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Child development and intersectoral approach: contributions from Occupational Therapy

Desenvolvimento infantil e abordagem intersetorial: contribuições da Terapia Ocupacional

Desarrollo infantil y enfoque intersectorial: aportaciones de la Terapia Ocupacional

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Objective: to analyze the understanding of professionals from multidisciplinary teams about risk concepts for child development and the contributions of Occupational Therapy. **Methods:** qualitative study, with professionals who are members of health, social assistance and education teams. A semi-structured interview and research on routine documents of the participating teams were used. The interpretation of data occurred through the technique of content analysis. **Results:** eight professionals participated, four from the health area and four from social assistance. The following categories were constructed: *Conception and Identification of risk signs for CD*; *CD assessment with a standardized instrument*; *Entry flow into the care network*; C*ase follow-up method*. The concept and type of observation of risk for child development varied among professionals in each area, as well as their actions in the services. **Conclusion:** professionals work with an expanded notion of risks, but in isolation. Occupational therapists can develop actions to identify situations of child social vulnerability and to train and train teams, from an intersectoral perspective, for the work of follow-up and monitoring of early childhood development.
Descriptors: Child development; Risk factors; Occupational Therapy; Intersectoral collaboration.

Objetivo: analisar a compreensão de profissionais de equipes multiprofissionais acerca de conceitos de risco para o desenvolvimento infantil e as contribuições da Terapia Ocupacional. **Método:** estudo qualitativo com profissionais integrantes de equipes da saúde, assistência social e educação. Utilizou-se entrevista semiestruturada e pesquisa em documentos da rotina das equipes participantes. A interpretação dos dados ocorreu por meio da técnica de análise do conteúdo. **Resultados:** participaram oito profissionais, das quais quatro eram do setor de saúde e quatro da assistência social. Foram construídas as seguintes categorias: *Concepção e Identificação de sinais de risco para o DI; Avaliação de DI com instrumento padronizado; Fluxo de entrada na rede assistencial; Método de acompanhamento dos casos*. O conceito e o tipo de observação de risco para desenvolvimento infantil variavam entre os profissionais de cada área, assim como suas ações nos serviços. **Conclusão:** os profissionais trabalham com uma noção ampliada de riscos, mas de forma isolada. Os terapeutas ocupacionais podem desenvolver ações de identificação de situações de vulnerabilidade social infantil e de formação e capacitação das equipes, na perspectiva intersetorial para o trabalho de acompanhamento e monitoramento do desenvolvimento na primeira infância.
Descritores: Desenvolvimento infantil; Fatores de risco; Terapia Ocupacional; Colaboração intersetorial.

Objetivo: analizar la comprensión de profesionales de equipos multiprofesionales sobre conceptos de riesgo para el desarrollo infantil y las aportaciones de la Terapia Ocupacional. **Método:** estudio cualitativo, con profesionales de los equipos de salud, asistencia social y educación. Se utilizaron entrevistas semiestructuradas e investigación en los documentos de rutina de los equipos participantes. La interpretación de los datos se realiza mediante la técnica de análisis del contenido. **Resultados:** Participaron ocho profesionales, de los cuales cuatro eran del sector de la salud y cuatro de la asistencia social. Se construyeron las siguientes categorías*: Concepción e identificación de los signos de riesgo para DI; Evaluación de DI con instrumento estandarizado; Flujo de entrada en la red asistencial; Método de seguimiento de los casos*. El concepto y el tipo de observación del riesgo para el desarrollo infantil variaron entre los profesionales de cada área, así como su actuación en los servicios. **Conclusión**: los profesionales trabajan con una noción amplia de riesgos, pero de forma aislada. Los terapeutas ocupacionales pueden desarrollar acciones para identificar situaciones de vulnerabilidad social infantil y capacitar y potenciar a los equipos, en una perspectiva intersectorial para el trabajo de seguimiento y monitoreo del desarrollo de la primera infancia.
Descriptores: Desarrollo infantil; Factores de riesgo; Terapia Ocupacional; Colaboración intersectorial.

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INTRODUCTION

Occupational Therapy has historically constituted a field of research and institutionalized practice within the scope of actions related to Child Development (CD) in the Brazilian context[1-3].

Advances in scientific knowledge about childhood make it possible to reveal the specifics of child development and dedicate greater attention to the care and protection of children. Occupational Therapy contributes to these advances, through important actions with this population, in favor of their development, autonomy and participation in social life[1].

