

## Chapter 1

# Introduction to Occupation-centred Practice for Children

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If we don't stand up for children, then we don't stand for much.

*Marian Wright Edelman*

### Preliminary questions

1. Why a book on occupation-centred practice for children?
2. Think about your childhood: what did you most like doing?
3. Think about your childhood: what did you least like doing?
4. What were the environments that you engaged in (e.g. home, park, school, neighbourhood)? How did they afford opportunities for occupation?
5. Did you play sports, learn an instrument or go to clubs or organised activities?
6. How might your childhood be different to those of children today?
7. How might living in the city vs country, suburb vs. high rise impact on children's occupations?

## Introduction

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The primary aim of this chapter is to set the scene for this book and in doing so to fulfil the following objectives:

1. Briefly describe the resurgence of occupation within the occupational therapy profession.
2. Outline some global trends that have occurred in parallel with the refocusing of the profession.

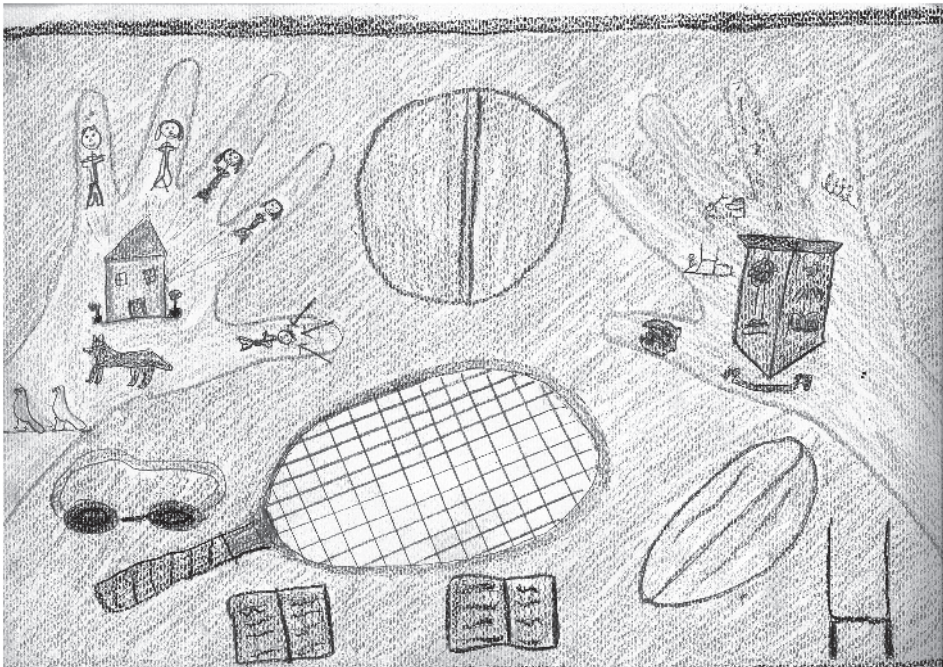
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3. Describe some of the challenges to traditional developmental theory that has historically informed occupational therapy practice with children, as well as emerging views and theories of occupational development that have the potential to better inform our practice with children and their families.
4. Identify the impact of these professional and global trends on occupational therapy practice with children.

Children engage in many social and occupational roles every day. They are variously grandchildren, children, nieces/nephews, siblings, friends, peers and playmates. In addition, they are school or kindergarten students, players or self-carers/maintainers, albeit they are developing independence and autonomy in these latter roles (Rodger, 2010; Rodger and Ziviani, 2006). Healthy active children engage in occupations relevant to these roles all the time: they play, dress, eat, manage their personal care needs, engage in household chores and schoolwork tasks and extra-curricular activities, such as soccer, ballet, scouts, tae kwon do and playing musical instruments. Children engage in these occupations in a range of environments, such as with their families at home, friends at school and in their communities (e.g. church, neighbourhoods, local parks, sports clubs) (Rodger and Ziviani, 2006).

The children's artwork in Figure 1.1 and Figure 1.2 illustrates the daily occupations of two boys, one growing up in metropolitan Brisbane, Australia and the other in a village in East Timor. Figure 1.1 illustrates the boy's daily life with family, friends and his occupations of schoolwork, playing sports, ball games, listening to music and the importance



**Figure 1.1** Daily life and occupations of a boy aged 11 years in metropolitan Brisbane. Source: Courtesy of Thomas Beirne (2008).

of school. By contrast, Figure 1.2 illustrates the outdoor environment in which this Timorese boy lives, his home, the hills, his village and his role in tending crops. These drawings demonstrate some of the many cultural differences in children's occupations and daily lives.

