



The provision of play in health service delivery

Fulfilling children's rights under Article 31 of the United Nations Convention on the Rights of the Child

A literature review



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Author

Dr Alison Tonkin

This literature review was commissioned by NHS England and conducted as part of a project to celebrate the 25th anniversary of the United Nations Convention on the Rights of the Child (UNCRC). Publication coincides with Play in Hospital Week 2014, which is organised by the National Association of Health *Play Specialists (NAHPS)* and Starlight Children’s Foundation. Play in Hospital Week aims to raise awareness of the benefits of play in the treatment of sick children across the UK and the theme for 2014 was ‘Play is good for your health’.

National Association of Health Play Specialists (NAHPS)

NAHPS is a charity which promotes the holistic health and wellbeing of children and young people who are patients in a hospital, hospice or receiving medical care at home or in the community. It pays particular attention to the physical and mental wellbeing of children and young people and supports siblings and families as part of a family centred approach to health service provision.

The charity aims to promote high professional standards for Health Play Specialists (HPS), and to ensure that the provision of play opportunities and appropriate therapeutic play interventions are embedded in the child’s care plan. Play is accepted as vital to healthy growth and development and a natural part of childhood which enables children to explore and make sense of the world they live in. For children and young people who undergo medical and surgical procedures, access to play carries greater significance, and the provision of age and developmental stage appropriate play opportunities and therapeutic activities is central to the role of the HPS.

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“Article 31 (Leisure, play and culture): Children have the right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities” (Unicef 2014)

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Appendix 1 can be obtained from the NAHPS website <http://www.nahps.org.uk/>

Introduction

Article 31 from the United Nations Convention on the Rights of the Child clearly states that all children have the right to "relax and play, and to join in a wide range of cultural, artistic and other recreational activities" (Unicef 2014). Play is seen as a contributory factor to children’s holistic health and wellbeing and as such, its promotion should be a priority. However, for children who are unwell or have chronic health issues that restrict their access to play and recreational activities, additional support may be needed to enable them to fulfil their right to play.

The 'emotional value of play' is well recognised, and the benefits of play are strongly advocated within healthcare settings. However, the fiscal benefits are not so well defined, particularly as the contribution of play provision to the clinical outcome is hard to measure (Kennedy 2010). At a time of finite resources and fundamental change within the NHS, the government is basing more decisions on evidence of what actually works (Department of Health 2013) and this is reflected throughout government policy. This literature review seeks to explore the role of play and why it’s inclusion within health service delivery is so important. It will also discuss the role of policy at a local, national and international level, and how government support is needed if children who are ill or have chronic health conditions are to fulfil their rights to play as stated within article 31.

Summary overview

“Play, leisure and recreation are vital ingredients of a healthy, happy childhood”
(Play England 2012)

Play and recreation are seen as essential for children’s holistic development and participation in play related activities should form a daily part of every child’s life (Committee of the Rights of the Child 2013; International Play Association 2013; Play Scotland 2012). In fact, play is considered to be so important for children’s holistic development, that it is a universal right for all children under article 31 of the United Nations Convention on the Rights of the Child (UNCRC) (Committee on the Rights of the Child 2013). Enshrined in law, the UNCRC applies to all children aged 17 years and under, and requires States to promote and protect children’s rights, which must be seen to be implemented within policy and practice (GOV.UK 2014).

In 2014, the United Nations Convention on the Rights of the Child, which is a global Convention, reached its 25th anniversary and this historic landmark was met with much celebration. However, the anniversary also served as a reminder that many children do not enjoy these rights on a universal basis and there is still much to be done (Unicef 2014). Children who are ill or have chronic illness are one such group of children, and therefore, additional help and support is required for these children to fulfil their rights to play.

Using a scoping study approach to review the literature, a wide range of sources have contributed to this short overview of the benefits of play in relation to children’s health. Particular attention is paid to the provision of play in health service delivery for children who are ill or have a chronic illness. The literature shows that there is strong advocacy for play provision and the ‘emotional value’ of play is clearly evident. However, there are difficulties in measuring the ‘value of play’ in fiscal terms, particularly when the contribution of play to clinical outcomes is not measurable (Kennedy 2010). With the growing emphasis on the need to provide evidence of what works as part of the decision making process (Department of Health 2013), play services within the health sector are under threat (Tonkin and Jun-Tai 2014). This review raises awareness of the need for the government and the devolved governments of the United Kingdom to promote and protect play provision in health service delivery in an effort to help children fulfil their right to play at a time when they are considered to be even more vulnerable through illness or a chronic health condition.

Two key questions provided the focus for the scoping of the literature

- How important is play for children’s health, particularly when they are ill or have a chronic illness?
- How does current health service provision fulfil children’s rights to play as defined by article 31 of the UNCRC?

Key points emerged as each question was explored.

The importance of play for all children’s health

- Play is good for all children’s health: the associated benefits are extensively documented within the general play focussed literature (Skills Active 2013; Public Health England 2013; Gleave and Cole-Hamilton 2012; Play Scotland 2012; Goldstein 2012; Whitebread 2012; Lester and Russell 2008)
- Play is holistic in nature and promotes each aspect of health: includes physical, social, emotional, mental, environmental and spiritual health (Bruce et al 2010)
- Play enhances children’s wellbeing and resilience: play allows children to rehearse and experience a range of emotions (The Children’s Society 2014; Play Wales et al 2012; Play Wales 2012; Play England 2009; PlayBoard Northern Ireland n.d.) and allows them to develop resilience when faced with stressful situations (Play Scotland 2012)
- Play promotes developmental processes that contribute to children’s ability to cope: these include the development of “creativity, imagination, self-confidence, self-efficacy and physical, social, cognitive and emotional strength and skills” (International Play Association 2013, p.2)
- Play provision tends to be concentrated on physical health: the promotion of outdoor activity and the provision of safe play environments dominates the play landscape (HM Government 2014; Play Wales et al 2012; Play Scotland 2012; Play Wales 2012; Play England 2009)

The importance of play and recreation for children who are ill or have a chronic illness

Play for children who are ill or have a chronic illness can offer many additional health benefits and these are summarised with reference to each of the six aspects of health in Table 1.