There may be several possible interventions by the occupational therapist with children, whether from the perinatal period to puberty, passing through typical and atypical development, in the areas of early intervention, in the face of the first neuropsychomotor acquisitions, in cognition and learning, in inclusive education, participation in Activities of Daily Living (ADL), among other areas of activity[1-3].

The study by Gomes and Oliver (2010)[1] pointed to a growing production of articles in the area of Occupational Therapy in working with children in Brazil, but most of them in experience reports, and proving the need for research publications. Still, the review found that the most studied problems are related to care for children at: social risk, illness and hospitalization process and school inclusion, not being found articles on the subject of child development as a field of Occupational Therapy, bringing this as a gap to be explored in future studies.

A unique case study presented by Peruzzolo, Barbosa and Souza (2018)[3] highlights the importance of occupational therapists testing and disseminating studies on new clinical treatments in the field of Child Development (CD). In this sense, there is a need for reflections on how intersectoriality can contribute to Occupational Therapy practices that can promote CD.

It is known that CD is subject to a series of risks/commitments that can occur due to physiological issues of the child (such as genetics), as well as non-organic issues (environmental factors)[4].

Factors such as prematurity, high-risk pregnancy, negative relationship between mother and baby, maternal age, poor prenatal care, low birth weight, birth length under 45 centimeters, perinatal asphyxia, intracranial hemorrhage, congenital infections, breastfeeding for less than six months and low maternal educational level can compromise the child's development both in the perinatal and neonatal periods[5]. Also, children may present risks and delays in development related to socioeconomic conditions and family living and environment[6]. All these conditions permeate the field of study and practice of Occupational Therapy, as they will

directly affect the performance of these children in their occupations and their participation in the routines of their families.

Based on Urie Bronfenbrenner's Bioecological Theory of Development, which points to a dynamic development model with complex interactions of systems that combine biological, environmental, family and social factors[6], Davis and Polatajko[7-8] structured the Occupational Development Theory, which comprises that CD occurs from and for the realization of occupations by children. Therefore, Occupational Therapy assumes that the relationship between CD and children's occupations is intrinsic[9].

Services aimed at children with a view to preventing injuries in their development have been the subject of studies. A survey carried out at a Basic Health Unit (BHU) in the city of Belo Horizonte found that about a third of the children evaluated were at risk of developmental delay, showing the importance of applying screening tests in Primary Health Care (PHC), with a view to enabling early identification and intervention, with a view to improving the quality of life of children and families, with better prognosis[6]. Knowing that these teams are generally multidisciplinary and that occupational therapists usually integrate them, there is an urgent need to talk about intersectoriality and CD.

Insofar as child growth and development are responses to expected patterns or milestones as a function of neurological maturation, careful assessment makes it possible to monitor, in a timely and pertinent way, performance as a sensitive parameter of the health/disease process at an individual level (or clinical) and collective (epidemiological). Social pediatrics brings principles and practices that must be updated, especially with the recognition of the “1,000 critical days”, considering the nine months of fetal life and the first two years of a child’s life, days that represent a period of great vulnerability (in relation to survival and CD), and adequate stimulation is important[10].

The Brazilian Ministry of Health assumed the commitment to support the surveillance of child development with the establishment of the Comprehensive Assistance Program for Children's Health (PAISC) in 1984. However, development itself was not valued when compared to other basic care treated in this document, such as immunizations, growth, breastfeeding, and other preventive and curative strategies applied to diseases prevalent in childhood, despite their importance[10].

Until 1980, the government focused its efforts on combating infant mortality, since, until then, there was no express recommendation to record development milestones on the Children's Card, nor the impact that these records could have. The CD only started to be referenced and recommended by the Ministry of Health in 2004[10].

For years, attention to CD was delegated only to the health area. However, the idea of intersectoriality allows for more skilled attention to children, using sectors and specialists from different areas that dialogue with a view to comprehensive care; articulating actions in the care and education of the child. This enables comprehensive and integrated care, as the intersectoriality model seeks new ways of dealing with problems based on an integral view of the child as a person and citizen[11]. In the field of Occupational Therapy, specifically, intersectoriality corroborates both multiprofessional practices and within the scope of the profession itself, since it is possible to find occupational therapists integrating both health and education and social assistance teams. The prerogative of intersectoriality, therefore, strengthens the network of attention and care for CD.