Typically, occupational therapists come into contact with children when there are concerns about their occupational performance (e.g. ability to engage fully in their roles, issues with performance of tasks or activities associated with various occupations, or environmental hindrances to their performance and participation). However, it has been proposed (Rodger and Ziviani, 2006) that as a profession we also have a role in advocating for children's place and rights in society, their need for health-promoting occupations and for safe, supportive, healthy environments that can optimise their occupational performance and participation. This may be through supporting campaigns promoting healthy lifestyle choices such as: having smoking banned in children's playgrounds, lobbying for traffic calming and pedestrian footpaths/pavements to enable safe walking to school, advocating for more green spaces, such as parks, and raising awareness about excessive involvement in virtual environments (e.g. computers and handheld games) which may lead to decreased engagement in physical activity and social isolation. In recent times, issues of children's health and well-being in detention centres have been raised in Australia, and elsewhere in conflict zones and refugee camps. From an occupational perspective, these environments lead to significant occupational deprivation for detainees, and impact negatively on children's development and mental health (Australian Human Rights Commission, 2014). In essence,



**Figure 1.2** Daily life and occupations of a boy aged 15 years in East Timorese village. Source: Courtesy of Jorge do Rosario (2008).

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occupational deprivation is caused by the lack of access to the typical activities, routines and objects (toys, books, games, outdoor recreation spaces) that support children's development and skill acquisition due to the restrictive institutional environment of detention centres.

There are many advocacy and professional groups whose websites provide information for parents about children's health and well-being issues such as the American Academy of Pediatrics ([http://www2.aap.org/obesity/community\\_advocacy.html?technology=2](http://www2.aap.org/obesity/community_advocacy.html?technology=2)) and Play Australia, which promotes the value of children's play (<https://www.playaustralia.org.au/>).

In addition, we have a role as individuals, health professionals and occupational therapists to advocate for children whose lives are deprived of health-giving occupations and safe environments as a result of war, natural disasters, dislocation, social disadvantage, poverty or neglect/abuse, for example the World Federation of Occupational Therapists Position Statement on Human Rights (WFOT, 2006) and the Occupational Opportunities for Refugees and Asylum Seekers (OOFRAS, 2016). The WFOT (2006, p. 1) Position Statement declares occupation a human right. Specifically it espouses a series of principles:

- People have the right to participate in a range of occupations that enable them to flourish, fulfil their potential and experience satisfaction in a way consistent with their culture and beliefs.
- People have the right to be supported to participate in occupation, through engaging in occupation, to become valued members of their family, community and society.
- People have the right to choose for themselves, to be free from pressure, force or coercion, in participating in occupations that may threaten safety, survival and health, and those occupations that are de-humanising, degrading or illegal.
- The right to occupation encompasses civic, educative, productive, social, creative, spiritual and restorative occupations.
- At a societal level the right to occupation is underpinned by the valuing of each person's unique contribution to the valued and meaningful occupations of society and is ensured by equitable access to participation regardless of difference.
- Abuses to the right to occupation may take the form of economic, social or physical exclusion through attitudinal or physical barriers, or through control of access to necessary knowledge, skills, and resources, or venues where occupation takes place.
- Global conditions that threaten the right to occupation include poverty, disease, social discrimination, displacement, natural and man-made disasters, and armed conflict.

While this book focuses primarily on the occupational therapy practitioner engaging with children and their families at an individual, group or family level, it also addresses occupation-centred practice in school environments (Chapter 11) and in the context of community-based leisure pursuits (Chapter 13). The broader benefits of occupational engagement for children who are deprived of occupations is not specifically addressed; however, readers are encouraged to consider the opportunities they may have for advocacy and engagement at a societal and political level in instances where children experience poor health (Spencer, 2008) or occupational deprivation, alienation and injustice (Kronenberg *et al.*, 2005; Whiteford and Wright St-Clair, 2005).

## Re-affirming occupation: The core of occupational therapy

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Over the past several decades, there has been a major focus within occupational therapy on the provision of client-centred services, with its counterparts in child- and family-centred practice. Emanating from Canada, the emphasis on guidelines for enabling occupation- and client-centred practice has spread throughout the occupational therapy profession internationally (CAOT, 1991; Sumsion, 1996). This is discussed at length in Chapters 2 and 3.

There has also been a resurgence of interest in occupation at the core of occupational therapy. This occurred in response to critical reflection by a number of occupational therapy theorists and researchers (e.g. Clark, 1993; Fisher, 1998; Kielhofner, 2007; Molineux, 2004; Pierce, 2001; Yerxa, 1998). This has led to the reclamation of occupation as the defining feature of our profession and practice focused on occupation, its meaning for individuals, its importance for health and well-being (Kielhofner, 2007; Molineux, 2001; Wilcock, 1998) and the importance of an individual's occupational identity as a way of defining self within relevant social and cultural contexts (Christiansen, 1999). The centrality of occupation to occupational therapy practice was referred to by some as the 'renaissance' of occupation (Whiteford *et al.*, 2000).

