6

Social Services Occupational Therapy Services: Paediatrics

Gwen Joseph and Jennifer Gordon

Background to Children's Occupational Therapy services in social care

Children's Social Care Occupational Therapy Practice is governed by several pieces of legislation. The Children's Act 1989 and 2004 help to promote the welfare of the child and support a Child in Need. The legislative definition of a Child in Need is a child with disabilities that are physical, sensory, emotional, behavioural or a learning disability. The Autism Act 2009 and the Chronically Sick and Disabled Act 1970 apply to adults; however, many UK children social services provide for either a child or young person up to the age of 25 if not in full-time education. In addition, some social care OT services also use the definition of a disability as defined by the Equality Act 2010 to outline their eligibility criteria – those with 'physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'.

Many families typically approach children's OT social care services for adaptations to their home to best meet the needs of their child. The Housing Grants, Construction and Regeneration Act (1996) provides government funding via a Disabled Facilities Grant to fund these works. The grant is managed and assessed by each local authority and any proposed or recommended works must be deemed as 'necessary and appropriate, reasonable and practicable'. Local authorities decide how the funds are used and may have subsidiary or alternative funding streams to meet the local needs of their residents.

The increased awareness of services for children and young people has had a knock-on impact on the provision of children's occupational therapy. It has been anecdotally noted by the authors that some areas in London with large settler communities have a higher demand for occupational therapy, but the families are rarely of Caribbean descent. When Caribbean families finally do approach OT services, many cite not being heard or having requests repeatedly denied as reasons why they don't access OT services. Instead, they problem-solve and self-fund or use charitable organizations and the third sector to meet their individual needs. Shockingly, both authors have over 40 years' combined experience but have assessed only a handful of children of Caribbean descent in the totality of their professional careers.

Service provision and local eligibility criteria

This is defined by each local authority to meet the needs of the residents. Children's occupational therapists in a social care setting assess for a child's access to essential facilities within the home, such as the bathroom, bedroom and living areas. Many older children with disabilities are lifted and carried by their parents, but an OT can work with the family to address safe equipment and adaptations to minimize moving and handling risks. The OT can also assess for developmentally age-appropriate bathing, toilet and seating that are not commercially available/high street products. Some local authorities will fund only home seating if not provided by health or school services. Local policies will also determine whether equipment or funding can be provided for home safety items, small aids and sensory toys or equipment. For items that are not provided by the service, families are signposted to charitable organizations or other services for funding assistance.

Families that are struggling to meet the needs of their child with sensory needs or challenging behaviours often approach Social Care for assistance. These difficulties can cause a strain on all family members especially siblings, and parents often feel that alternative housing or specialist adaptations and equipment will solve all their problems. However, parents are expected to initially engage with appropriate services such as CAMHS (Child and Adolescent Mental Health Service) and the resources available in educational settings. Local agreements and policies will define how community services work with the social care OT to ensure the most appropriate intervention for the child. A multi-disciplinary approach will help identify any social or environmental factors that may be contributing to the child's behaviour, e.g. parenting skills that will need to be addressed by other services.

Challenges to the service

Managing parental expectations can be a main source of conflict and a barrier to providing timely interventions in social care. Families with complex needs or social care concerns are already navigating bureaucracy and what they view as unnecessary barriers. In London, there is a great demand for housing and some families in large settler communities struggle with housing needs, such as overcrowding or unsuitable housing conditions. Such needs complicate the OT role as recommendations for equipment or adaptations are restricted by the limitations of the home environment and/or tenancy. Local authorities with housing stock

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shortages but with a high local demand will create local policies grounded in housing legislation to ensure the families most in need will be supported. The OT will be expected to make clear recommendations based only on the needs of the child. This is often a challenging situation as moving handling needs or essential equipment cannot be safely addressed or provided due to the property or the environment.

Families will often request equipment or adaptations that are not clinically justified by the occupational therapist. The challenge can increase when a therapist or other professional has made recommendations that contradict the remit or decision of the Social Care OT. Such disagreements with family and other professionals can trigger official complaints or correspondence from local MPs if the family has escalated their concerns. Occasionally a family will legally challenge the OT service if they feel their concerns and needs have not been met. All occupational therapists are expected to maintain the professional standards as outlined by the governing body, the Health and Care Professions Council (HCPC), which will be crucial if OT's judgement is ever subject to legal scrutiny.