Child protection networks in Brazil have been structured, providing a common language of unique understanding, and shared action in early childhood care. The Brazilian National Early Childhood Network - RNPI, is an articulated group that includes around two hundred organizations from government and civil society, multilateral organizations of the United Nations, research institutes and foundations, the academic environment and the business environment, who are committed to defending and promoting the rights of children in early childhood[11].

This network is the living and strong expression of a common and joint purpose of the various areas or sectors, unified in the conception of the child as a person subject to rights and a citizen[11]. Intersectoral and team-integrated work has been relevant to public policies. New learnings come from it, which benefit the protection of the child and its full development. Thus, this study aimed to analyze the understanding of professionals from multidisciplinary teams about risk concepts for child development and the contributions of Occupational Therapy.

METHODS

This study is characterized as an exploratory qualitative research, carried out with professionals in social, educational and health areas, indicated by managers, between May and July 2019, in a small municipality in the eastern-central region of the state of São Paulo; starting from the following hypotheses:

- that there is no clarity and connection on the part of health, education and social assistance teams about risk factors in CD;
- that the work of child care and monitoring of the CD is carried out only on the basis of specific complaints and referrals;
- that standardized instruments for the assessment or monitoring of CD are not used by

professionals in child care services; and,

- that although there is communication between team members, there is no connection/unification of information, nor subsequent action.

Thus, the questions that guided this work were::

1) *What is the conception of CD risk that the team professionals work on?*

2) *How do teams identify risks in CD?*

3) *What instrument/theory are they based on?* and

4) *What tools do teams use or would need to use to identify risks in CD?*

Semi-structured and e-mail interviews were used to understand the methodology used by each team to identify risks to CD, following the theoretical framework of early intervention by Franco[4] and the social research by Oliveira & Oliveira[12]. Participants were also asked to send documents and/or protocols they used in their services to identify risks to CD, for analysis.

Professionals in the following areas were considered: Health - Family Health Support Center (NASF), Family Health Units (FHU) and Center for Comprehensive Care for Children and Adolescents (NAICA); Social - Reference Center for Social Assistance (CRAS) and Service of Protection and Comprehensive Assistance to the Family (PAIF); Education - Municipal Center for Early Childhood Education (CEMEI).

The interpretation of the data was carried out by the content analysis of Bardin[13], namely:

- *Pre-analysis* - floating reading of the set of material (in this case, derived from interviews and document records), with a view to providing interaction as content manifested there, already considering relationships with the focus on exploration and the categorical elements highlighted;

- Extensive reading with the construction of categories.

This study was approved by the Ethics Committee in Research with Human Beings of the Universidade Federal de São Carlos, under number 2,066,963, and began with the professionals, after authorization from the appropriate secretariats and signing of the Free and Informed Consent Form.

RESULTS

Eight professionals participated, two from Social Assistance, two from Early Childhood Education and four from Health, as shown in Chart 1.

Chart 1. Professionals involved with child development according to area of activity and service. Small city in the East Center of São Paulo. 2019.

Idetification	Area of Work	Works*
Professional 1	Social Assistance	CRAS
Professional 2	Social Assistance	PAIF
Professional 3	Health/ Occupational Therapy	NAICA
Professional 4	Health/Speech Therapy	NAICA
Professional 5	Health	NASF
Professional 6	Health	Basic Health
Professional 7	Education	CEMEI
Professional 8	Education	CEMEI

* CRAS - Reference Center for Social Assistance / PAIF - Protection Service and Comprehensive Assistance to the Family / NAICA - Center for Comprehensive Care for Children and Adolescents / NASF - Family Health Support Center / CEMEI - Municipal Center for Early Childhood Education.

Only two documents used by the services were sent, one from Social Assistance and the other from Health. The following categories were constructed: *Conception and Identification of risk signs for CD*; *CD assessment with a standardized instrument*; *Entry flow into the care network*; *Case follow-up method*.

Conception and Identification of risk signs for CD

Depending on the professional/service's area of activity, the conception of risk to CD may vary, depending on their experience.

In terms of frequency in relation to the concept of risk that these professionals used, social and vulnerability-related factors were present in most reports in 10 lines; emotional factors/family and social relationships were identified as a possible risk factor in seven statements; factors related to health/biological and genetic components were mentioned in five statements; factors related to the environment appeared in four statements; and the concept of risk related to the violation of children's and adolescents' rights demonstrated in two statements. Only one speech mentioning the risk identification process through intersectoral work.