This in turn resulted in a call for the use of occupation-based assessment (Coster, 1998; Hocking, 2001) as a key way of focusing our resulting interventions on the healing power of occupations (e.g. particular schoolwork or play activities), rather than focusing specifically on performance components (e.g. fine-motor or visual-perceptual skills) that may not lead to significant changes in an individual's occupational functioning. Assessments that facilitate goal setting are addressed in Chapter 5 and those that are occupation-centred in Chapter 7. Paediatric frames of reference have also been developed that specifically enhance children's occupations such as Synthesis of Child, Occupational Performance and Environment in Time (SCOPE-IT) (Haertl, 2009; Poulsen and Ziviani, 2004).

Despite the international movement in occupational therapy calling for a focus on occupation, there has been discussion within the profession as to how that looks in practice (Fisher, 2014; Rodger *et al.*, 2010, 2012) and recognition that contemporary practice is not always consistent with contemporary theory (Gillen and Greber, 2014; Gustafsson *et al.*, 2014).

There has also been an increased interest in scholarship about occupation and the growth of a body of research in the field of occupational science. Since the start of the new millennium, there has been an emphasis on meeting the needs of underserved groups, with seminal books by Kronenberg *et al.* (2005) and the writing of advocates of occupational justice (Townsend and Whiteford, 2005; Townsend and Wilcock, 2004; Whiteford, 2002). Townsend and colleagues described occupational alienation (where occupational choice is limited by external forces), occupational apartheid (where individuals are denied access to meaningful occupation due to organised political or social agendas) and occupational deprivation (prolonged blocking of access to meaningful occupation due to environmental restrictions) (Polatajko *et al.*, 2007; Townsend and Whiteford, 2005; Townsend and Wilcock, 2004). Children may be caught up in warzones and refugee camps or detention centres, where they experience occupational alienation and deprivation or are victims of neglect and impoverished environments.

Coinciding with these trends within occupational therapy, a number of global influences and other changes within health/social care systems have occurred which have also impacted on our practice.

Within our discipline, there has also been a growing emphasis on children's participation as being a desired outcome of improving children's occupational performance and activity engagement. Participation is defined as an individual's involvement in life situations (WHO, 2001) and it is conceptually influenced by the individual's health condition and a range of intrinsic and extrinsic factors. Children with disabilities are at risk of restricted participation. Promoting children's participation is increasingly recognised as a clinically important goal and outcome for healthcare and rehabilitation (King *et al.*, 2003; Law *et al.*, 2004). The role of environments in children's participation is also recognised in the International Classification of Functioning, Disability and Health (ICF) and in theoretical models (Kang *et al.*, 2014; King *et al.*, 2003). There is accumulating qualitative knowledge (Bedell *et al.*, 2011; Harding *et al.*, 2009) that supports the role of environment in enhancing participation. Recent concepts such as 'helicopter parenting' and 'bubble wrapped children' are likely to have negative impacts on children's occupations and participation through restrictions on their occupational engagement (in playgrounds, walking to school, playing ball in a cul-de-sac out of sight and not being able to take risks/solve problems because of hovering parents). The move towards playgrounds that are so safe they no longer provide sufficient 'just right challenge' for children has been criticised by developmental and education experts alike (Bundy *et al.*, 2011; Hyndman and Telford, 2015).