Aspect of health	Additional health benefits
Physical	<p>New technologies are enabling different forms of exercise to be delivered in health settings (Oxford Brookes University 2013).</p> <p>Activity can be tailored to individual’s ‘unique’ capacity and tolerance levels (Fairburn 2013; Philpott et al 2010).</p> <p>Adaptations to wheelchairs by occupational therapists can enable participation in play related activities (Tonkin and Etchells 2014).</p>
Social	<p>Play is considered to be the ‘language of childhood’ (Play Scotland 2014) and aids the communication process (Mental Health Foundation 2014; Ranmal et al 2008). Promoting creative play is important when children are traumatised as social situations can become difficult for them (Lovett 2009, cited by Gleave and Cole-Hamilton 2012).</p> <p>Illness and hospitalisation can cause isolation (Fairburn 2013; Yeo and Sawyer 2005) so opportunities to socialise are viewed by young people to be important (Weil 2013; Patient Experience Network 2013) providing they are developmentally appropriate (Lambert et al 2014; Coyne and Kirwan 2012; DH – Children and Young People 2011; Kennedy 2010; Healthcare Commission 2007; Yeo and Sawyer 2005).</p> <p>Play helps promote and maintain strong family bonds (Gleave and Cole-</p>

	<p>Hamilton 2012; Play Wales 2012; Ginsburg et al 2007). This is particularly important when children are in to hospital (Hubbuck 2009; Aldiss et al 2009).</p> <p>Siblings need help to deal with their own feelings and experiences: there is some coverage (Proctor 2007), but this is not well documented in the literature (O'Brien et al 2009) It is becoming increasingly factored into family centred care (Kirby, cited Tonkin 2014).</p>
Emotional	<p>Play is fun and a joyous experience in its own right (Whitaker 2014). Exploration of feelings linked to needle phobia and the resulting fear, anxiety and stress can be explored through play (Barbour and Jun-Tai 2014; Jelbert et al 2005). Play also alleviates boredom and makes time go more quickly (Ekra et 2012; Macqueen et al 2012; Aldiss et al 2009). Play can build resilience and develop coping strategies across the age range (Play Scotland 2014; 2012; Play Wales 2012; Gleave and Cole Hamilton 2012).</p> <p>Therapeutic play techniques such as preparation, distraction and post procedural play are effective in reducing stress and anxiety (Uman et al 2013; Macqueen et al 2012; Koller 2008; Jun-Tai 2004).</p>
Mental	<p>Play enables children to explore health conditions and link them to their own experiences, which can help them to redefine their 'sense of self' when they are ill (Play Scotland 2012).</p> <p>Children encountering stressful experiences are more likely to develop mental health problems (Mental Health Foundation 2014). Play and play based techniques can alleviate stressful experiences (Craske et al 2013; Uman et al 2013; Wente 2013; Clift et al 2007) and enhance subjective wellbeing (The Children's Society 2014).</p> <p>Humans have a natural affinity with nature (Lester and Maudsley 2007) and interaction with nature is shown to reduce mental health problems due to its association with a 'sense of self and wellbeing' (Play Scotland 2012; Goldstein 2012).</p>
Spiritual	<p>Bringing nature 'into the setting' is becoming increasingly important, through nature themed design (Lambert et al 2014; Bayliss Robbins 2012).</p> <p>Rooftop play areas (BBC News 2008) and roof gardens can enhance the patient experience (University College London Hospitals 2013).</p> <p>The importance of rituals in children's lives is linked to spirituality and play can form part of a ritual and help children to express their feelings (Thayer 2009, cited by Play Scotland 2012).</p>
Environment	<p>A child-friendly environment with play and recreation opportunities is important to children and young people (Lambert et al 2014; Ekra et al 2013; Randall and Hallowell 2012; Mathers et al 2011; Coates-Dutton and Cunningham-Burley 2009; Koller 2008; Clift 2007) and can help alleviate boredom when children are waiting for appointments (Lambert et al 2014; Biddiss et al 2011).</p>

Table 1: Additional benefits play can offer to children who are ill or have a chronic illness

What types of play are provided within health service delivery?

Play is complex (Henricks 2008) and distinguishing between the different types of play is important (Koller 2008; Glasper and Haggarty 2005; Mountain et al 2005). Play provision is generally divided into 'normal' and 'therapeutic play': -

Normal play	Therapeutic play
Normal play has a significant contribution to be made to the current health agenda, particularly when it is freely chosen and intrinsically motivated (Skills Active 2013).	The use of more focussed, adult directed play opportunities allows children to express their feelings and develop coping mechanisms to deal with traumatic or painful experiences (Barbour and Jun-Tai 2014; Macqueen et al 2012).
Normal play provision receives coverage within the literature, mainly linked to the significance of the environment (Lambert et al 2014; Care Quality Commission 2014a; 2014b; National Association of Health Play Specialists 2013; Ekra 2012; Bayliss Robbins 2012; Randall and Hallowell 2012; Mathers et al 2011; Kirkelly 2011; Koller 2008; Clift 2007).	Play preparation can provide information about what is going to happen and enables children to explore and in turn understand and cooperate with hospital procedures in an age appropriate manner (Macqueen et al 2012; Jun-Tai 2004). Play preparation is valued by children and their parents (So et al 2014; Craske et al 2103; Coyne and Kirwan 2012) but published empirical evidence to support its use is limited.
Child centred environments enhance the patient experience: reciprocal determinism links the environment to our thinking and behaviour, which influences how we feel (Allen and Gordon 2011). It is important to see play reflected within the environment when children use health services (European Association for Children in Hospital 2014).	Distraction, using a variety of resources (Jun-Tai 2004) is used when children undergo a procedure that may be frightening or painful (Weldon and Peck 2014; Macqueen et al 2012). Distraction as non-pharmacologic pain control/relief is effective (Ullan et al 2014; Canbulat et al 2014; Craske et al 2013; Uman 2013; Wente 2013; Koller and Goldman 2012; Inal and Kelleci 2012; Smith et al 2011) and there are a variety of interventions that support its provision (Hayes 2007).
Parents value the 'normality' that play brings to the hospital experience: especially when children have complex medical needs (So et al 2014; Hubbuck 2009).	Post-procedural play can help to explore misconceptions and fears following a procedure, especially when treatment was unplanned (Jun-Tai 2004). Coverage in the literature is limited (Ullan et al 2014).
Observation of normal play can be used to assess children's levels of involvement and wellbeing (Leavers 1997) and can contribute to diagnosis and treatment (Jun-Tai 2004) and the holistic care of the child (Weldon and Peck 2014).	Therapeutic play activities provide the majority of empirical evidence from the primary research but producing good empirical evidence is difficult (Uman et al 2013; Koller and Goldman 2012) and the evidence base is considered to be weak (Ranmal et al 2008).

