expresses its symbolic world and, with the help of a psychologist, will find coping resources to enable it to position itself in healthier ways in relation to the world, and avoid daily life experiences that may be harmful. Also, play provides a potential space for creation that will help the child develop personal skills for relating to the group.

Winnicott (1975) found that playing offers experiences of the subject and of the perceived object, because play performs the function of communicating real content of the individual. Playing has to do with the subject's inner and outer realities – the child can bring content and characteristics of the outside world and demonstrate imagined experiences during the act of playing. Play can develop from something personal into shared playing, which may subsequently lead to cultural knowledge.

> Of the play materials available in the room, it is normally the child who chooses whatever it wants to use in the course of the session and this itself will reveal something about the child. The therapist is guided by the child and accompanies the play, intervening or interpreting significant aspects. Patients often accept interpretations better when they do not refer directly to them, but to their play and the personifications it creates. The play makes it possible to share fears and to live through situations at a distance in place and time, displacing anxieties and conflicts that can then be elaborated on (Castro; Sturmer, 2009, p. 105).

Accordingly, in child psychological monitoring, the therapeutic setting constitutes a safe space where the child can express needs and desires in relation to his or her present situation. The proposal is that, in that setting, the child can find outlets for expressing its inner world and grow stronger. It is a question of gradually building autonomy, always respecting each child's pace and particularities.

At the same time as the children are being monitored, conversations formatted as guidance or feedback are held with the people responsible for the children. The purpose of these meetings is to understand the context of the child's life better and to help parents or those responsible for the child with the issues that have been observed and are being dealt with in the child psychological monitoring.

Whenever necessary, conversations are also held with the child's school. The objective is to understand the context of the school in which the child in care is placed, the relationship of the child with the school and the school's view of the child. In addition, the dialogue with the child's school is important especially when some form of intervention may be necessary in the child's day-to-day activities.

If specialised monitoring is needed, the child is referred to facilities in the network. Referral is intended to allow the child to access appropriate treatment near the home. The facilities in the regions where Dara families live have been actively researched and mapped by the team at the start of the project.