The macro, meso, and micro context

Over-diagnosis of Social, Emotional and Mental Health (SEMH) in school-aged children

St Cross College (2019) reviewed the findings of a report written by Professor Strand, which also concluded that Black Caribbean and Mixed White & Black Caribbean pupils were twice as likely as their White British peers to be identified with Social, Emotional and Mental Health (SEMH) needs. The report, led by Professor Steve Strand at the Department of Education, University of Oxford, examined all school-aged children (5–16 years) who had been identified with various types of Special Educational Needs (SEN) across England.

The findings suggested that some Black Caribbean children may have been subject to an inappropriate or overly narrow curriculum due to unwarranted over-identification, particularly during secondary education. However, variation between schools played a more significant role in the over-representation of Black Caribbean and Mixed White & Black Caribbean students with SEMH needs. This was especially evident in the secondary phase and in schools located in areas of high poverty, which may have reflected differing local

contexts such as elevated crime rates, gang activity, or variations in school disciplinary practices.

The project also produced reports for each of the 150 Local Authorities (LAs) in England, which highlighted ethnic disparities in SEN identification rates. While differences between LAs were not the primary factor driving disproportionality, they were nonetheless present. For example, Black Caribbean pupils were less likely than White British pupils to have been identified with SEMH needs in Newham, whereas in Kensington and Chelsea, they were three times more likely to receive such identification.

Richardson (2019) also commented on the report, stating Professor Strand explained that over-diagnosis of SEMH needs cannot be fully explained by socio-economic factors or early childhood development. He noted concerns that some children may be misidentified. Professor Strand also suggested that school disciplinary policies might unintentionally contribute to the over-identification, questioning whether behavioural perceptions or external factors such as gang culture might play a role. He emphasized the importance of schools reviewing their policies to prevent systematic bias in identifying SEMH needs.

According to the Department for Education (2024), pupils identified as 'Traveller of Irish heritage', 'Black Caribbean', and 'Other Black background' had the highest proportions of Education, Health and Care (EHC) plans, at 7.3%, 6.4%, and 6.3% respectively.

Among pupils with EHC plans, Autistic Spectrum Disorder (ASD) was the most frequently recorded primary type of need, accounting for 132,200 pupils (33.0%). In contrast, for pupils receiving SEN support, the most common primary type of need was Speech, Language and Communication Needs (SLCN), with 291,700 pupils (25.6%) affected.

These statistics may help explain the relatively lower representation of children of Black Caribbean heritage being assessed by social care occupational therapists. Their primary needs often relate to speech, language, and communication, which may not typically prompt social care involvement. For those with needs on the autism spectrum, concerns at home might focus on safety; however, families may be proactively addressing these needs themselves, such as by installing window restrictors or additional locks on doors.

Case study: Marcus

Background information given by the social worker

The social worker attended a duty drop-in session, the established model within the service for discussing urgent referrals. He shared concerns regarding Marcus, the eldest of three siblings, who lived with his parents in a third-floor flat. Marcus's mother was British-born of second-generation Jamaican heritage, while his father, originally from Antigua, relocated to the UK at the age of 12 to join his parents. Marcus's younger siblings were aged 5 and 3.

During the session, the social worker explained that the mother was reluctant to engage with him and that both parents had minimized the incident in which Marcus left the home, describing it as a one-off event and stating they did not require additional support. The social worker expressed significant concern based on his observations during an earlier assessment visit. He described the home environment as chaotic. The younger children were seen climbing onto window ledges, jumping off the furniture, while disregarding verbal instructions from their mother. Marcus was observed repeatedly opening the fridge, removing food, and discarding it onto the floor, which the mother passively cleaned up without addressing the behaviour. Upon the father's return, his approach was markedly authoritative; he commanded the children to sit quietly and immediately sent Marcus to his room.

The social worker was concerned the family were not receiving appropriate support. He noted that Marcus had delayed language development and had only recently been diagnosed as being on the autism spectrum following limited progress at school. He expressed concern regarding the mother's emotional presentation and her apparent lack of insight into the potential risks associated with Marcus leaving the property unsupervised. Given the level of concern, the case was accepted for an urgent OT duty visit. The author arranged to visit the family the following afternoon, at a time convenient for the mother.

Initial engagement with Marcus

Initial engagement with Marcus proved challenging, as he appeared apprehensive and cautious. Attempts to engage him were met with no eye contact or verbal response. The purpose of the initial engagement was to observe Marcus's level of understanding and his ability to communicate, either verbally or through non-verbal gestures. His mother explained that Marcus usually enjoyed having a yoghurt after school, and he was encouraged to leave

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his bedroom with the offer of one. As he followed his mother into the open-plan kitchen/lounge area, where his younger siblings were finishing their own yoghurts, Marcus repeated the phrase 'yoghurt, yes'. When his mother placed the yoghurt on the table, Marcus began flapping his hands while he repeated the phrase, he did not sit down at the table. His mother explained that she typically needed to remove his siblings from the table before Marcus would sit, if this was not done promptly, his hand flapping and verbal repetition often escalated. She described these behaviours as his way of expressing his needs and preferences.