Table 2: The main types of play provision within health service delivery

Who supports play provision within the health service?

- Provision of good quality play needs embedded knowledge AND understanding of child development: age/stage appropriate play and recreation opportunities need to be applied flexibly for optimum provision (Kennedy and Binns 2014; Lovett et al 2014; Fairburn 2013; National Association of Health Play Specialists 2013; Macqueen et al 2012)
- Health Play Specialists study developmental and therapeutic play (Healthcare Play Specialist Education Trust 2014) and this is shared with other members of the multi-disciplinary team (Nuttall 2013; Macqueen 2012; Kayes 2005)
- Play specialist input often appears in practice standards and guidelines (The Royal College of Anaesthetists 2014; British Association of Paediatric Surgeons 2013; Williams 2013; The Royal College of Radiologists, Society and College of Radiographers, Children's Cancer and Leukaemia Group 2012; Royal College of Nursing 2011; Society and College of Radiographers 2009).
- Health Play Specialists lead on the delivery of play within health service delivery (NHS Careers 2014) and when present, help to deliver a high quality patient experience (Care Quality Commission 2014a; Patient Experience Network 2013; Kennedy 2010; Healthcare Commission 2007)
- Play service teams also include a range of healthcare professionals that cater for differing age ranges: these include nursery nurses, play workers, youth workers and specialist care workers (Ware 2007)
- Play service provision extends beyond the hospital environment: there is a growing recognition of the role of play service provision within community based services (Warren and Kirby, cited Tonkin 2014; McKane 2008)

What is the evidence base for providing play within health service provision?

- Children see play as a significant feature of their care: young children (Lambert et al 2014; Coyne and Kirwan 2012; Aldiss et al 2009) and young people need and want age appropriate leisure and recreational activities when accessing health services (Viner 2013, DH Children and Young People 2011; Clift et al 2007; Yeo and Saywer 2005)
- Play is a process – in its truest sense, it has no outcome – it's 'value' cannot be measured (Lester and Russell 2008)
- Therapeutic play does have an emerging evidence base BUT it is weak and requires improvement (Koller and Goldman 2012; Ranman et al 2008)
- Evidence is beginning to emerge of the money that can be saved as a result of play service provision (Petty 2013; O'Donnell 2013; White 2012; Jelbert et al 2005). For example: -

“In 2008-2009, University College Hospital in London provided preparation for children aged three to five years of age who were to undergo a six week course of radiotherapy. For the children, this resulted in reduced anxiety, less medication and enabled them to cope better with the treatment process. However, it also reduced the need for daily general anaesthesia from 71% to 22%, making a significant reduction to the £18,500 associated with each course of treatment”

(Tonkin et al 2009)

- This should be promoted as a unique selling point when engaging with the commissioning process.
- However, this should not detract from the value of play that is freely chosen and follows the interests of the child (Whitebread 2012).

Article 31 and its fulfilment at a national level

- Governments define policy priorities and allocate funding accordingly (BMA Board of Science 2013): play for children who are ill or have a chronic illness receives minimal coverage in policy documents from the four home nations or the UK government – only Northern Ireland explicitly states the need for hospital play (Office for the First Minister and Deputy First Minister 2011), while the Scottish government mentions the need for therapeutic services (Scottish Government 2013).
- Article 31 has become known as the most overlooked, misunderstood and neglected article in the UNCRC (Casey, cited Play Wales et al 2012). States are focussing on ‘physical activity’ and not fulfilling all the elements of article 31 (Committee on the Rights of the Child 2013). This is reflected in the UK Government’s 5th Periodic Report to the UN Committee on the Rights of the Child (HM Government 2014).
- The Committee on the Rights of the Child (2013) issued General Comment 17 due to this concern and challenges States to fully implement all the rights within article 31, whilst providing the necessary policy frameworks and resources to enable such provision (International Play Association 2013)
- Ultimately, and irrespective of whether the evidence base in terms of efficacy and cost effectiveness is present, article 31 of the UNCRC clearly states that play is a right for all children and that States are obligated to fulfil their role in making this happen.

Conclusion

Play is a universal right for all children and is fundamental to developing their holistic health and wellbeing. By raising awareness of the distinct needs of children who are ill or have chronic health needs, play related policy and strategies can enhance the provision of play within the context of health service delivery. However, the evidence base showing the efficacy of play needs to be developed and strengthened which in turn should encourage commissioning groups to allocate financial resources for this specialised area of provision. The UK government has done much to respond to the Committee on the Rights of the Child call for action in relation to article 31.

Acknowledgement of the significance of play and the provision of play for all children within health service provision will further enhance the government’s reputation.