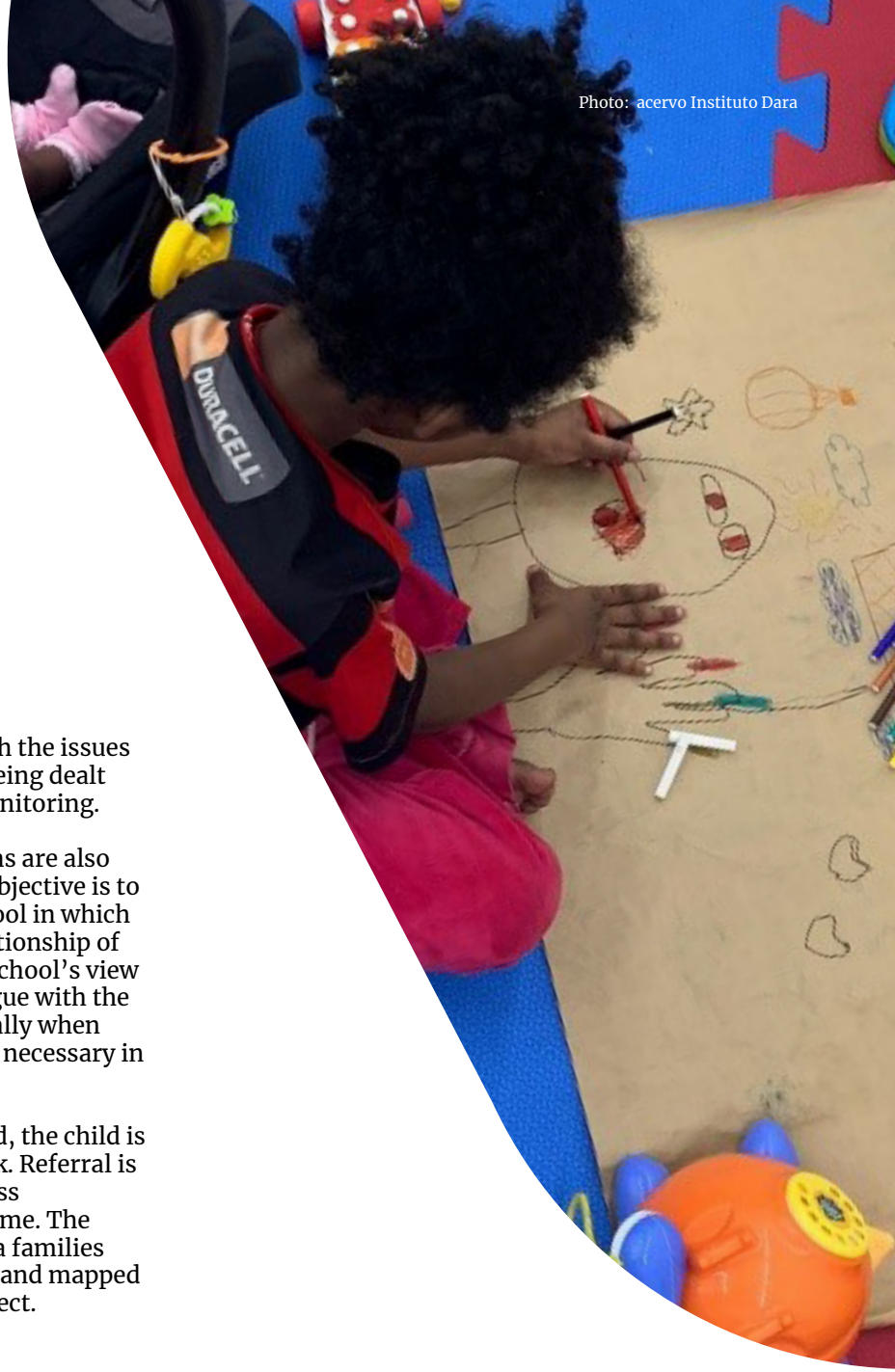


Photo: acervo Instituto Dara

The role of the educators

The educators' activities in the project are:

- Observing the child's development, listening, creating, organising, executing and evaluating educational strategies and resources that enable the child's abilities to be understood and the degree of progress in the child's development. The educators also consider the child's school and family, because engagement by the adults with the educators responsible for the child is fundamental for development;

- Planning activities with the psychologist to identify any behaviour that may affect the child's development, as well as participating in the diagnosis with the psychology team.

- Monitoring the development of each case and providing guidance for parents to work at home on the educational demands that were raised in recreation;

- Providing daily guidance regarding activities and at monthly meetings with volunteers;

- Observing, from an educational standpoint, how the children are doing in reading and basic mathematics.

- Observing that a type of toys that can contribute to a particular child's development is needed. If there is such a need, the toys are donated.

- Maintaining continuous dialogue with the multiprofessional team at Dara to understand each case better and permit more precise interventions; and

- Producing and sharing teaching content (videos, audios, flash cards, images), via Whatsapp, on topics that can support the families in their child's development. For example:

FROM THE FIRST MONTH TO THE FIRST YEAR

That caring look, an easy smile, the first sounds.
OBSERVING YOUR BABY attently is the first step towards helping it develop completely.

NEWBORN BABY

* Move **COLOURFUL OBJECTS** slowly in front of the baby. Up to its first month, it will only distinguish things close up, so get in really close.
* Put on **CALM MUSIC** and talk to it a lot. Through you, it will discover the world around you both.
* Alternate positions when you hold your baby to help it steady its head. From the first month, you can lay it **FACE DOWN** for a few minutes, several times a day, but always stay nearby, keeping an eye on it. This will strengthen the muscles in its neck and arms.