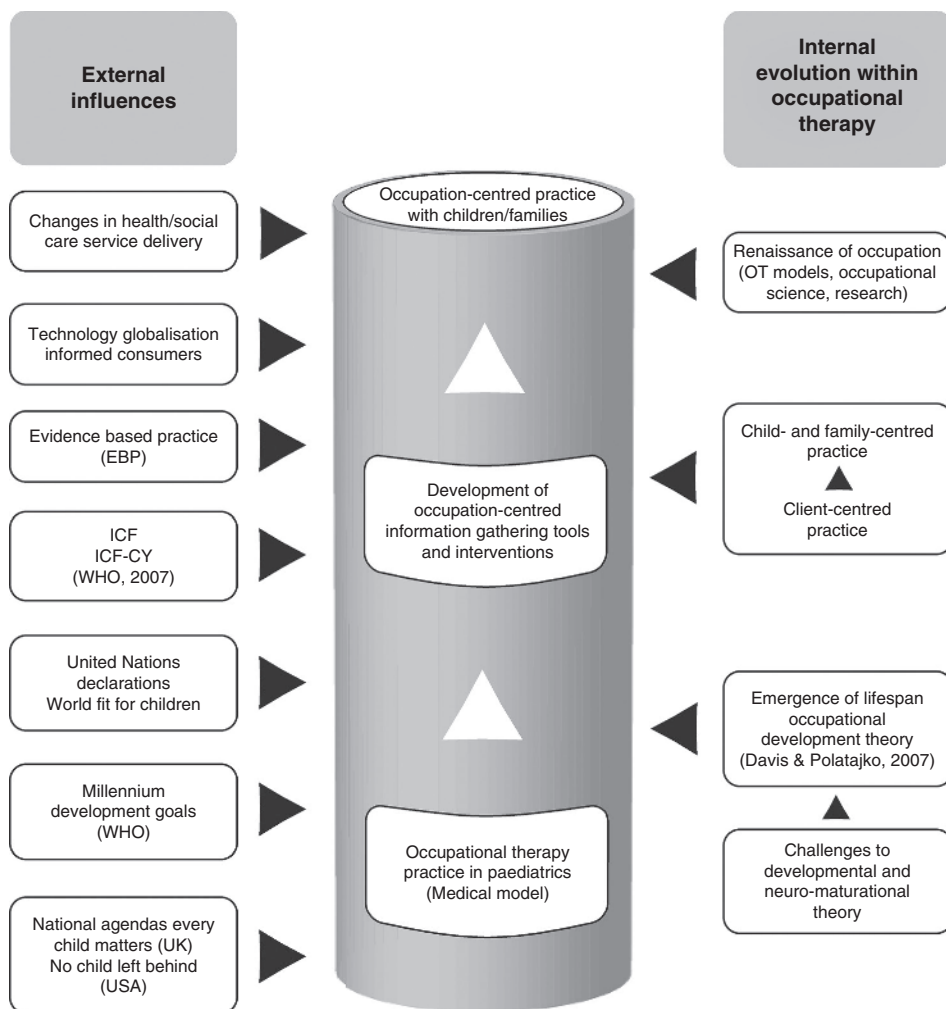
### External influences impacting occupational therapy practice

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Changes in health and social care impacting on occupational therapy practice over the past two decades include: (1) the emergence of evidence-based practice (Sackett *et al.*, 1996; Taylor 2007; Whiteford, 2005); (2) managed health care (Pierce, 2003) and health care reform (Mackey, 2014; Russi, 2014); (3) increased incidence of lifestyle-related diseases (e.g. Rippe *et al.*, 1998; Sokol, 2000); (4) diseases of meaning such as mental illness (Christiansen, 1999); (5) increasingly informed consumers; and (6) increased global awareness of human rights' abuses amongst marginalised groups, refugees, and asylum seekers (many of whom are children) (Kronenberg *et al.*, 2005). Figure 1.3 illustrates the influences both external to and within the profession that have led to the evolution of occupation-centred practice with children and families.

Media reports of schools banning physical activities such as handstands due to the risk of injury are frequent in the media (e.g. *Courier Mail*, 2014). Such societal concerns reinforce the importance of vigilance and for our profession to contribute to the enhancement of children's health and well-being.

Furthermore in service contexts, reduced funding, mergers and new models of care (e.g. clinical pathways, diagnostic related groups, managed care) have changed the way allied health services are delivered in the health/human service sectors (Layman and Bamberg, 2003). From a health sector perspective, significant changes have occurred with respect to financing and the organisation of health care (such as programme



**Figure 1.3** External influences and internal evolution within the profession leading to occupation-centred practice with children and families.

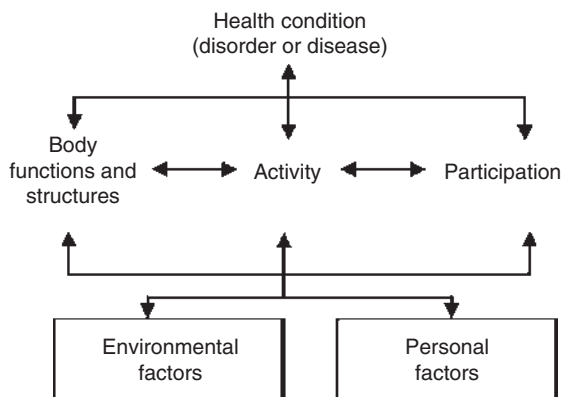
management, regionalisation) and service delivery (such as technological advances impacting on life span, quality of life and the shift of care from institutions to the community) (Layman and Bamberg, 2003).

According to Wood (1998), occupational therapists have not easily implemented occupation-centred and evidence-based practices. Wood *et al.* (2000) challenged us to think outside the box to fully meet the occupational wants and needs of persons receiving our services. Chapter 16 in this book highlights how professional reasoning can be utilised along with evidence-based and occupation-centred practice to better meet the needs of children and families. The next section turns to international classifications/frameworks and declarations that have impacted on our practice.