Recommendations

- The significance of providing children’s play opportunities under article 31 of the UNCRC needs to be promoted as part of routine health service delivery
- The inclusion of play opportunities for children using health service provision needs to be incorporated within the policy framework of the UK government and the devolved governments of the home nations
- Commissioning groups need to be challenged to show how they support, promote and protect children’s right to play under article 31
- Research that demonstrates the efficacy of play within the health sector is needed but this needs to be carefully planned to ensure academic rigour that will stand up to scrutiny

Background

“Play, leisure and recreation are vital ingredients of a healthy, happy childhood” (Play England 2012).

Play is good for your health and the associated benefits are extensively documented within the literature (Skills Active 2013; Gleave and Cole-Hamilton 2012; Lester and Russell 2008; Play Scotland 2012). In fact, play is considered to be so important for children’s holistic development, that it is a universal right for all children under article 31 of the United Nations Convention on the Rights of the Child (UNCRC) (Committee on the Rights of the Child 2013a). Enshrined in law, the UNCRC applies to all children aged 17 years and under, and requires States to promote and protect children’s rights, which must be seen to be implemented within policy and practice (GOV.UK 2014). The first part of article 31 states that children have the right to “rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts” (International Play Association 2013c). However, there is concern that article 31 is not given sufficient prominence within national policy development (Committee on the Rights of the Child 2013a) and this is reflected in limited funding, particularly in times of austerity (Voce 2014; Whitebread 2012).

Children who are ill or have chronic health conditions may need additional support to fulfil their rights under article 31 of the UNCRC (Play Scotland 2012; Play Wales 2012; Office of the First Minister and the Deputy First Minister 2011; Play England 2009). As such, the ‘value’ of play within health related provision is strongly advocated (Macqueen et al 2012; Royal College of Nursing 2011a; Davies and Davies 2011; Kennedy 2010; Jun-Tai 2008) and has a rich history (Ware 2013) stretching back to Victorian times (Whitaker et al 2014). However, the evidence base that underpins the provision of play for sick children in the health sector is not clearly identified. Play is a process (Skills Active 2013) that has no defined, measureable outcome. This makes play services vulnerable to funding cuts, particularly when they are considered a ‘luxury’ within an overstretched NHS budget (Webster 2000). Article 31 of the UNCRC may provide a vehicle for protecting and promoting children’s right to play at a time when play can make a significant difference to their lives and their experience of health service delivery (Patient Experience Network 2013).

In 2014, the UNCRC, which is a global Convention, reached its 25th anniversary and this historic landmark was met with much celebration. However, the anniversary also served as a reminder that many children do not enjoy these rights on a universal basis and there is still much to be done (Unicef 2014). One area of concern relates to article 31 which has long been considered ‘the forgotten article’ of the Convention (International Play Association 2013). In an effort to rectify this, the Committee on the Rights of the Child (2013a) issued General Comment 17 after concerns were raised following reviews of the implementation of the UNCRC submitted by national governments. One of the key concerns identified was a lack of recognition by States of the significance play has in children’s lives and this has

resulted in a “lack of investment in appropriate provision” (Committee on the Rights of the Child 2013a, p. 1). If this is the case when reviewing play provision for all children, then it is likely that the effects are magnified for children who need additional support to fulfil their rights under article 31. Therefore, this scoping review of the literature aims to raise awareness of the importance of play for children who are ill or have a chronic illness by exploring the rationale and evidence base for play provision, and using this to promote the fulfilment of article 31 within health service delivery.

Methodology

Literature reviews have their own methodological tools and this review was undertaken as a scoping study. Scoping studies can be used to “map *rapidly* the key concepts underpinning a research area and the main sources and types of evidence available... especially where an area is complex or has not been reviewed comprehensively before” (Mays, Roberts and Popay 2001, cited by Arksey and O’Malley 2005, p.21). Arksey and O’Malley (2005) provide a five stage framework for conducting a scoping studies and this was used as follows.

1. Identifying the research question – there were two research questions:-
 - *How important is play for children’s health, particularly when they are ill or have chronic health conditions?*
 - *How does current health service provision fulfil children’s rights to play as defined by article 31 of the UNCRC?*

2. Identifying relevant studies

A systematic approach was essential for the identification and collation of data, as a variety of sources were searched (Aveyard 2010). The majority of the academic literature was accessed through electronic sources - the academic database *CINAHL* and the platform *Science Direct* - using key words and search terms in isolation or combined. Key words included: - play, health, hospital, children, young people, adolescents, preschool, infants, specialist, therapy, cost effectiveness, occupational, physiotherapy, nursing, radiography, radiotherapy. The database *Maternity and Infant Care* was also searched but this yielded no results. NHS Evidence yielded alternative sources of information that led to further investigation. References cited in reviewed articles provided a rich source of additional literature. Selected journals were searched using the search terms above and these included the *Journal of Child Health Care, Nursing Children and Young People* (formally Paediatric Nursing). *The Journal of the National Association of Health Play Specialists* (formally The Journal of the National Association of Hospital Play Staff) was searched manually. A variety of web based resources yielded significant sources of information. For example: -

- Play related websites and charities for advocacy and evidence demonstrating play efficacy
- International, UK and national government websites for reports and policy statements.
- Books and e-books that had significant coverage of play within the health setting were also searched.

3. Study selection

Scoping studies do not necessarily evaluate or attempt to generalise the findings of the literature identified through the search process (Randall and Hallowell 2012). The only limiter was the time frame – only articles from 2004-2014 were used. This provides a 10 year period but also coincides with the introduction of the quality standards identified within the National Service Framework for children, young people and maternity services (Department of Health 2004a) and the Knowledge and Skills Framework (KSF) under Agenda for Change (Royal College of Nursing 2014).