FROM 3 TO 5 MONTHS OLD

* Leave **TOYS** within reach of the child's hands, so it can try to grasp them.
  Better still if they are of different textures, such as foam foam plastic, cloth and rubber.
* "Where is it? Here it is!" Games like this are **PURE FUN** and sure to bring smiles.
  Listening to the noises the baby makes and imitating them also stimulates communication. Did you know that?
* On a firm, soft surface, encourage the baby to sit, holding it by the arms or under the armpits and pull gently forwards. You can leave the toys a little further away, so that it will bend its body forwards and practise **BALANCE**.

WHAT NOT TO DO DURING THIS PERIOD

1 **RUSH THE BABY**
Development does not happen the same for everyone, that the advances and setbacks form part of the part of the PROCESS. When in doubt, consult the health team.

2 **DO NOT COMPARE YOUR BABY WITH OTHER CHILDREN**
Growth is **DIFFERENT** for every one of us.

The role of the psychologist

The role of the psychologist is:

- selecting play activities with the educators that are conducive to better observation of the child;

- producing and sharing teaching content (videos, images), via Whatsapp, on topics that can support the families in their child's development.

- holding conversation groups on topics relating to child mental health and that promote awareness, always pointing to the importance of care;

- maintaining continuous dialogue with Dara's multiprofessional team concerning the children's psychological monitoring in order to understand the case better and permit more precise interventions by teams.

- participating in case studies with the multiprofessional team;

- monitoring of mental processes characteristic of childhood, carefully working with emotions, perceiving and monitoring the children's emotional development by observing their language, images and relationships. These aspects are observed both in the recreation space and in psychological monitoring, through each individual's experience in detecting conflicts and resignifying occurrences;

- when necessary, conducting the initial assessment with the adults responsible for the child, to learn about the child's present situation to decide if an issue can be resolved in conversations with the parent or the persons responsible or if the child needs to enter monitoring for more continued support. After the first assessment, the specialists produce a diagnosis of the child's situation;

- applying the child wellbeing questionnaire to the person responsible for the child, at the start and at the end, so as to have an indicator of progress at the end of the process;

- conducting individual psychological monitoring sessions.

- holding group activities with the children in the recreation setting;

- Observe the need for toys that can

contribute to a particular child's development. When such a need is detected, the toys are donated;

- identifying cases that need to be referred elsewhere for specific treatment and directing the case to the appropriate facilities;

- when necessary, holding guidance or feedback sessions with the persons responsible for the child, holding conversations with schools and other professionals who work with the child receiving care at the Dara Institute;

- when necessary and/or requested, holding occasional guidance sessions with those responsible for a child who is not necessarily in monitoring;

- mapping of the referral network for the children receiving care;

- supervising the work of the psychology interns or trainees and leading meetings to discuss and align theory and actual practice; and,

- on a weekly basis, with the intern or trainee, examine the Recreation journal produced by the team, focusing on accounts that may signal a need for child psychological monitoring.

It is extremely important that the psychologists be careful not to pathologise or medicalise lives. Qualified listening is fundamental, as is not overstating or labelling certain kinds of behaviour or unnecessarily medicalising (CRP SP, 2008).

Psychology intern or trainee

Functions:

- welcoming and working with children in the recreation setting;

- observing the behaviour of the children who come to recreation and recording observations in the field journal;

- filling out the recreation attendance sheet;

- reading texts that give theoretical grounding for the activities that are conducted.

- holding group activities with the children with the supervising psychologist;

- with supervision, examining the field journal to help think of play interventions with the children in the recreation setting and to identify the need for psychological monitoring at the Dara Institute;

- take part in the initial assessments and psychological monitoring performed by the supervising psychologist;

Note that, in Brazil, under Art. 8 of the Psychologist's code of professional ethics, in addition to needing appropriate training and experience, in cases where care is 'not occasional', the psychologist must be authorised by at least one of the persons responsible:

> Art. 8 – In order to provide non-occasional care for a child, adolescent or ward, the psychologist must obtain authorisation from at least one of the persons responsible, and comply with the provisions of current legislation:
> §1 – in the even there is no legally responsible person, the care must be provided and communicated to the competent authorities;
> §2º - the psychologist shall be responsible for whatever referrals become necessary in order to guarantee comprehensive protection for whoever is receiving care. In addition, in view of the principle of professional confidentiality, it is important that care be taken to communicate 'to the person responsible only what is strictly necessary to enable measures to be taken for the benefit of those receiving care' (CFP, 2005, pp. 12-13).

