PROPOSAL · INDEPENDENT INITIATIVE · NOT AN OFFICIAL DOCUMENT

Two systems for the health of adolescents in the juvenile justice system

Statistical monitoring with anonymized data, and continuity of care between the juvenile justice system and the health network

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Adolescent health in the juvenile justice system of the Federal District, Brazil

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What this document is

A proposal. It describes two systems in development, which do not run on the socioeducativo.bsb.br site and will not use real data without the authorizations and data protection assessments listed in Section 6. It is the personal initiative of a public servant, offered for evaluation by the institutions — **it is not an official document, does not represent the position of the Federal District Health (SES-DF) or Justice (SEJUS-DF) departments, and does not replace current regulations.**

About this translation

English translation of the original in Brazilian Portuguese. In case of any discrepancy, the Portuguese version is the reference text.

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1. The problem

An adolescent goes through many doors in a short time: apprehension, initial intake, pre-adjudication detention, a court-ordered socio-educational measure, release. At each step, health staff identify needs and refer the adolescent to the network — primary care units, community mental health centers (CAPS), shelters, the Guardianship Council (the local child protection body). The record of this path, however, is scattered across e-SUS APS, TrakCare, Jornada, SISREG, SEI and spreadsheets that do not talk to each other.

Half of all entries at initial intake are adolescents who have been there before (Federal District Juvenile Justice Statistical Yearbook, 2022/2023: 51% in 2022, 49% in 2023). And the receiving network is overloaded: in August 2026, the Federal District Public Prosecutor's Office reported more than 11,000 people waiting for a general psychiatry appointment, some of them since 2019.

- **Free-text records and manual spreadsheets.** There is no reliable way to say how many arrive with mental distress, use substances or have overdue vaccinations.
- **Referrals with no status tracking.** With no traceable deadline or owner, nobody knows whether the adolescent reached the CAPS or ran out of medication.
- **Counting visits, not people.** Those who come back are counted again; readmission and continuity cannot be measured.

Two questions, two systems

System 1 — statistical monitoring: who arrives, and what do they need?
System 2 — continuity of care: has the care that started continued?

2. System 1 — statistical monitoring

Health visits in the juvenile justice system are recorded in text documents. The system turns these documents into aggregate indicators — health profile, substance use, mental health, vaccination, referrals — to plan services and evaluate what works. It runs in five steps, always in this order:

1. **Local anonymization, first of all.** A program runs on the service's own computer, offline, and removes names, ID numbers, addresses, medical record numbers and staff names. Files are given codes. The key linking codes to documents stays outside the processing, held only by the person responsible.
2. **Standardized fields.** The same fields are extracted from every visit, using a closed vocabulary (for example: substance use, vaccination status, referral). When extraction is assisted by a language model, the model only ever receives text that has already been anonymized.
3. **Rules that check meaning.** "Denies use", a fact about someone else ("the mother uses") or an ambiguous answer becomes a pending item, never a finding. Phrases that come pre-filled in the document template are counted separately.
4. **Blinded validation.** A sample is checked by two reviewers who do not see the extractor's output; agreement is measured and disagreements are adjudicated. Only then does a number become an indicator.
5. **Aggregate numbers only.** Counts and proportions by period. No individual result leaves the processing, and very small counts are not published.

What it delivers

- Health profile by period, with source and date
- Indicators for planning and monitoring
- A measure of how often each item is actually recorded

Stated limitations

- It measures what was recorded: no record does not mean no problem
- It counts visits, not people, until System 2's identifier exists

- Documented, reproducible methods and rules

- No figure is published before validation and institutional acknowledgment
- It does not diagnose or make treatment decisions

3. System 2 — continuity of care

A local registry, controlled by the health team, that follows the flow of care: what was requested, where to, by when, who is responsible and what happened.

Principle — pointers, not copies

Clinical content stays where it has always been: in the official systems, behind their own authentication. The system keeps only the minimum the team itself enters, the status, and a pointer (case number, facility, date).

Capabilities

1. **Requests with an owner and a deadline** — every referral, test or action becomes an item with a destination, priority, owner and due date; delays raise an alert.
2. **Medication and therapy without gaps** — prescription validity (including controlled drugs under Brazilian regulation SVS/MS 344/1998), expected end of medication supply and psychotherapy schedule, tracked ahead of time.
3. **Fast response to severe cases** — explicit severity criteria at entry and exit; a risk signal triggers case discussion and active outreach with primary care.
4. **Minimal counter-referral** — the receiving service reports back in three fields, in thirty seconds, via a secure link, with no new system to learn: attended?, a short note, and where the official record is.
5. **Indicators without manual spreadsheets** — monitoring indicators come straight from the structured registry and feed System 1.
6. **Person identifier** — a stable pseudonym, with identity kept separately, to measure readmission and continuity per adolescent.