In the area of Social Assistance, the concept of risk was brought, based on the perspective of the system of guaranteeing rights, and its violation or negligence in relation to the recommended and planned care for the child, with emphasis on: *poverty* or even deprivation (lack of income in the family nucleus, precarious housing conditions, and others); *fragility in affective bonds and exposure to adverse contexts*, such as drug addiction and alcoholism by parents and/or caregivers; *negligence in care* (hygiene, health); *lack of access to public policies*; and *suspected or confirmed violence* (physical, psychological, sexual, child labor).

For Health, issues of *deprivation and neglect* were also identified as risk factors for CD

that can affect the course of the child's skills development (such as abuse, psychological violence, lack of resources, food), as described below:

The risk factors for CD are related to several variables (biological, genetic, environmental and social) that can negatively interfere in the child's life and increase the probability of occurrence of behavioral, emotional, social disorders, among others. (P4)

P6 is a primary health care professional and brings a concept of risk based on biological, family and environmental factors. He points out risks that serve as warning signs for the team: violence, family problems, low weight/malnutrition and risk of overweight and obesity, prematurity, delay in neuropsychomotor development, changes in the child's behavior, learning difficulties.

Education participants bring a conception of risk for CD more linked to some element (*physical, emotional, behavioral*) that compromises the global development of the child and the pedagogical proposal. They also point out that the early childhood education teacher has elements to identify risks by being in very close and daily contact with children and families.

CD assessment with a standardized instrument

It was observed that no professional/area makes use of a standardized instrument to detect CD risk. A health professional uses an instrument in specific cases to identify possible risk for attention deficit disorder and autism. An education professional says that the risks are identified through the child's manifestations, through the teacher's daily observation and the closer relationship between family and school.

The documents made available by the participants were only through a form of the social assistance service, called Psychological Referral Form, which brings questions about the child's behavior (aggressiveness, agitation, or mood swings), school performance, family structure and relationships, and health problem/illness of the child or a family member. In health, the instrument sent was a specific screening instrument for Autism Spectrum Disorders - ASD, the Modified Checklist for Autism in Toddlers (M-CHAT).

The two instruments available take into account the behavior of children observed by parents/caregivers. One of them is completed in the form of a report, and the other, M-CHAT, can be scored and generates a risk identification score that can lead to referral to specialists, but is specific for when there is a chance of a specific disorder, ASD.

Entry flow into the care network

In this category, professionals stated that there is an intention to work in an intersectoral network of care in the municipality, including health services, education and social assistance, which was cited in six statements.

The most common gateways and services for CD identification identified by participants were: CRAS, CREAS (Specialized Reference Center for Social Assistance), Health, Education and Guardianship Council network.

Referrals linked to the Guardianship Council are worth mentioning and were mentioned in three statements, as it makes referrals to all areas of care in the protection network. However, it appears in the report of an Education participant that the identification of risk occurs either by the Guardianship Council or through a first conversation between the school manager and the person responsible for the child. Depending on the severity, that is, the high risk to which the child is subjected, admission to the day care center is immediate and a place is offered. This report reaffirms the hypothesis that CD risk identification is not systematized across sectors, being open to subjective interpretations and the priorities to address the risk may be weakened.

In this study, it was also noticed that when a health service is the gateway to the care network, it referred the family/child to other sectors (mainly social assistance, but also to education). It can be inferred the primary role of health in the surveillance of CD, which is the sector that receives and forwards the most cases.

Case follow-up method

Two respondents (social and education) reported that preventive social work was carried out with families on a continuing basis through the PAIF and also in line with the guidelines of the Municipal Department of Education. In the same way, they mentioned actions to prevent risk situations, where the follow-up takes place with the entire family nucleus, including guidelines for family members (social and health). Assessments, diagnostic hypotheses and treatment were also mentioned (health). Families with some identified risk are referred to services in different sectors: health, social assistance (*Programa Criança Feliz*) and education, as needed, which was cited in three statements (health and education). Monitoring through the Guardianship Council was also mentioned, as well as in other places of child care, such as schools, APAE, USE, CAPS, PROARA, CRAS and CREAS, in two statements (health and education).

The factors the most were related to social vulnerability and family context, and there is

no systematic use of a standardized and specific instrument to detect CD risk, the most mentioned being related to: health/biological and genetic components; to the environment; emotional/family and social relationships; and the violation of the rights of children and adolescents.