Photo: Daniel Alves

Cases

CASE 1

Pedro (pseudonym), 9 years old, has been in psychological monitoring since September 2022. The following activities have been performed: initial assessment with the person responsible, fortnightly monitoring and sessions with the person responsible (maternal grandmother) for feedback and guidance regarding the child's issues.

Pedro came in for psychological monitoring through the multiprofessional team and because of his grandmother's complaints. She said that Pedro had been harming himself since he was little – banging his head against the wall and hitting himself with his hands, breaking all his toys and often "crying on his own" and saying that nobody liked him or "my mother doesn't like me". Pedro also strongly resisted going to school because he said he didn't like "that place". Sometimes he said he was not of this world.

Pedro's birth mother had died 2 years earlier, killed by her partner. At the time when Pedro was born, his parents were drug users and lived on the streets. His history is marred by a series of episodes of violence and neglect. In the end, his grandmother took him in to raise. In her account, the grandmother showed no signs of an affectionate relationship with Pedro, but displayed concern over what she considered basic needs for his subsistence. Pedro knew about his life story, which was told to him by his grandmother with no concern for the gravity of the events or the boy's age. She said, "Pedro has always been agitated and nervy".

The monitoring focused mainly on building an environment that could be welcoming to Pedro and providing support to his apparent disorganisation so that he could start to exist from and for himself and not just adaptively.

The first meetings with Pedro were necessary to form a bond of trust with the psychologist. Some themes in his life story and context came out in the course of the monitoring sessions. At the outset of the process, Pedro brought out content through conversation and literally, without using any play resources as a medium of communication. Later, visibly anxious, he began to bring it into the context of his interaction in the monitoring, through play, games, drawing and material that he produced at home.

In conversations with the grandmother during monitoring, she began to get involved in Pedro's issues and to take interest in his needs. The bond between them began to grow stronger – Pedro's efforts to establish a bond of affection with

his grandmother began to be corresponded. She also began to intervene in the poor relationship with his aunt and managed to reduce the conflicts between them. In addition, over the course of monitoring, toys and play resources were donated to the grandmother, the intention being to enable her to give them to Pedro as presents to play with and express himself.

During monitoring, Pedro could be seen to resume his emotional development. He began to want to go to school, to voice wishes spontaneously, such as wanting to work hard to move up a class at the end of the year and to become a fireman or teacher. He displayed no more self-harm or frequent crying and has played with his toys.

Statement by person responsible: "He hasn't had any more of those crises. After her started here, he stopped hitting himself [...]. These days, he's anxious to go to school... After the holidays, on Thursday and Friday, it was really hot. I was going to leave it and only take him back on the Monday. He said: 'You don't want to take me to school, do you? I want to go'. He didn't use to like school. He used to say: 'I don't want to go to that horrible place'. Yesterday, I found it funny, he said to me that he was going to study hard to move up a class at the end of the year".

CASE 2

Miguel (pseudonym), 2 years old, has been in psychological monitoring since August 2023. The following activities were carried out: initial assessment with the person responsible, monthly care sessions and sessions with the person responsible (mother) for feedback and guidance with regard to the child's issues.

Miguel started psychological monitoring because he was very agitated and had difficulty sleeping, as well as being highly distressed when away from his mother. Ana, Miguel's mother, had been the victim of sexual, psychological and physical violence committed by her partner since the start of her pregnancy. The violence continued through the early years of Miguel's life. Ana and Miguel managed to leave the house and live far away from the aggressor. Today, they are in safety.