My initial observations of Marcus were that he avoided interaction with others; demonstrated no direct eye contact; repeated phrases; had difficulty making his needs known with words; and demonstrated self-stimulatory behaviours, e.g. his hand flapping, possibly to manage the anxiety he was experiencing with his brothers seated at the table where he wanted to sit.

Mother's description of the incident when Marcus absconded

Marcus's mother reported that she was alone at home with the children on a hot day during the school holidays. As she found it challenging to take children out by herself, her usual routine involved opening the balcony door and supervising them as they played, allowing them to move freely between the family living space and the balcony while she remained nearby.

On this occasion, the youngest child developed a sudden upset stomach and began to vomit. In response, mother reported bringing all of the children inside, locking the balcony door, and carrying the youngest child, through the property to the bathroom for cleaning. Afterwards, she changed the child's clothes and settled him in the bedroom. She went into the kitchen to prepare warm water to help soothe his stomach. She observed the 5-year-old sitting in the living space watching television and assumed Marcus was in his bedroom. After settling the youngest child to sleep, she returned to the living space and went to check on Marcus. Discovering that Marcus was not in his bedroom or anywhere else in the flat, she contacted his father at work, who advised her to call the police.

She remained at home with the other children and did not leave the property to search for Marcus. Marcus's father returned home from work. The police contacted the family to confirm that a child matching Marcus's description had been found. His father went along to the local police station to collect him. Marcus was located approximately half a mile from the

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family home, walking alongside a large park. He had crossed two residential roads, which mother reported were not particularly busy roads, as Marcus had no safety awareness.

Mother's reflections and concerns

Marcus's mother reported that she may have forgotten to engage the top latch on the front door after her husband left for work, which may have allowed Marcus to leave the property undetected. She stated Marcus had never previously attempted to leave the flat and expressed confusion as to why he chose to do so on that day. She speculated he may have been enjoying playing with his toys on the balcony and became upset when they had to go back inside. She acknowledged the reason remained unclear, as Marcus was unable to communicate his thoughts or motivations. There were no CCTV cameras in the courtyard so it was unclear how Marcus left the courtyard and his mother thought he may have followed someone through the open gate.

Marcus's mother shared that, having experienced his developmental journey, she believed her youngest son was also on the autism spectrum. At 3 years old, he had no verbal speech, demonstrated little to no awareness of safety, and primarily communicated through screaming, lying on the floor and having tantrums when his needs were not understood. She reported that she had expressed her concerns to her husband, but he dismissed them, suggesting the children's behaviours were a result of her being 'too soft', rather than indicative of developmental difficulties.

Marcus's mother reported she had made several attempts to introduce a second bed into Marcus's bedroom with the intention of moving his 5-year-old brother in with him. However, these efforts were unsuccessful. She explained that although both children would initially settle to sleep, at some point during the night Marcus would wake, physically remove his brother from the bed, dragging him onto the floor, prompting his brother to run to the parents' bedroom in distress. As a result, the sleeping arrangements involved both younger brothers sleeping in the master bedroom with their parents. The room was furnished with a double bed and a single bed placed adjacent to it, one child to sleeping at the head and the other at the foot of the single bed.

Mother stated that the social worker had offered support in the form of short breaks for Marcus specifically, a four-hour weekend session where he could participate in activities

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outside the family home, providing her with some respite. However, she expressed uncertainty about accepting the offer, she was apprehensive about how she would explain her need for a break to Marcus's father. She was the primary caregiver and had left her full-time job to care for her young family, due to the challenges they experienced in settling Marcus into nursery and later school, prior to receiving a formal diagnosis.

Marcus's functional abilities

Communication and language

Marcus was using only two to three words to express his needs and had only begun to combine two words together within the six months prior to OT assessment. He could name certain objects or food items, but he would not always verbalize them when prompted. On occasions, he would pull mother by the hand and point to what he wanted without using words. At other times, Marcus engaged in echolalic speech, repeating the same phrase over and over with increasing vocal intensity.