4. Charting the data

Key information from the reviewed primary studies were charted chronologically and alphabetically for each year and can be found in Appendix 1. Summary details from each study included: - authors, date and title, aim of the research, country of origin, participants of the research, methodology, findings, thoughts about the study (as formal evaluation is not required) and a conclusion. This is similar to a 'narrative review' which allows a broader view to be documented (Arksey and O'Malley 2005).

5. Collating, summarizing and reporting the results

The literature was initially organised under the two questions and as the review progressed, additional significant themes emerged.

In addition, a 'consultation exercise' can be undertaken to "inform and validate the findings from the main scoping review" (Arksey and O'Malley 2005, p.23) and this will be a recommendation from this literature review.

Findings

The majority of the scoped literature reviewed fits into the following categories: -

44 primary research studies - summarised in Appendix 1, 19 published documents relating to the role of play based practitioners, nine documents from the four home nations play agencies or charities, six reports or policy statements from the UK government or devolved governments, nine health related practice documents, four international documents relating to article 31, four play focused literature reviews or reports, two quality reports by the Care Quality Commission and a variety of other documents and web based resources.

Scoping the literature enables a much broader, more narrative presentation of the results (Arksey and O'Malley 2005) and therefore the 'findings' from the literature review are presented within key themes that emerged as the review progressed.

The first question to be addressed was: -

- How important is play for children's health, particularly when they are ill or have chronic health conditions?

- *The importance of play for all children's health*

Two published literature reviews (Gleave and Cole-Hamilton 2012; Lester and Russell 2008) provided substantial advocacy, giving a comprehensive and holistic

overview of the benefits of play for health as part of the child's holistic development. There were two research-based reports on play (Goldstein 2012; Whitebread 2012) and three reports and practice standards advocating play and recreation for holistic health and wellbeing (Children Society 2014a; 2014b; NAHPS 2013; Brooks 2013). One article was specifically linked play to health (Alexander et al 2014). Virtually all the primary research reports reviewed started by advocating the role of play for children's healthy development. This tended to be under the aspects of physical, social, emotional and mental health, while wellbeing focussed on resilience.

All four nations have a play agency or charity that also specifically identified this (Play Wales 2012; Play Scotland 2012; Play England 2009; PlayBoard n.d.). The Scottish Government (2013a; 2013b) has also advocated this within their *Play Strategy*. On a global level, the International Play Association (2013a; 2013b; 2013c) and the Committee for the Rights of the Child (2013a) include this as key benefits from the provision of play under article 31 of the UNCRC.

- *The importance of play and recreation for children who are ill or have a chronic illness*

Many practice based standards and reports advocate for play within the health setting (NAHPS 2013; Committee on the Rights of the Child 2013a; Play Scotland 2012; Play Wales 2012; Kennedy 2010; Play England 2009; Society and College of Radiographers 2009; Department of Health 2008a; Battrick 2008; Healthcare Commission 2007). However, only the government of Northern Ireland specifically advocate the role of play in hospital.

Virtually all of the 43 primary research studies identified play as an important part of a child's health service experience. Books (Hubbuck 2009) and chapters within books (Tonkin and Etchells 2014; Macqueen et al 2012; Weaver and Groves 2007; Mountain et al 2006; Glasper and Haggarty 2006) as well as narrative articles that describe professional practice (Metzger et al 2013; Duffin and Walker 2012; Knight and Gregory 2009; Sorensen et al 2009; Barry 2008; Wilmot 2007; Brindle 2006) all note the contribution play makes to children who are ill. There is also the professional Journal of the National Association of Health Play Specialists (formally National Association of Hospital Play Staff) which has been running for 40 years providing a significant body of experience and practice based knowledge.

Young children see play as a significant feature of their care (Lambert et al 2014; Coyne and Kirwan 2012; Aldiss et al 2009) and young people want and need age appropriate leisure and recreational activities when accessing health services (Viner 2013, DH Children and Young People 2011; Clift et al 2007; Yeo and Saywer 2005). The importance of play for maintaining strong bonds between children and parents is seen as significant (Ginsburg et al 2007) and play provision in hospital is appreciated by parents (So et al 2014; Smith et al 2011; Varkula et al 2010;). The wider literature acknowledges this but support is needed to enable this to happen (National Association of Health Play Specialists 2013; Action for Sick Children Scotland 2011; Department of Health 2008). The importance of involving siblings in play opportunities was not well documented in the research literature– it was not

mentioned in relation to their health in any of the primary research obtained, although there is coverage in other areas (Hubbuck 2009; Jun-Tai 2008; Proctor 2007; Mountain et al 2006). O'Brien et al (2009) reported on a literature review undertaken to investigate this. It is more likely this is covered within the field of disability (Arnold 2006).

The second question to be addressed was:-

- How does current health service provision fulfil children's rights to play as defined by article 31 of the UNCRC?

- *Article 31 and its fulfilment at a national level*

The Committee on the Rights of the Child (2013a) issued General Comment 17 as a result of concerns that States were not presenting information covering how they implement article 31 within their five yearly review (International Play Association 2013a, 2013c, 2013d). For those States that did, this focused mainly on physical activity (Committee on the Rights of the Child 2013a; International Play Association 2013d). This is true for the UK government submission in 2014 (HM Government 2014) leading to a joint statement from all four home nation Children's Commissioners calling on the UK government to fulfil its obligations under article 31 (The Office of the Children's Commissioner 2013). Only Scotland's Commissioner for Children and Young People (2014) specifically responded to General Comment 17. Play England (2013) published a separate report. The devolved play agencies have fed into the International Play Association response (Play England 2013). Preparation for the UK government submission to the United Nations Committee on the Rights of the Child (HM Government 2014) had been informed by all four home nations at a symposium in 2012 (Play Wales et al 2012). Voce (2014) comments on this. The Committee on the Rights of the Child (2013a) provide challenges for the full implementation of article 31, which are highlighted by the International Play Association (2013a; 2013c and 2103d). Play is not mentioned in General Comment 15 (Committee on the Rights of the Child 2013b) looking at article 24 and the right to 'good quality healthcare'. Specific mention of article 31 and the need to implement this within health service delivery was not found within any health-related policy documentation. Most of the primary research articles made reference to article 31.