Miguel displayed great difficulty being away from his mother. She, in turn, whenever her son became agitated, tried to make his stop by shouting, a certain aggressiveness and words that in the end made the child even more insecure. In addition, the mother was going through a difficult time in her life and exposed her most intense emotions with the child on her lap.

The main aim of the monitoring was to build a safe, welcoming environment for Miguel, with room for him to express his needs and receive the support to organise them.

Miguel attended few sessions, at which he asked for play material to express himself. The conversations with his mother enabled her to understand better the importance of taking care, as far as possible, with how things should be presented to Miguel, (her profoundly sad emotional state, for example). Also, some of Miguel's behaviour, which were apparently not understood or seen as wrong, were redefined through the guidance meetings. Other ways of seeing and handling Miguel's agitation were also worked through as much as possible.

With time, Miguel began to use words more to express his needs and to convey them more clearly. He started to feel more secure when away from his mother at the Dara Institute. His sleep also improved. Little by little, his emotional development proceeded more healthily.

CASE 3

Julia (pseudonym), 10 years old, came for child psychology care by referral by the Psychology sector at Dara, where her mother was being seen. The initial assessment was carried out in July 2022. Since then, Julia is being monitored every two weeks by the sector. During the monitoring process, conversations were held with her school, she was referred for speech therapy assessment; the team talked to the speech therapist and with the persons responsible for Julia.

At the first meeting, her mother brought a referral from the school for neuropsychological and speech therapy assessment because of the learning difficulties Julia had displayed since she was six years old. She had a history of severe distress episodes, bullying at school, a large number of learning difficulties and major inhibition in expressing herself in speech. At the start of monitoring, she also showed diet-related issues. Her family context was turbulent and lacked the structure to address and give support to her needs.

Julia's fortnightly psychological care was designed to create an environment of trust and welcome to allow her to express herself on her own terms regarding her life and experiences. The early meetings with Julia were necessary to construct a bond of trust with the psychologist. At the start of the process, Julia nearly always brought out content through play. As time went by, she began to express herself by talking more often.

Conversations were held with the persons responsible for Julia. The family was supported by the team and gradually a space was created where Julia could open up and where her needs could be considered.

During monitoring, Julia was referred for assessment by a speech therapist and lastly by an educator. Over the course of the process, conversations were held with the speech therapist to enable Julia's difficulties at school to be understood better.

Conversations with the school, to understand Julia's life context and her school difficulties, were also very important. The school also sought guidance from other professionals to think about what could be done about Julia's difficulties. After the speech therapy assessment, the school was able to construct a teaching strategy better suited to Julia's needs and her learning process.

With the psychological monitoring, Julia began to express her wishes and needs more often by talking, take an interest in organising her space at home and improve her eating habits. In the closure process, she said she was very satisfied with her life.

Statement by person responsible: "As J's mother, I am really very grateful to the Dara Institute's child psychology project. When my daughter arrived at Dara, she hardly spoke and today has progressed so much, she now knows how to stand up for herself and accomplish things for herself. Psychology did her a lot of good, has brought a lot of good things to my daughter. I will never have the words enough to thank you for all the care and kindness you have shown her. If she smiles today and does more it is thanks to psychology, which made her discover that she is capable, that she has a voice and needs to speak out. At the most difficult times, in those instants when we needed help and support, the psychologist took the first step and made everything easier by her presence. My gratitude will be eternal".

Case 4

Sara (pseudonym), 10 years old, came to child psychology care after her mother took part in a conversation group on the subject of "Child mental health" and approached the Psychology sector to assess her daughter. The mother was afraid Sara was developing an eating disorder, because she had an aversion to food and ate very little. She also had the feeling that her daughter was losing her interest in things, "losing her sparkle".

The initial assessment was carried out in June 2022, since when Sara had been monitored by the sector every two weeks.