## International Classification of Functioning, Disability and Health (ICF)

On the international stage, the World Health Organization (WHO; 2001) released the ICF, which evolved from an earlier iteration, International Classification of Impairments, Disabilities and Handicaps (Wood, 1980). It was proposed as a scientific framework for understanding and studying health and health-related states, outcomes and determinants. Its authors also argued that it would enhance communication between health-care workers, researchers and the public by providing a classification system for a person with a given health condition (WHO, 2001). See Figure 1.4. This re-conceptualisation outlined the impact of a health condition on an individual's functioning at the levels of body structures and functions, activities and participation. The domains of activity and participation are of special interest to occupational therapists and include: learning and applying knowledge; general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interactions and relationships; major life areas; and community, social, and civic life (WHO, 2001). Equally it illustrates the importance of understanding the personal characteristics and environmental factors that impact on how a health condition may be experienced and how these may help or hinder the person's engagement in activities and participation in life situations. Under environmental factors, one needs to consider the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors, though not classified in the ICF, comprise features such as a person's gender, race and age, which are features of an individual but not part of a health condition or health states.

In adopting a 'biopsychosocial approach' (WHO, 2001), the ICF acknowledges the bidirectional impact of body functions on the ability to perform activities and hence enable participation, but also that environmental factors can impact on the performance and even modify body function and structures. International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) (WHO, 2007) was designed for the purpose of recording characteristics of the developing child and the influence of his/her environment. For children, the mediating roles of environment and



**Figure 1.4** Interactions between the components of the ICF. Source: Reproduced with permission of World Health Organization.



development are highly significant as their environments change across the stages of infancy, early childhood, middle childhood and adolescence. In addition, adults, usually parents/carers or teachers, exercise significant control over children's environments and opportunities for engagement. There are a number of assessments available for children that are compatible with the components of the ICF (see Simeonsson *et al.*, 2003). Since 2010, there has been a dramatic increase in the number of assessment tools to address children's occupations and participation. These are discussed further in Chapter 7.

The ICF classification system and framework have proven useful for occupational therapists and other health team members in conceptualising where they provide the most input/expertise in assisting the individual manage and promote his/her health and well-being. In contrast to its predecessor, it provides a more global view of health and well-being that is highly consistent with occupational therapy philosophy and practice (Baum and Baptiste, 2002), particularly with its emphasis on participation (Christiansen *et al.*, 2015). Health professionals endorse best practice interventions that effectively support a person's meaningful and satisfactory participation in real life activities and situations (Law and Baum, 1998; WHO, 2001). With the availability of the ICF-CY, occupational therapists working with children and their families can use this version to consider a child's development in health, education and social sectors (WHO, 2007).

## United Nations' declarations

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### World Fit for Children

Other global declarations have also developed in parallel with the work of the WHO, such as the United Nations' (2002) declaration of a World Fit for Children (WFFC), an action plan with 21 goals and targets for improving children's welfare (e.g. eradicating poverty, caring for every child, education, protection from harm, war, combating HIV/AIDS, listening to children and ensuring their participation, and environmental protection). Most pertinently, the declaration acknowledges the rights of children and young people for self-expression and participation in all matters relating to themselves according to their age and maturity. Consistent with this declaration, the Canadian Association of Occupational Therapists (CAOT) produced a position statement on healthy occupations for children and youth (CAOT, 2009). This position paper recognises that children and youth have the right for opportunities to develop healthy patterns of occupations and outlines CAOT's approach to advocacy for children and youth to protect and fulfil this right. In addition, the statement recognises the inequities and occupational injustices that limit children's and young people's opportunities for engagement in healthy occupations (e.g. indigenous youth, immigrants, refugees, children with disabilities and those living in poverty or care/protection). The role of occupational therapists, in advocacy and taking collective action at multiple levels (systems, provincial/state and national) raised in this document is exemplary. Occupational Therapy Australia contributed to the Australian Human Rights Commission's (2014) consultation and report *The Forgotten Children* that addressed children in detention providing advocacy for children's needs for education, right to play and to engage in developmentally appropriate, purposeful and meaningful occupations.