The practice of identifying risk situations for development depends on the expertise and perception of the professional, as evidenced in the speeches:

I notice some cases in which the family is unstructured and cannot offer all the necessary care to the child. (P5)

I see that there is a guideline for comprehensive health care for children and adolescents, but there is no specific conception of child development in the area. (P6)

DISCUSSION

The fact that formal risk identification procedures are not used makes these professionals use observational resources, with a possible subjective assessment of the risk to development or, even, in a strictly clinical assessment, without considering contextual aspects. A study shows that the solely clinical judgment for CD problems only detects alterations in about 30% of cases, so the use of instruments as auxiliaries in the clinical evaluation is extremely important[14].

Occupational Therapy can offer contributions to the team, in the context of intersectoral practices, notably on the environments frequented by children and their families, questioning how these can promote or limit children's participation in occupations and, consequently, CD[15].

In addition to reinforcing the need for an instrument accessible to early childhood professionals, the research points to the need to expand the repertoire of actions to ensure that if problems with development are identified, rapid referral to early intervention is possible, and/ or specialized services.

It is worth highlighting the need and importance of developing an instrument for screening risks to CD, which has an interdisciplinary proposal and is based on the realities experienced by the services. From the perspective of early intervention, Franco[4] emphasizes the importance of using instruments to assist in the diagnosis and assessment of the child and the family; considering risk factors: biological, which includes the prenatal, perinatal, postnatal and others.

Also family issues should be taken into account, such as: characteristics of the parents, the family, stress during pregnancy, in the neonatal and postnatal periods; environmental, understanding the environmental context as a stress factor and factors of social exclusion of

the family; and thus, using instruments that systematize this information, it is possible to have an expanded and real conception of the situation[4].

Pinto *et al* (2015)[16] shows that there is a shortage of standardized and reliable instruments to assess skills in the first years of life of Brazilian children, which makes it difficult to identify early developmental changes, as well as hinders, prevents or delays referrals to multidisciplinary teams.

The M-CHAT, the instrument mentioned in the research results, is based on the child's observations and presents the parents with social aspects, their games and activities, and their behavior related to the senses; At the end, responses are considered and the result is reached, which can vary from "low risk", "moderate risk" and "high risk" for autism, and as it is a screening instrument, it can signal the need for child undergo evaluation by a specialist in the area and conclude a diagnosis of ASD[17]. As of April 26, 2017, through Law 13,438, the adoption of risk detection instruments for psychic development by the Unified Health System became mandatory, as a risk assessment protocol for the psychic development of children[18].

In addition to the M-CHAT, other instruments can be highlighted here, as they can be used by the multidisciplinary team, which allows them to be conceived as potent in intersectoral approaches, such as the Denver Protocol II[19] and the Alberta Infant Motor Scale[20].

In the category of analysis related to the conception and identification of risk used by these professionals, it was noted that most of them have an expanded notion of this concept, taking into account different factors, mainly related to social vulnerability, which is consistent with recent studies[21-23], which reaffirm the influence of environmental and social factors on CD.

The scarcity of material resources can affect the child's development, constituting an environmental risk factor and creating challenges for the child development monitoring system. And yet, in certain circumstances, routine experiences can be prejudicial when families live in situations of vulnerability and are neglected by the system[23:15].

Research separates the risks for CD problems between biological and environmental, with the biological ones being caused in the pre, peri or postnatal periods[4,21]. This same type of classification can be seen in the analysis of the professionals' interviews, but with other variations and details in these major areas.

It is possible to assess the context of children and families considering factors such as: access to basic health care, good hygiene conditions, balanced diet, adequate housing conditions, living in a quiet space and a relationship with a primary caregiver who invests, wants and respect the child. Thus, when one or several of these conditions are absent, risk factors for CD are characterized, since the failure to resolve some deficits installed in early

childhood may result in more complex problems in the future[24].

The gap regarding the intersectoriality of the professionals' actions is visible. The actions mentioned only bring the flow of entry and referrals, which in the network proved to be compartmentalized actions with little mobility between sectors.

The Brazilian National Early Childhood Network[11] defined Intersectoriality applied to policies for Early Childhood through the Technical Committee as being "a programmatic and financial strategy to meet the rights of children based on themselves in their personal integrality and in their social, cultural and environmental relationships. " (p.16).