The early meetings with Sara were necessary to form a bond of trust with the psychologist. However, from the first session, Sara brought up her contents by talking. She showed a wish to talk and to link up with people, but she was very inhibited and anxious about it, and often managed to speak only with the help of a colleague. She also complained of having occasional outbursts of anger.

The purpose of the psychological monitoring was to create a space where Sara could express herself and elaborate whatever was necessary for her to find more authentic pathways that would enable her to meet her needs and fulfil her wishes.

Over the course of the monitoring, Sara made a lot of friends at her school, got involved in group activity workshops and her anxiety crises disappeared. She discovered activities that made her feel good, such as writing stories and poems and reading books in her school's library. She was able to resume her emotional development healthily and became active in the choices she made and understood more about her needs and wishes.

Declaration by the child receiving care: "I think that after I started here, I began to understand the things that I like and what I want, and that ended up making me bother less about what other people think. Last year I was hardly eating, there were days when I went the whole day without eating. Now I eat more or less the right amount, which doesn't do me any harm from overeating, but also isn't too little. It's really good when you understand what you like and what you don't like, because things start to affect you less".

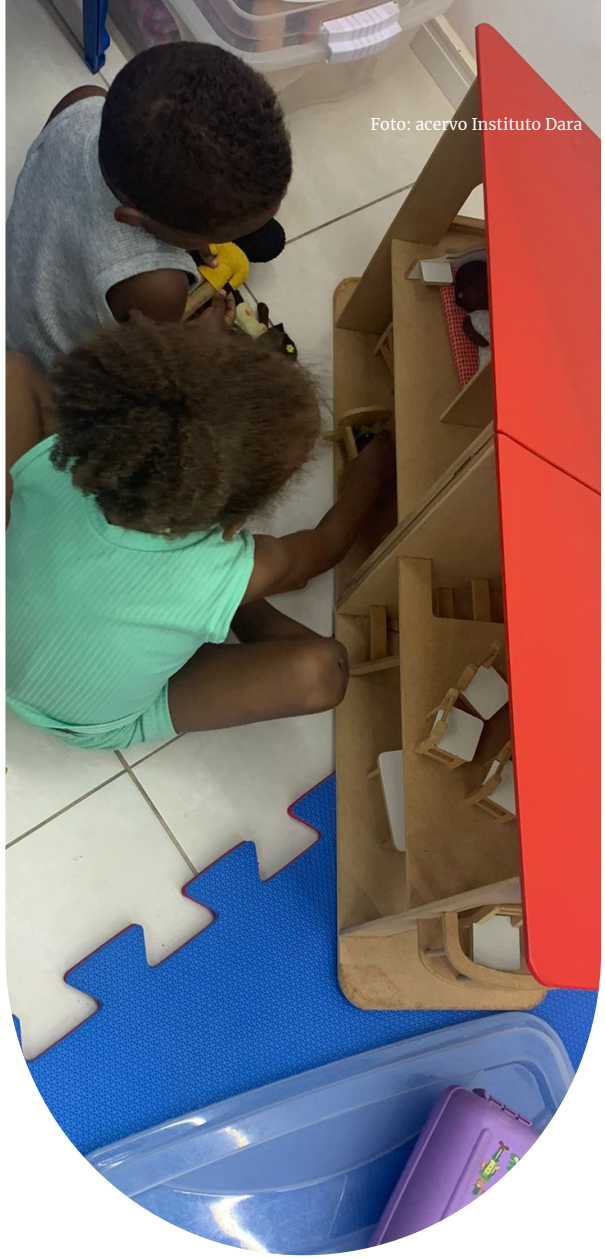


Foto: acervo Instituto Dara

Project outcomes

Since the start of the project in 2022, up to 31 October 2023

557

children have been monitored in the recreation space (that number include children who frequented recreation in both 2022 and 2023, because the families continued to receive care the following year).

66

started psychological monitoring.

80

underwent the initial assessment in psychology.

15

were referred to specific treatment centres.

The main demands presented in the period were: retraction; irritability; declining school performance; phobia; sleep problems; autism/suspected; self-harm; late speaking; anxiety; aggressiveness.