What it is — and what it is not

It is a working tool for the health team, with a data model aligned with the national **FHIR R4** standard (Patient, ServiceRequest/Task, Encounter, MedicationRequest, CarePlan, Flag), compatible with future integration with Brazil's National Health Data Network (RNDS). **It is not** an electronic health record; it does not store other agencies' clinical content; it does not replace e-SUS APS, TrakCare, SEI or SISREG; it is not a commercial product.

4. How the two fit together

Statistical monitoring works with what has already been recorded and shows where the gaps are. Continuity of care starts recording, in structured form, what today sits in free text — and, with a per-person pseudonym, makes it possible to measure readmission and continuity per adolescent, not just per visit. Over time, the second system reduces the work of the first.

5. Data protection

The data subjects are adolescents in vulnerable situations. That is why both systems start from data minimization: keep the minimum, point to the rest, audit everything.

- **Impact assessment before real data.** Health data about adolescents is high-risk processing: no use of real data before a Data Protection Impact Assessment (LGPD, Brazil's data protection law, art. 38) with the Data Protection Officer, and before institutional authorization.
- **Anonymize and pseudonymize.** Statistics only read anonymized text. Continuity of care works with pseudonyms; identity is stored separately, encrypted, and re-identification is restricted and always logged.
- **Audit trail** of who accessed what and when (LGPD, art. 37).
- **Controlled hosting.** Identifiable data does not go to a public cloud.
- **Legal basis.** Health protection by health professionals (LGPD, art. 11, II, "f"), execution of public policy (art. 23) and the best interests of the adolescent (art. 14). Anything adolescents may use follows the Digital ECA, Brazil's Digital Statute of Children and Adolescents (Law 15.211/2025): privacy by default, no profiling.

6. Implementation in stages

Each stage is useful on its own. Nothing moves forward without the matching authorization.

Stage	What it delivers	Depends on	Who authorizes
0 · No personal data under way	This site, the guides and the forms that generate PDFs in the browser; development and testing of both systems.	Nothing external.	No authorization needed: personal initiative, public content only.
1 · Use by the health team	Statistical monitoring of visits and a local registry of the flow of care (requests, deadlines, prescription and medication alerts), with a per-person pseudonym.	Data Protection Impact Assessment; controlled hosting; access policy.	The institutions responsible for the service and the Data Protection Officer, on formal record.
2 · Partner services	Three-field counter-referral via secure link; confirmation by shelters that the adolescent is in their care.	Stage 1; each service joining, one at a time.	Each CAPS, primary care unit or shelter, by formal agreement.
3 · Integrations	Case processing in SEI, structured health data in juvenile justice systems, submission to and queries from the RNDS using FHIR.	Stages 1 and 2; credentials.	The Federal District Health and Justice departments, by joint act or agreement.
4 · Other populations	Reuse of the core for people experiencing homelessness, institutional care, people released from prison and migrants.	Evaluation of stage 2; cross-service governance.	Institutional decision by the departments involved.

The juvenile justice system is the starting point because it concentrates a great deal of vulnerability in a short time — and it is where loss of continuity costs most. The same core serves people on the street, in institutional care, leaving prison or arriving from another country. The choice is one of method, not of scope.

7. Commitments

- **A proposal to the institutions.** A personal initiative of a public servant, offered for evaluation and possible adoption by the responsible institutions. If adopted, the systems move under their governance and infrastructure.
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- **Acknowledged risks.** Overload of a small team (goals sized accordingly); change of administration; regulatory change (periodic review); data leaks (minimization, pseudonymization, no public cloud, impact assessment).

Legal and policy framework (Brazil)

Statute of Children and Adolescents (ECA), art. 88, V · SINASE (Law 12.594/2012) · PNAISARI (national adolescent health policy in juvenile justice) · Federal District Operational Plan (POD/DF), 3rd ed. (2023–2026) · Law 15.413/2026 (ECA art. 11-A) · National Socio-Educational Plan 2026–2036 · Digital ECA (Law 15.211/2025) · LGPD (Law 13.709/2018).

Contact

Professionals in juvenile justice and health can write to contato@socioeducativo.bsb.br. **Please do not send any adolescent data.**