## Millennium Development Goals

Another important United Nations' Declaration is the Millennium Development Goals (United Nations, 2000). The Millennium Development Goals (MDGs) agreed to in 2000 range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, by the target date of 2015. These were agreed to by all the world's countries and leading development institutions. They have spurred international efforts to meet the needs of the world's poorest citizens many of them being vulnerable children. The eight goals were to:

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Improve child mortality (by two-thirds for children under 5 years).
5. Improve maternal health.
6. Combat HIV/AIDS, malaria and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

While many of these have not been achieved, a recognition of these goals taps into occupational therapy's interest in social justice and preventing occupational deprivation and alienation (Townsend and Whiteford, 2005; Townsend and Wilcock, 2004) experienced by individuals, especially children, in countries affected by war, natural disasters, occupation forces, where issues of extreme poverty, lack of education, poor health outcomes due to sanitation issues, lack of clean water, low rates of immunization, and infectious diseases are pervasive. While in Western developed countries we do not face these issues on a daily basis, there continue to be examples of children who are disadvantaged through poverty, domestic violence, abuse and neglect, and lack of appropriate housing in many large cities and in rural locations where there are large indigenous communities. Despite many successes with the MDGs, the world's poorest and most disadvantaged continue to be left behind (United Nations, 2015). (See Chapter 4 for discussion of the cultural implications of occupation-centred practice.) Until early 2016, Australia's policy on asylum seekers also resulted in a large number of children being kept in closed immigration detention while awaiting assessment of their refugee status. Children living in closed detention have very limited opportunities to engage in meaningful occupations appropriate for their age and level of development. They are not able to engage in usual family routines or eat the food they are accustomed to and are being raised by parents who, due to the circumstances, have high levels of stress and mental illness, which impacts on their ability to provide a safe and predictable environment. Furthermore, children held in detention are potentially exposed to adults engaging in self-harm and witnessing adults in deep distress. As a profession and as individuals, we still have an obligation to reflect and take action to improve the situations in which future generations of children grow and develop.

## The evolution of occupational therapy practice with children

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Paediatric occupational therapy researchers have supported the renaissance of occupation and have made very strong calls for a better understanding of the essence of children's occupations and their optimal participation. Some examples are illustrative. Lawlor (2003) called for a better understanding of the significance of 'being occupied' and the social construction of childhood occupations given that children do so many things 'with' significant others (e.g. parents, siblings, peers and teachers). She argued that occupations are socially co-constructed and negotiated with others. Hence, how children interpret and engage in their everyday social worlds is pivotal to our understanding of human development and childhood occupations. Understanding the social engagement of children during their 'doing' of occupations is critical so that we can optimise their participation. Specific frames of reference have been described that focus on enhancing social participation (Olson, 2009) in recognition of the social nature of many occupations.

Equally, Segal and Hinojosa (2006) argued that we need to better appreciate the contexts or settings in which childhood occupations occur. They researched the 'doing of homework' as an example of a productive occupation that occurred at home. In order to better assist children and parents with this (at times stressful) occupation, we need to understand the activities, tasks, values and goals of children and their parents and the social interactions that occur around the task performance. Further, Larson (2004) called for an understanding of children's work/productivity occupations and children's decisions about whether activities are work or play. Her qualitative study explored chores and schoolwork tasks and how parents graded children's participation in household tasks with age. She also documented the scaffolds, supports and supervision provided to enable task completion. The application of such occupational science research focusing on understanding occupations helps occupational therapy clinicians to better support parents and children with issues related to a broad range of occupations.

## Changing views of child development and maturation

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Coster (1998) proposed that one of the largest obstacles to practitioners becoming more occupation-centred (especially in assessment) was the dominance of the developmental model. This model promulgates development as linear and emphasises performance components and abilities and was seen as a critical determinant of children's behaviour. Major criticisms of this model are that it: (1) lacks extensive consideration of the context (environment), the characteristics of the child (person), such as a focus on personal goals, motivation, and temperament and (2) ignores multiple developmental pathways (Horowitz, 2000). The pervasive use of standardised developmental tests and interventional approaches aiming to normalise underlying developmental processes continues to feature strongly in paediatric practice many years later. Coster (1998) argued for a focus on the primacy of tasks/activities and occupations and the environmental context in organising a person's behaviour.

Alternate theories of development arising in the mid-1990s such as dynamical systems theory (Thelen, 1995) and motor behaviour/motor relearning theories (Mathiowetz and Bass Haugen, 1994) challenged occupational therapists to reconsider their views about children's developmental progress as being reflex orientated, neuro-maturational and hierarchical in nature. They also challenged the previously accepted linear nature of development expressed as genetically pre-determined ages and stages. The traditional models also failed to address the role of the environment in motor control.

Systems models such as dynamical systems theory (Mathiowetz and Bass Haugen, 1994) have been proposed based on a heterarchical model that focuses on the interaction of a person with his/her environment and emphasise task performance as well as the unique task and environmental constraints. Both functional tasks and the environmental context are used to organise behaviour. Use or modification of personal and environmental constraints leads to optimal strategy development for functional task performance. This approach arose from an ecological view of perception and action by Gibson (1966) and Bernstein (1967) both cited in Mathiowetz and Bass Haugen (1994). This ecological approach focuses on studying the person-environment interaction during daily functional tasks. Some occupational therapy models related to these concepts include the Ecological Model of Human Performance (Dunn *et al.*, 1994), Person-Environment-Occupation Model (Law *et al.*, 1996), and the Person, Environment Occupational Performance Model (Christiansen *et al.*, 2005).