Final remarks

In the context following the covid-19 pandemic, it is of fundamental importance to keep an attentive, careful eye on children, especially their mental health and educational challenges. What has been seen is not just an increase in anxiety, sleep difficulties, eating disorders and learning difficulties, but also financial difficulties of Brazilian families, which contribute negatively to their children's full development.

One important point we have observed during implementation of this project at the Dara Institute is that recreation became established as a therapeutic setting. We saw that certain issues confronting the children who participated could be solved in the recreational setting, without having to evolve to a situation of psychological distress that would call for specialised interventions. This shows the importance of creating an environment that fosters more comprehensive, holistic growth in the children by involving them in interesting, age-appropriate activities.

Photo: Daniel Alves

This work was carried out at the Dara Institute considering the specific characteristics of the public attending the Institute. For other organisations and other territories and publics, it is important to consider the specific features of the place and public and adapt the information in this publication accordingly.

Instruments

Educational psychology and recreation for children's mental health

SCRIPT FOR CHILD'S INITIAL PSYCHOLOGICAL ASSESSMENT

Date		
Responsible for completion		
Child's name	Age	Family
Main complaint		
FAMILY CONTEXT (who has contact; who does not have contact; with whom lives; family dynamic)		
INFORMATION ON PREGNANCY AND CHILDBIRTH		
HISTORY OF DISEASES		
DEVELOPMENT (walked, spoke, read, wrote)		
ROUTINE (include work routine of persons responsible)		
DOES ANY FAMILY MEMBER MAKE HARMFUL USE OF A SUBSTANCE (e.g.: alcohol, tobacco, other drugs)? AND YOU (person responsible)? Explain what constitutes "harmful use", if necessary.		

FAMILY HISTORY OF DISEASES
SIGNS OF INTRAFAMILY VIOLENCE (includes neglect, mistreatment, gender violence)
SCHOOL TIMES
TIMES AVAILABLE FOR CARE
RESULT OF THE ASSESSMENT (tick): ( ) Needs psychological monitoring ( ) Needs, but does not want, psychological monitoring ( ) Does not need psychological monitoring
PSYCHOLOGICAL OPINION (Insert summary of case assessment, indicating whether the person responsible wants to proceed with monitoring for the child).

CHILD WELLBEING QUESTIONNAIRE	Family				
	Day/Group				
	0	1	2	3	
1. How safe do you consider the child in the environments outside the home?					
2. How curious do you consider your child?					
3. How playful is your child?					
4. To what extent does your child express what it thinks and feels?					
5. To what extent does your child seek to interact with its peers?					
6. To what extent do you think your child manages to control aggression?					
7. Does your child have friends? Does it share with friends? Does it make new friends?					
8. Does your child receive affection from the family?					
9. Does your child experience positive affect? (feel happy, feel peaceful, feel love)					
10. Does your child concern itself with helping others?					
11. Does your child learn well at school?	Score				
12. Does your child have leisure times?	Date				
PSYCHOLOGIST					

Educational psychology and recreation for children's mental health

Selection criteria for children to take part in the project:

- Children (0-12 years old) present in the Dara Institute are invited to recreation;

- Educational activities appropriate to each child's are conducted (with reference to a list of activities by age range);

- At the end of recreation, a report is written on each child attending, describing what was or was not done and what was observed in the child, specifying the child's name and age. This is delivered to the educationalist in charge.