- *What types of play occur within health service delivery?*

The type of play and the context in which it is offered alters across the studies, particularly in relation to the child's age. 18 studies specifically 'involving' children covered the following age ranges: - 0-2 years: 2 studies, 2-4 years: 10 studies, 5-12 years: 19 studies and 13-19 years: 4 studies (studies that had children across age bands are recorded more than once). Many of these also noted the importance of play for children's development, particularly when illness can cause disruption to 'normal' developmental progress. Developmental aspects of play for children who are ill were also promoted elsewhere (Committee on the Rights of the Child 2013a; Play Scotland 2012; Play Wales 2012; Yeo and Sawyer 2005).

Normative or routine play provision receives coverage within the literature, mainly linked to the significance of the environment (Lambert et al 2014; Care Quality Commission 2014a; 2014b; National Association of Health Play Specialists 2013; Ekra 2012; Bayliss Robbins 2012; Randall and Hallowell 2012; Mathers et al 2011; Kirkelly 2011; Coates-Dutton and Cunningham-Burley 2009; Koller 2008; Coad and Coad 2008; Clift 2007). The provision of age/stage appropriate environments makes a significant difference to the experience (European Association of Children in Hospital 2014; The Royal College of Radiologists et al 2012; Royal College of Nursing 2011b; Kennedy 2010; Department of Health 2006).

The 'normative' or routine provision of unstructured play activities are particularly valued by children (Lambert et al 2014; Ullan et al 2014; Coyne and Kirwan 2012; Aldiss et al 2009; Koller 2008) but provision for children within the primary school age range needs to be more appropriate to meet their needs (Coates-Dutton and Cunningham-Burley 2009). There are difficulties providing empirical evidence for this type of provision (Tonkin and Jun-Tai 2014; Koller 2008). The notion of 'fun' as a play medium is gaining popularity (Ford et al 2011) and the role of clown doctors is growing (Ford 2014). However, there was limited acknowledgement within the health-related literature that play was fun and an enjoyable experience..

The more structured and purposeful therapeutic play activities such as preparation, distraction and post-procedural play are covered to varying degrees in books (Weldon and Peck 2014; Macqueen et al 2012; Hubbuck 2009; Glasper and Haggarty 2006; Weaver and Groves 2005). Therapeutic play activities such as preparation and distraction provide the majority of empirical evidence from the primary research with 16 studies covering therapeutic play interventions. Use of play as a non-pharmacologic means of pain control/relief demonstrated effectiveness in a number of studies (Ullan et al 2014; Canbulat et al 2014; Craske et al 2013; Uman 2013; Wente 2013; Koller and Goldman 2012; Inal and Kelleci 2012; Smith et al 2011; Kortessluoma et al 2008; Leahy et al 2008). Techniques are varied and cover a range of differing interventions Hayes(2007).

However two systematic reviews (Uman et al 2013; Ranmal et al 2008) and a critical review of the literature (Koller and Goldman 2012) highlight the difficulties in producing good quality empirical research and Uman et al (2013) highlight the lack of evidence relating to adolescents. Provision of recreation and leisure for adolescents in general is lacking (DH – Children and Young People 2011; Kennedy 2010; Ranmal 2008; Clift 2007) although evidence of community provision does exist (McKane 2008).

- *Who supports the provision of play within the health service?*

When looking for literature about who provides play, it was mainly health play specialists. Even when specific professional groups were used as a search term i.e. physiotherapy or occupational therapy, there were very few direct hits and these were of minimal use. Play workers, youth workers, play assistants and play leaders can also form part of the play service team (Ware 2007). Health Play Specialists (HPS) are a distinct category of health professionals (Nuttall 2013) and are seen as the main providers of play within health services (NHS Careers 2014). This includes

links with schools (Action for Sick Children Scotland 2007) and working in the community (Central Manchester University Hospitals 2014; Warren, cited Tonkin 2014; Action for Sick Children Scotland 2011). Play specialists are considered to be non-clinical (Kennedy 2010; Healthcare Commission 2007) but what is seen as a 'clinical activity' is not always clear (Sinnott and Doyle 2010).

Within the primary research reviewed, HPS are seen as key members of the multi-disciplinary team (Lambert et al 2014; Action for Sick Children Scotland 2011; Mathers et al 2011; Smith et al 2011; Robinson 2010; Aldiss 2009; Truman 2009; Linck et al 2008; Action for Sick Children Scotland 2007; Coles et al 2007). This is also reflected in reports (Care Quality Commission 2014a; 2014b; Weil 2013; Patient Experience Network 2013; Kennedy 2010; Healthcare Commission 2007; Department of Health 2006;) as well as standards for practice (National Association of Health Play Specialists 2013; The Royal College of Radiologists et al 2012; Royal College of Nursing 2011b; Society and College of Radiographers 2009; Department of Health 2004a; 2004b). There is also coverage in books and other journal articles (Whitaker et al 2014; Nuttall 2013; Macqueen et al 2012; Duffin and Walker 2012; Hubbuck 2009; Gasper and Haggarty 2006; Weaver and Groves 2005). Children advocate the role of play specialists (Patient Experience Network 2013; Weil 2013). Play specialist provision is often noticed when it is not available (Care Quality Commission 2014a; 2014b; Patient Experience Network 2013; Kennedy 2010; Healthcare Commission 2007). Health Play Specialists need to share their expertise and model play techniques with other members of the MDT (National Association of Health Play Specialists 2013; Macqueen et al 2012; Kennedy 2010; Society of Radiographer 2009; Lawes et al 2008; Healthcare Commission 2007; Department of Health 2003). Advocacy for play specialist provision from other professions is cited within their reports and guidelines (The Royal College of Anaesthetists 2014; British Association of Paediatric Surgeons 2013; Williams 2013; The Royal College of Radiologists, Society and College of Radiographers, Children's Cancer and Leukaemia Group 2012; Royal College of Nursing 2011b; Society and College of Radiographers 2009).