His mother indicated he demonstrated basic understanding and was able to follow simple instructions such as 'go to the toilet', 'sit at the table', or 'go to your bedroom'. Marcus was receiving speech and language therapy at school. His mother reported therapists had introduced the use of a communication board and had begun teaching him basic signs to support his expressive communication.

Cognitively, Marcus presented with some developmental delays. His mother reported challenges with attention and focus, noting that he had recently begun receiving support in school following a diagnosis of Autism. The diagnosis would lead to the development of an Education, Health and Care (EHC) Plan to support his ongoing educational needs. Marcus appeared to rely more on behaviour than spoken language to communicate his needs and preferences. These behaviours included hitting, biting and scratching his siblings. She explained that managing this had been particularly challenging, especially as the youngest child, frequently attempted to play with the same toys as Marcus.

Physical abilities

Marcus demonstrated age-appropriate gross motor skills. Marcus's fine motor skills were still developing. While he was able to use a spoon to feed himself, he experienced difficulty with

tasks such as pencil grasp for mark-making. He was also not yet able to manage fastenings such as zips or buttons independently.

Marcus was reported to be incontinent of both urine and faeces and when out of the house they would use nappies to manage his continence. His mother explained that he did not yet indicate when he needed to use the toilet. To support toilet training, he was taken to the toilet every two hours at home.

All of Marcus's daily living activities were supported by his mother. Due to the demands of the morning routine, she reported she assisted him with showering in the evenings to ensure he was clean and ready for school the next day. Marcus did not attempt to engage in washing activities. Marcus was not able to dress himself. When his clothing was laid out on the bed his mother reported, he could follow a simple instruction such as 'pick up your top', but once he had the item in hand, he appeared unsure of what to do. Mother reported Marcus was able to follow concrete, body-part-specific directives, i.e. 'put your arm out' or 'lift your leg', indicating he understood simple, direct instructions linked to physical movement and body awareness. However, he did not appear to understand more complex, functional instructions, e.g. 'put your top on'. Marcus had recently been referred to the Health Occupational Therapy service for support with strategies to develop his washing and dressing skills and was awaiting assessment. Marcus was able to undress. His mother reported that she often found him in a state of undress in his room, though the reason or trigger for this behaviour was unclear.

Contextual factors

Marcus's mother expressed uncertainty about the support she hoped to receive from Occupational Therapy. Her primary concern was that, following the incident in which Marcus absconded, the involvement of police and other professionals might lead to perceptions that she was struggling to care for her children.

She shared that her husband held a different perspective on Marcus's needs. He believed Marcus was simply developing more slowly and would benefit from a firm and more disciplined approach to building his independence. Marcus's father arrived towards the end of the assessment and shared his perspective, which was shaped by cultural beliefs and his own upbringing in Antigua. He explained that he was unfamiliar with the concept of Autism

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and described in his experience, children like Marcus were seen as ‘a bit slow’ and expected to catch up through firm teaching rather than receiving additional support.

In that moment, the most effective tool I had was my own presence and ability to listen with openness and empathy: the therapeutic use of self (Taylor, 2020). I focused on creating a space where both parents felt heard and respected, acknowledging differing views without judgement. I acknowledged Marcus’s father’s viewpoint and gently explored the differences in understanding around neurodevelopment and Autism, recognizing how cultural beliefs can influence perceptions of a child’s needs. By building trust and engaging in a calm, respectful dialogue, I was able to begin bridging the gap between cultural perspectives and clinical understanding, laying the groundwork for collaborative planning to support Marcus’s development.

Goals set

- To reduce the risk of Marcus leaving the property unsupervised by implementing appropriate environmental safety measures and supporting parental awareness and consistency in maintaining these measures.
- To implement environmental modifications to reduce risk of Marcus accessing unsafe areas within the home.
- To support Marcus’s parents in building confidence and consistency in managing his safety at home, through education, short breaks, and collaborative planning with services.
- To support Marcus’s parents in developing and consistently implementing strategies that reduce Marcus's unsupervised access to the fridge and promote healthy eating habits at home.

Case study: Use of the KAWA Model

What is the KAWA Model?

1. The Kawa Model is a therapeutic method developed in Japan by occupational therapists.
2. Kawa is the Japanese word for ‘river’.