- During recreation, the children's behaviour is observed and any that may jeopardise the child's overall development is reported to the educationalist in charge. Examples are:

- Children showing any difficult that may reflect an emotional concern (children who are excessively attached to their mothers after one year of age; children who display a lot of fear or anger; children who are excessively mistrusting; irritable children);

- Children with signs or a diagnosis of Attention Deficit Hyperactivity Disorder (easily distracted by outside stimuli; seem not to hear when spoken to directly; has difficulty playing calmly; difficulty concentrating on one single activity);

- Children displaying aggressive behaviour (harming colleagues or recreation leaders; breaking toys angrily, even after guidance from recreation leaders);

- Children without boundaries: children who do not follow the rules of Recreation, such as not breaking toys, not hurting colleagues; who do not follow the guidance of recreation leaders when invading a colleague's space or using space inappropriately (climbing where they should not climb, using materials inappropriately);

- Problems in mother-baby bonding (observe whether the mother-baby bond is strong, whether the mother has adapted to the baby's needs; whether there is love, kindness and understanding in the relationship);

- Children who show signs of anxiety (who display agitation with muscular tension);

- Children who show signs of depression (slumping, apathy, isolation, pessimism, difficulty paying attention, memory and reasoning, aggressiveness);

- Children showing signs they may develop an eating disorder in the future (rejecting major food groups, nausea and vomiting when given new foods, tantrums at mealtimes);

- Children with Autism Spectrum Disorders or who show any sign (not maintaining eye contact for very long; not responding when called by name; not interested in other people; verbalising little; repeating phrases or words without proper function – echolalia; unusually upset by loud noises);

- Children with physical and/or behavioural signs they may be suffering from some kind of violence (signs of physical violence, reproducing violent behaviours or speech, extremely fearful reactions to adults);

- Children from families classified as highly vulnerable by the Dara Institute;

- Children involved in any way in official child protection processes;

- Pre-adolescents with signs of self-harm.

Educational psychology and recreation for children's mental health

FIELD JOURNAL

Date		
Person responsible for completion		
Child's name	Age	Family number
Which children attended Recreation or which did you monitor and what are your overall observations about them? (here, give the child's name and an overall opinion of its behaviour and interaction during the time it was in the toy room – calm, aggressive, shy, fearful, outgoing).		
Which activities/games were engaged in and how were they conducted? (here, talk about the planned-for activities that you conducted with the child. What educational dynamic and materials were used? E.g., pick up sticks; painting with tempera; drawing with coloured pencils; rope skipping; skittles; dominoes etc.).		

What games did the children play spontaneously?
What points about the child and the setting deserve attention? (highlight here anything that deserves attention so as not to become a problem. E.g., broken toys that may harm a child; planned activities at are not appropriate etc.; children's speech or behaviour).
Progress and highlights (highlight here whether, during your day of activities with the child, you perceived any progress in this child's behaviour and/or learning).
Report conversations with persons responsible for the child (if any).

Legal aspects and public policies

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BRASIL. Ministério da Educação. **Resolução n.º 5, de 17 de dezembro de 2009.** Sets out national curricular guidelines for preschool education. Brasília, DF: 2009. Available at: http://www.seduc.ro.gov.br/portal/legislacao/RESCNE005_2009.pdf. Accessed on: 11 Nov. 2023.

BRASIL. Ministério da Educação. **Base Nacional Comum Curricular.** Brasília, DF: Ministério da Educação, 2018.

CONSELHO NACIONAL DE SAÚDE (Brasil). **Resolução Conselho Nacional de Saúde n.º 466/12, 12 de dezembro de 2012.** Approves the guidelines and regulatory rules for research involving human subjects. Brasília, DF: CNS, 1996. Available at: https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf. Accessed on: 9 Nov. 2023.

CONSELHO FEDERAL DE PSICOLOGIA (Brasil). **Resolução CFP n.º 10/97, 20 de outubro de 1997.** Sets criteria for dissemination, publicity and professional practice of psychologists, as regards practices at variance with established scientific criteria in the field of Psychology. Brasília, DF: CFP, 1997. Available at: https://site.cfp.org.br/wp-content/uploads/1997/10/resolucao1997_10.pdf. Accessed on: 9 Nov. 2023.

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Vera Regina Gaensly Cordeiro – Founder and President
Candace Maria Albertal Lessa – Vice-President
Layout: Aryane Lozin e Tássila de Lima - Agência Tropicália
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