- *What is the evidence base for providing play within health service provision?*

The empirical research of play in health settings has not received much attention (Ullan 2014; Koller 2008). This mirrors findings in the general literature on play (Whitebread 2012; Lester and Russell 2008). Walker identified this is 2004 when retiring as the Chair of the National Association of Hospital Play Specialists (NAHPS) and challenged the profession to start creating evidence of the child centred care they had been delivering for years (Walker 2004). The evidence base for 'therapeutic play' is becoming more substantive but as noted above, the evidence base is not strong and coverage of the adolescent age range is limited. This is also reflected in the lack of current play related literature as demonstrated below: -

Macqueen et al (2012) have written an excellent chapter that provides a comprehensive overview of *Play as a therapeutic tool* within the context of Children's Nursing Practices. However, when reviewing the extensive range of literatures sources at the rear of the chapter, the majority of sources pre-dated the year 2000, with just 22% of the total sources (n=67) dated from 2000 – 2003 and just one

reference from 2010, from the cited key texts 41% (n= 17), references 3% (n=33) and further reading 24% (n= 17).

Discussion

This scoping review of the literature was undertaken to explore the evidence that links the provision of play and recreation to the promotion of health and wellbeing. It makes particular reference to the needs of children and young people who may require help to fulfil their rights under article 31 of the UNCRC due to illness or chronic health conditions.

The UNCRC is an international human rights treaty that applies to all children aged 17 years and under, providing them with a universal set of rights (GOV.UK 2014). Enshrined in law, the UNCRC was ratified by the United Kingdom in 1991 and this means that “all government policies and practices must comply with the UNCRC” (GOV.UK 2014).

Article 31 from the UNCRC specifically states that:-

1. “States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.
2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity” (Office for the High Commissioner 1989).

Two questions were posed as the basis for this literature review and these will be discussed below, using the same themes that emerged in the ‘findings’ section.

1. How important is play for children’s health, particularly when they are ill or have chronic health conditions?

- *The importance of play for all children’s health*

Play and recreation are seen as essential for children’s holistic development and participation in play related activities should form a daily part of every child’s life (Committee of the Rights of the Child 2013a; International Play Association 2013a; Play Scotland 2012). Play is good for health and this is extensively documented within the general play focused literature (Gleave and Cole-Hamilton 2012; Goldstein 2012; Whitebread 2012; Lester and Russell 2008). Play is holistic in nature and promotes all six aspects of health, namely physical, social, emotional, mental, environmental and spiritual health (Play Scotland 2012; Bruce et al 2010). Play also makes a significant contribution to children’s wellbeing (The Children’s Society 2014; Play Wales et al 2012, Play Scotland 2012; Play Wales 2012; Play England 2009; PlayBoard Northern Ireland n.d.).

Play and recreation “promote the development of creativity, imagination, self-confidence, self-efficacy and physical, social, cognitive and emotional strength and skills” (International Play Association 2013a, p.2). Recently, the benefits of play for

brain development have also been documented (Goldstein 2012; Lester and Russell 2008) and this contributes to a growing body of knowledge that links play to an ever widening range of benefits. Play, particularly when it is freely chosen and intrinsically motivated (Skills Active 2013) “has a significant contribution to make to the current health agenda” (Play Wales 2012, p.2).

- *The importance of play and recreation for children who are ill or have a chronic illness*

Providing play for children within hospitals has a rich history (Whitaker et al 2014; Macqueen et al 2012) and the emotional ‘value’ of play is strongly advocated throughout the literature (Barbour and Jun-Tai 2014; Macqueen et al 2012; Royal College of Nursing 2011a; Davies and Davies 2011; Kennedy 2010; Jun-Tai 2008; Healthcare Commission 2007). Children who are ill or have chronic health conditions are considered to have increased vulnerability (Barbour and Jun-Tai 2014; Committee on the Rights of the Child 2013a; 2013b; Hubbuck 2009) and will often need additional support to fulfil their rights under article 31 of the UNCRC (Weir 2013; Play Scotland 2012; Play Wales 2012; Office of the First Minister and the Deputy First Minister 2011; Play England 2009).

Play for children who are ill can offer many additional health benefits and these can be specifically linked to the six aspects of health, as defined by Bruce et al (2010).

Physical health

The advent of new technologies has increased the scope for promoting physical health through play based activities (Tonkin and Etchells 2014). Different forms of exercise can now be delivered in healthcare settings, for example the Nintendo Wii Fit has been used with children who have motor skill difficulties and this has the added benefit of enhancing their social and emotion wellbeing at the same time (Oxford Brookes University 2013). Adaptations to equipment such as wheelchairs by occupational therapists can enable participation in play related activities (Tonkin and Etchells 2014). These activities can also be tailored to an individual’s ‘unique’ capacity and tolerance levels (Philpott et al 2010) and circumstances. Brown (2012) describes how play specialist input was used when a child suffered paralysis from the neck down and how this provided support at a very traumatic time for the child and their family.