According to current Brazilian policies[11], comprehensive care and protection for children must be based on the logic of intersectoriality and connection between health services, social assistance and education[25]. Therefore, it is important that professionals re-signify their practice based on the understanding of these concepts to work with the child population, especially when they are in a vulnerable situation. Intersectoriality also allows professionals to better understand the reality of children, and although it is still fragile, in this complex context it has proved to be an important resource for facing social vulnerability and protecting children through the co-responsibility of people involved with the in order to overcome the problems of certain territories[23-24].

Occupational Therapy also brings contributions to favor the understanding of situations of social vulnerability, as they affect a large number of children in Brazil[25]. The area has focused on the investigation of these situations, which usually involve the precariousness of housing and sanitation conditions, parental care, access to education and the guarantee of rights in general. Often, the families of these children are identified as the main cause of vulnerability, which end up losing the parental reference as caregivers and group with which they maintain affective relationships[25,27].

Despite this discussion on childhood vulnerabilities from an intersectoral perspective, the health sector still remains the most burdened area in CD surveillance actions. It can be observed that there is a predominance of the flow between Social Assistance and Health, with the Guardianship Council and the Social Assistance Reference Centers (CRAS) as the main agents of Social Assistance and the Family Health Units (USF) (also including Community Health Agents and home visits) as the main health agents. The actions have been individualized in areas of each performance, and despite the professionals having an expanded notion in the conception they have of risk, the actions occur superficially and this notion does not enter the practice of the services.

The work in the field of CD and, specifically, in Early Intervention (EI) refers to an

intersectoral perspective, given its complexity[26]. Occupational therapists, specialists who are experts in the field of CD, both because the content is widely covered in academic training and because of their experience in professional practice, can contribute with their expertise on childhood, typical and atypical development and children's occupations to foster relevant and necessary discussions with these teams, promoting training and seeking to establish effective criteria in the assessment and monitoring of children and their families.

A work on the teaching-learning process in the context of primary health care with Community Health Agents (CHA) working in teams of the Family Health Strategy (FHS) promoted understanding of the Unified Health System and potentiated discussions about the Occupational Therapy performance in the community beyond rehabilitation actions; with emphasis on themes related to CD and the possibilities of working together, such as development milestones and risks, food, hygiene, vaccination, home care, children's rights and the Statute of Children and Adolescents (ECA), noting there is a powerful exchange of knowledge and training between CHA and undergraduate students in Occupational Therapy[28].

This ability to work with team training is also explored in other studies of intersectoral experiences with occupational therapists from the perspective of intersectoriality, as it involves the areas of health and education[27,29-30].

Caring for, educating and preventing the risks of child development are part of the Occupational Therapy action and are essential aspects of early childhood care, as well as the observation of real contexts and environments in the constitution of the subject. And the work with children has the logic of intersectoriality and articulation of public services of health, education and social assistance that are destined to the fulfillment of the social rights of this population, mainly in a situation of vulnerability[25].

The expanded notion of risk to CD, which appears in the results, also dialogues with comprehensive childhood care[31] and allows working with the occupational perspective of CD, to contribute to collaborative work and/or training of multiprofessional and inter/transdisciplinary teams working with the children's audience. In addition, the low frequency of use of instruments and theoretical references and the lack of intersectoral actions in the surveillance of child development, demonstrated by the professionals interviewed, denote the possibility of contribution of Occupational Therapy in the context.

Intersectoral actions carried out with children and their families will have a direct impact on the motor, psychic, cognitive and social skills to be developed within the scope of CD. And these skills will influence the performance of these children's day-to-day structuring occupations, reverberating throughout their childhood and life[9,28].

CONCLUSION

Regarding the professionals' understanding of CD, the results suggest that they share an expanded notion of risk for CD, taking into account several factors, such as: social, biological/health, environmental, emotional and family relationships, violated rights and violence and developmental delay.

As contributions, we highlight the possibility for occupational therapists to develop training and qualification actions for intersectoral teams for the work of follow-up and monitoring of CD in early childhood, as well as the identification of situations of child social vulnerability. Therefore, it is suggested that the adoption of the occupational perspective of CD can engender intersectoral professional practices with a view to promoting CD, which will have an impact on the participation of these children in everyday occupations that are important for them and their families.

This study has the limited number of participants and the lack of contact with accompanied families as limitations. Suggestions for future work are: the use of action research, which adopt instruments for the evaluation and monitoring of CD, showing their impact on professional practices; works that include occupational monitoring of children and their families; and the improvement of team interaction from an intersectoral perspective.

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