Dynamical systems (Thelen, 1995) acknowledge that order and patterns emerge from the interaction and cooperation of many systems that lead to self-organisation. This model explains the relative stability of movement patterns in the face of efficient movement requiring the least amount of energy (attractor states). The reciprocity between person and environment is also emphasised. Mathiowetz and Bass Haugen (1994) proposed a systems model of motor control for occupational therapy, illustrating the interaction between the personal characteristics or systems of the person (sensorimotor, cognitive, psychosocial) and the environment (physical, socioeconomic, cultural) that lead to occupational performance (ADL, work, play/leisure) enabling role performance.

The traditional view of development incorporating invariable stages guided therapists' intervention using developmental milestones to mark progress and led to the extensive use of reflex testing and developmental assessment, with normal developmental sequences being the organising framework for therapy. While the emphasis was on working at the child's developmental level, it lacked a focus on functional tasks. These were considered to result in 'splinter skills' that would not generalise and might interfere with developmental sequences. However, contemporary theories of motor learning view nervous system maturation as only one influence with other systems having important roles to play. Motor learning relies on practice or experience leading to changes in the capabilities of the learner using random rather than blocked practice and practice of the whole rather than parts of the task. It also focuses on the use of physical and verbal guidance during practice and the use of feedback (e.g. intermittent, random and after multiple trials) (Mathiowetz and Bass Haugen, 1994).

Ongoing research with individuals with disabilities and in naturalistic versus lab/clinic-based settings is needed. Cognitive Orientation to daily Occupational Performance (CO-OP) (Polatajko and Mandich, 2004) is an example of an occupation-centred intervention based on contemporary views of development and motor control

that has been evaluated with children with a range of occupational performance problems (see Chapter 8). The contemporary approaches to motor skill acquisition focus on the goal of helping clients to become competent problem solvers when they engage in functional tasks within relevant performance contexts. Similarly Perceive, Recall, Plan and Perform (PRPP) (Chapparo and Ranka, 1997a, 1997b) and Occupational Performance Coaching (Graham *et al.*, 2009) provide other examples of occupation-centred interventions discussed in this book (Chapters 9 and 10 respectively).

Occupational therapists, such as Humphry (2002), claimed that we know little about the role of occupational engagement as both a process for and outcome of development, nor about children as developing occupational beings. She challenged us to research occupation and to foreground our occupational knowledge with respect to how early childhood health and educational professionals are learning to view children's developmental progress. Humphry (2002) argued that there has been an over reliance by occupational therapists on other disciplines such as psychology for our understanding of child development, maturation processes and a lack of reliance on understanding the impact of context and dynamical systems theory. She also proposed that occupational engagement leads to the enhancement of developmental processes, skill acquisition and performance refinement. Through occupation or children's 'doing' their development progresses, skills are acquired and tasks/activities are mastered, hence occupation is regarded as a crucible for development. Further, she cogently posited a conceptual model that development of the occupational being does not just occur within the child. Participation in family life and sharing activities with significant others have been proposed as crucial developmental mechanisms. Hence, the importance of context and social interaction are highlighted as critical to children's learning about and doing of occupations (Muhlenhaupt, 2009; Olson, 2009). These are congruent with family- and child-centred practice and the use of naturalistic settings involving the child's natural social partners.

## Emerging views about occupational development

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Only since the beginning of this century has there been a significant focus on occupational development across the life span as distinct to traditional views of the linear stages of child and adolescent development. Davis and Polatajko (2006) described occupational development as a 'systematic process of change in occupational behaviours across time, resulting from growth and maturation of the individual in interaction with the environment' (p. 138). This development results in a life course occupational repertoire that is marked by changes in the specific occupations that individuals perform across the life course. They argued that infants are occupational beings from the outset and that the occupations engaged in develop and change over time. They are unique to the individual as they result from the interaction of the person and his/her skills, talents and interests with the opportunities and events that life presents. Typically, these occupations change gradually and predictably over the course of development and as a result of transitions but change may be sudden due to loss, disease or injury (Polatajko *et al.*, 2007). Davis and Polatajko (2006) postulated that occupational development occurs at micro, meso and macro levels.

