Occupation-focused interventions based on child/family-chosen goals

Evidence summary

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About this resource

This evidence summary is aimed at occupational therapists working with children, young people and families. It is accompanied by an infographic to provide an easy-to-understand overview with minimal text. The evidence presented below is taken from clinical practice guidelines and systematic reviews.

This resource brings together evidence that informs occupation-focused approaches to achieve goals identified with children, young people and families and has been developed in line with professional standards. [1, 2] Evidence has been uncovered that relates to the efficacy of interventions in relation to common diagnoses and specific occupational categories.

Key terms defined

Occupation-focused – interventions that have occupation at the core and actively engage the person in occupation. [3, 4] The terms task-oriented or task-specific interventions are also used.

Goal-directed – intervention/training/programmes to improve functional task performance. [5]

Goal – 'measurable and meaningful, occupation-based, long-term or short-term aim directly related to the client's ability and need to engage in desired occupations.' [6, p77]

Is this intervention effective?

Occupation-focused interventions have been shown to be effective for children and young people from 0-21 years with a broad range of conditions and in a range of contexts, including:

Attention Deficit Hyperactivity Disorder specifically using group sports and play interventions, [7] social skills. [8]

Autism using engagement in self-care activities and routines, group sports, play interventions. [7, 9, 10]

Cerebral palsy using home programmes, [5] engagement in self-care activities and routines [7] and goal-directed interventions. [5, 11, 12, 13]

Childhood stroke using goal-directed interventions. [14]

Developmental coordination disorder (DCD) using Cognitive Orientation to Occupational Performance (CO-OP), [5] handwriting task practice. [5, 15]

Intellectual disability using home programmes, [5, 16] functional living skills. [7]

Idiopathic arthritis using functional activities programme, engagement in self-care activities and routines. [7]
Mental health using occupation and activity-based interventions. [17, 10]
Typically developing children with handwriting difficulties using handwriting task practice. [18]
Infants from socially disadvantaged backgrounds using attachment and pro-social behaviours. [10]
Pre-term and early intervention using attachment and emotional regulation. [19, 12]

Occupation-focused interventions have been shown to be effective with a variety of tasks and compared to body function-oriented approaches, show better performance outcomes [15] with goals achieved in less time. [15, 5] The categories from the *Occupational therapy practice framework* [6] have been used to group the occupations and present supporting literature.

Academic participation (education)
- Literacy and educational participation [18]
- Handwriting [18, 20, 21, 22]
- Teacher-child interactions and relationship quality [10]

ADL, iADL, rest and sleep (self-care) [23]
- Self-care routines [7]
- Occupational engagement (dressing, grooming, eating, hygiene, pain management) [7]
- Sleep [7]

Play and leisure
- Play [9, 7]
- Group sports [7]
- Computer and video games [7]

Social participation
- Social skills and function [8, 24, 18]
- Teacher-child interactions and relationship quality [10]

What equipment is required?

No specific equipment is required other than any equipment relating to the occupation of interest. It is important to use the materials available to the child and family in the natural context of the occupation.

What processes support the success of this intervention/method of service delivery?

- Begin with a task-specific goal that is meaningful to the child and family. [5, 13, 15, 7, 10, 12]
- The child needs to be actively doing. [15, 5]
- Repeated practice of real-life activities in natural environments. [5, 13, 10]
- Active involvement of parents/carers. [15, 7, 18, 12]
- Scaffolded to be the 'just right challenge' to support success and enjoyment. [5]

Consider related interventions to enhance success, for example:
- peer involvement in intervention in the classroom [18, 10]
- parent training (mother-infant attachment training, play consultancy) [19, 10, 25]

- teacher training [10, 26, 27]
- modelling of play behaviours by an adult, peer or by video [9]
- imitation of the child's play using the same materials, verbalisations and intonation. [9]

What qualifications, skills and training are required?

Occupational therapists are qualified to use this approach. No specific further qualifications or training are required.

What is quantity of time, frequency and duration required for effectiveness?

The evidence recommends interventions should take place several times a week over the course of weeks or months.

The quantity, frequency and duration vary depending on the population and the approach being used. Some examples include:

- task-specific interventions based on three goals for children with cerebral palsy (15-25 hours, of which more than half can be family-led practice). [13]
- task/activity-oriented interventions for children with DCD (2-3 times/week for 4-18 weeks). [15]
- handwriting (at least two practice sessions/week for at least 20 sessions). [20]
- home programmes (every other day for about 15 minutes over 2-6 months). [28]
- PLAY (Play and Learning for Autistic Youths) consulting therapy for children with a diagnosis of ASD and PDD (3 hours/month over 12 months. The 3 hours include coaching, video modelling and consulting on parent-child interactions). [25]
- home-based cue-based responsive care for preterm babies (7.5-10 hours over 8 weeks to promote attachment). [19]
- Occupational Performance Coaching (4-12 sessions). [29]

What is the time commitment for the service provider?

The number and duration of sessions will vary according to individual need and service provider. Therapists may be required to allow travel time to carry out sessions in the natural context. Every approach should include:

1. an initial session to agree child and family-centred goals
2. collaboration with the team around the child
3. intervention sessions (length appropriate to the specific dose for relevant approach)
4. outcome measurement. [30]

What is the time commitment for this intervention for the family and child?

Family time commitment is greater than that of the therapist. Typically, it would include:

1. an initial session to agree goals
2. attending 'team-around-the child' meetings, plus travel time if required
3. attending therapist-led intervention sessions (length appropriate to the specific dose for relevant approach), plus travel time if not at home
4. practice in the natural context
5. outcome measurement. [30]

What settings are used to carry out this intervention? Are specialist venues required?

Natural contexts such as home, school or community environments have been shown to be the most effective settings for this intervention. [7, 18, 13, 10, 5, 12]

Cautions and contraindications:

Occupation-centred interventions require significant involvement from children and families in their own time and context. It is important to ensure that the family priorities, context and capacity are central to intervention planning.

Therapists and the team around the child need to consider the parent/carer's readiness to engage with the chosen intervention and be explicit about the time commitment required from the child and family. There may be potential for families to feel overwhelmed or burdened by the time commitment required.

Resource/cost implications:

Occupation-focused interventions based on child/family-chosen goals have been shown to result in larger functional improvements in a shorter time compared with general interventions aimed at body functions. [5]

Interprofessional considerations:

A team approach should be used, working in partnership with the child/family. [13, 14] For example, goal-oriented therapy and functional training have also been found to be effective in physiotherapy practice in addressing functional goals in activity and participation. [24]

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