3. The Kawa Model uses the natural metaphor of a river to depict one's life journey. The varying and chronological experience of life is like a river, flowing from the high lands down to the ocean. Along its meandering path, the quality and character of its flow will vary from place to place, from instance to instance. Occupational therapists try to enable, assist, restore and maximize their clients' life flows. See About – The Kawa Model

Key elements applied to a child with Autism

1. **The River (Life Flow/Well-being):** Represents the child's daily routines, emotional regulation, learning, play, and engagement with others. A narrow or obstructed flow may reflect difficulties in communication, self-regulation, or participation in school and social environments.
2. **Riverbanks (Environment):** Include the physical and social environment: home, school, therapists, teachers, and peer relationships. These either support or restrict the child's development
3. **Rocks (Obstacles and Challenges):** Represent the child's specific difficulties, such as:
    - Sensory sensitivities.
    - Delayed speech and language.
    - Meltdowns or behavioural issues.

    These are the main blockages in the river, disrupting the 'flow' of daily life.

4. **Driftwood (Personal Traits and Resources):** These include the child's strengths and characteristics:
    - Love of routines.
    - Strong memory for detail.
    - Interest in specific topics (e.g., trains, animals).
    - Supportive parents.

    These can either help clear obstacles (move rocks) or, if misunderstood, contribute to challenges (e.g., rigid thinking).

5. **Spaces Between (Therapeutic Opportunities):** This is where the OT works, finding room for the 'water to flow' by:
    - Adjusting the environment.
    - Building routines that support independence.
    - Coaching caregivers to reinforce positive interactions.

Benefits of using the Kawa Model in Autism:

- Focuses on function and participation, not just symptoms.
- Allows family-centred care, including the perspectives of caregivers.
- Flexible for non-verbal or minimally verbal children.
- Helps the OT set goals that are personally meaningful and culturally relevant.

Occupational Gifts

Caribbean gift to the reader from Gwen Joseph: my go-to St. Lucian breakfast: plantain, salt fish, and Johnny cakes

These three simple ingredients create an amazing breakfast dish renowned throughout the island of St Lucia.

Plantain Salted cod Plain flour

Source: altinosmanaj/123RF (left); Edward Westmacott/Shutterstock (middle); Rachel Husband/Alamy Stock Photo (right)

In St. Lucia, a Johnny cake is a delicious, flattened round of unleavened dough, fried until golden brown. Made from a simple mix of flour, butter, sugar, water, and baking powder, the magic happens in the frying. The result? A crisp, crunchy exterior and a soft, chewy interior, with just the right touch of sweetness. One interesting theory suggests that the name 'Johnny cake' evolved from 'journey cake'. These portable, long-lasting breads were ideal for travellers and could be prepared in advance and eaten over several days, a practical and tasty solution for long journeys.

Salted cod or salt fish (as it is endearingly known) is a preserved fish that has been dried after being heavily salted. It's an essential ingredient in Caribbean kitchens. When soaked and cooked properly, it becomes tender, flavourful, and the perfect savoury balance to the sweetness of ripe plantains and the doughy goodness of Johnny cakes.

Plantains may look like bananas, but they're starchy, not sweet, at least not until they're very ripe. In this dish, the plantains are best when they're almost black, just shy of being overripe. At this stage, they fry up beautifully, caramelizing to a sweet, soft interior with a slightly crispy edge. It's this contrast of textures and flavours that makes the dish so satisfying.

Of all the times I've had this dish, the most special were the Saturday mornings of my childhood. I'd wake to the unmistakable sound of country and western music blaring from the living room, and the comforting smell of Johnny cakes frying in the kitchen. My mother would be at the stove, her Dutch pot bubbling with hot oil, carefully turning each cake until it was perfectly golden.

Those Johnny cakes, fresh from the pot, steaming, slightly sweet, and irresistibly crispy, remain the gold standard in my mind. That meal, prepared with love, was more than just breakfast. It was a memory being made.

Plantain, salt fish, and Johnny cakes aren't just a breakfast, they're a connection to culture, to family, and to the beautiful island of St. Lucia. Whether you're enjoying it by the sea, in the hills, or in your own kitchen, this meal brings a little piece of paradise to your plate.

A finished dish at the Marina.

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Illustration: Johnny cakes top left with plantains top right and a mound of salted cod mixed with peppers and sweet onions, with a small salad of lettuce and cucumbers at the front of the plate. Image credit: Gwen Joseph,

Occupational gift to the reader from Jennifer Gordon: fresh Jamaican food

Fresh Jamaican food and produce have always been important to my family and have played a central part in the memories I hold dear of my maternal grandparents.

Below are items from their bountiful garden, where they grew breadfruit, tangerines and fresh yams among other organic fruit and vegetables.

Corn is grated down to make fresh cornmeal porridge, a traditional Jamaican breakfast. Image credit: Jennifer Gordon.

Freshly picked plantain. Image credit: Jennifer Gordon.

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