*Micro-occupational development* focuses on developing occupational competence along a continuum of novice to mastery for a specific occupation (Davis and Polatajko, 2006) and repeated for each new occupation. While the trajectory and speed is individual, it is dependent on the child's ability, capacity, growth and maturation as well as the supports and opportunities in place to enable competency development. *Meso-occupational development* focuses on developing an occupational repertoire. This repertoire of developing competence and mastery changes across the lifespan, expanding and shrinking. Innate drive, exposure, resources, opportunities and values influence the development of this repertoire (Wiseman *et al.*, 2005). *Macro-occupational development* or development of occupations results from exposure and opportunities. This development occurs across time with species evolution (Davis and Polatajko, 2006). This may be exemplified by the development of new occupations in recent years such as listening to iPods® and play using Nintendo Wii®, and virtual reality activities which did not exist several decades ago. *Occupational transitions* occur when there is a shift from one set of occupations to an alternative set as a result of life events or developmental processes such as moving from preschool/kindergarten to school. These occur at individual, group (e.g. nuclear to single-parent family) or societal levels (e.g. unemployment in a small town due to a particular industry closing down) (Polatajko *et al.*, 2007).

Gender, culture, socioeconomic, societal and other factors influence occupations across the life course, such as required time in the armed forces for young men at age 18 years, the increased age of women having their first child in developed countries or leaving the labour force for child-raising purposes (Polatajko *et al.*, 2007). Occupational loss is described as an imposed or unanticipated transition which typically results from environmental factors (e.g. parental unemployment leading to children not being able to continue with extracurricular activities) or permanent or temporary loss of body functions due to illness/injury (e.g. child who acquires a head injury after a bicycle accident or is disfigured as a result of burns). Macro environmental losses may occur as a result of natural disasters such as destruction after a tsunami, bushfire or earthquake leading to relocation and issues with basic survival needs (e.g. food, water, shelter and basic care routines) (Polatajko *et al.*, 2007). It is important for occupational therapists working with children and adults to keep abreast of this growing theoretical understanding of development from an occupational perspective, focusing on occupational roles, associated occupations and the environmental impacts on development. Further theoretical and research work in this area will enhance our capacity to be more occupation-centred in our practice.

## Re-focusing occupational therapy with children

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Arguably in the past, the occupational therapy profession has failed to realise that one of our most significant contributions is our focus on children's roles, their occupations, the contexts in which they live, work and play, as well as their interests, priorities and goals. Occupational therapy as a profession offers a unique approach to intervention which focuses on occupational performance and participation when children's lives

are impacted by illness, disability, social or environmental deprivation or disadvantage. This book promotes an occupation-centred approach to practice with children and their families. It introduces an occupation-centred occupational therapy process for working with children based on existing processes utilised with adults. Conceptually, occupation-centred practice for children allows occupational therapists to focus appropriately on the child (and family), the child's and family's occupations and environments during the stages of information gathering, intervention and evaluation within a client-centred practice framework. This process is described in detail in Chapter 2.

By focusing on the person, his/her environment and occupations, the therapist is able to optimise the child's and family's participation in relevant life situations, the latter being the critical outcome of any occupational therapy intervention. One of the key messages of this book is that to be *relevant* occupational therapy intervention must extend beyond the acquisition of skills and occupations to the optimisation of children's engagement in their life roles (Case-Smith, 2015). The ultimate aim of occupational therapy is to promote children's competence and participation at home, school and in their communities. An individual child's level of participation reflects the child's capacities, the opportunities available, the social and physical supports present (environmental affordances) and the family's and society's values about participation. Drawing from the literature, key characteristics of occupation-centred practice for children are introduced in Chapter 2. Knowing these characteristics will enable occupational therapists to evaluate whether their daily practice with children is truly occupation-centred, enabling practitioners to make informed choices about what they do and how they do it.

## Conclusion

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In applying an occupation-centred approach to practice with children, it is important that therapists are cognisant of contemporary frameworks in health care, such as the ICF, concepts such as evidence-based practice, and child and family-centred practice, and are aware of the global trends that have impacted service delivery in health/human services sectors. In addition, such practice focuses on the activities and participation levels of the ICF and on occupations related to children's social and occupational roles. Therapists must also consider the evidence suggesting the theoretical limitations of traditional views of child development and neuro-maturation and be open to contemporary theories of motor behaviour and learning, occupational development and child- and family-centred practice. This chapter has also challenged occupational therapists to act as individuals as well as members of a profession to advocate for societies that better enable children's participation in safe and supportive environments and developmentally appropriate life situations. This requires a global consciousness that recognises the impacts of natural disasters, poverty, detention, ill health and social, cultural and temporal environmental stressors on children's optimal development and participation and a willingness to advocate for children in these contexts.

### Reflective questions

1. Why are occupational therapists in a pivotal position to advocate for children's health, well-being, occupations and participation?
2. What are some of the internal and external factors that have influenced the evolution of the profession and the focus on occupation-centred practice?
3. Why is the ICF framework so critical to occupational therapy practice?
4. How do concepts of micro, meso and macro occupational development differ from traditional views of development?

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