Social health

Play is considered to be the ‘language of childhood’ (Play Scotland 2014) and is an essential part of the communication process (Mental Health Foundation 2014; Ranmal et al 2008). Illness and hospitalisation can cause isolation (Fairburn 2013; Yeo and Sawyer 2005) so opportunities to socialise enhances children’s wellbeing and the play room is often the ‘hub of normality’ for children and parents alike. Promoting creative play is especially important when children are traumatised as social situations can become difficult for them (Lovett 2009, cited by Gleave and Cole-Hamilton 2012). Play, including creative activities enables children to express their thoughts and experiences through activities such as drawing (Barter 2014,

winner of the Starlight Children's Foundation national art competition). Socialising is viewed by young people to be very important (Weil 2013; Patient Experience Network 2013) providing opportunities are developmentally appropriate (Lambert et al 2014; Coyne and Kirwan 2012; DH – Children and Young People 2011; Kennedy 2010; Healthcare Commission 2007; Yeo and Sawyer 2005). This point is also noted constantly by children within the primary school age range and their needs are often overlooked Children aged between seven to 11 years of age are often caught between early years play provision and the well documented needs of young people (DH Children and Young People 2011; Coates-Dutton and Cunningham-Burley 2009). Play is also considered to be invaluable part of family life (Gleave and Cole-Hamilton 2012) and helps to promote and maintain strong family bonds (Ginsburg et al 2007). This is particularly important when children are in to hospital (Hubbuck 2009; Aldiss et al 2009). However, the needs of siblings are not always catered for (O'Brien et al 2009).

Emotional health and wellbeing

For children, play is fun (Gleave and Cole-Hamilton 2012) and this is perhaps one of the most important and yet often undervalued benefits of play. Play is a 'joyous' activity in its own right (Whitaker 2014) and Ford et al (2011) advocate the inclusion the fun and humour as part of the routine practice of care. Play can be used for exploring feelings and can build resilience and develop coping strategies across the age range (Play Scotland 2014; 2012; Play Wales 2012; Gleave and Cole Hamilton 2012). Therapeutic play techniques such as preparation, distraction and post procedural play are effective in reducing stress and anxiety (Uman et al 2013; Macqueen et al 2012; Koller 2008; Jun-Tai 2004) and this receives much coverage in the literature. Exploration of feelings linked to needle phobia and the resulting fear, anxiety and stress can be explored through play (Barbour and Jun-Tai 2014). Play also alleviates boredom and makes time go more quickly (Ekra et al 2012; Macqueen et al 2012; Aldiss et al 2009).

Mental health

Mental health is closely associated with emotional wellbeing and it has been shown that play enables children to explore health conditions and link them to their own experiences, which can help them to redefine their 'sense of self' when they are ill (Play Scotland 2012). Children encountering stressful experiences are more likely to develop mental health problems (Mental Health Foundation 2014). Play and play based techniques can be used to alleviate stressful experiences (Craske et al 2013; Uman et al 2013; Went 2013; Cliff et al 2007) and this in turn may minimise the effects of painful or stressful experiences that are often associated with health service provision.

An aspect of health that is becoming increasingly important, is the role of nature and how this can be utilised within health related practice (Abbott 2014). Humans have a natural affinity with nature (Lester and Maudsley 2007) and interaction with nature is shown to reduce mental health problems due to its association with a 'sense of self and wellbeing' (Play Scotland 2012; Goldstein 2012).

Spiritual health

Bringing nature 'into the setting' is becoming increasingly important, through nature themed design (Lambert et al 2014; Abbott 2014; Bayliss Robbins 2012). There are examples of incorporating the outdoor environment as part of the patient experience such as the provision of a rooftop play area at Leicester Royal Infirmary (BBC News 2008) and a roof garden was incorporated into the design of the new £100 million Macmillan Cancer Centre at University College London Hospital (2013).

The importance of rituals in children's lives is linked to spirituality and play can form part of a ritual and help children to express their feelings (Thayer 2009, cited by Play Scotland 2012). Rituals bring comfort and familiarity and can also provide a focal point (Stillman 2014) which may be used to help children develop coping strategies.

Environment and the link to health

A child-friendly environment with play and recreation opportunities is important to children and young people (Lambert et al 2014; Ekra et al 2013; Randall and Hallowell 2012; Mathers et al 2011; Coates-Dutton and Cunningham-Burley 2009; Koller 2008; Clift 2007). It can help to alleviate boredom when children are waiting for appointments (Lambert et al 2014; Biddiss et al 2011) and this is considered to be an important factor when children are asked for their experiences of health service provision (Coates-Dutton and Cunningham-Burley 2009).

This role of the environment is discussed in more detail below.

Play and recreation is good for the collective health and wellbeing of families too (Play Wales 2012). Play can bring families together and strengthen relationships within the family (Gleave and Cole-Hamilton 2012) which in turn enhances children's subjective wellbeing (The Children's Society 2014a). Conversely, when families do not get on well together, this is associated with subjective feelings of low wellbeing in children (The Children's Society 2014a), which can often happen when families, and particularly siblings, have to deal with the consequences of a child who is unwell (O'Brien et al 2009). With the time pressures that many families find themselves under, opportunities for dedicated play do not always present themselves (Lester and Russell 2008) so Gleave and Cole Hamilton (2012) suggest play needs to be incorporated into the time that families do spend together. For children who are in hospital, this is particularly important. The provision of play opportunities that are tailored to children's individual needs (Coyne and Kirwan 2012) and environments that supports the family unit are considered to be essential by young children when they are in hospital (Lambert et al 2014). Parents also value the 'normality' that play brings to the hospital experience (Hubbuck 2009), particularly when children have complex medical needs (So et al 2014).

With so many benefits to health, particularly when children are ill or have chronic illnesses, the provision of play and play related activities should be a priority for any setting that caters for children on a daily bases. Therefore, the second question was designed to explore if this was the case and how play provision was delivered within the health sector.

2. How does current health service provision fulfil children's rights to play as defined by article 31 of the UNCRC?

- *Article 31 and its fulfilment at a national level*

The influence of policy on current provision is significant. Aynsley-Green (2013, cited by BMA Board of Science 2013) emphasises this when stating "Understanding, support and effective advocacy for the needs of children by politicians is especially relevant... since governments determine political priorities, define policy through legislation and allocate funding from taxation" (BMA Board of Science 2013, p.x). Voce (2104) states "National governments must take the lead and establish the right policy frameworks...for resources to be made available locally; and that these resources... should be allocated strategically and with a full appreciation of the play needs of child populations".

The *Fifth Periodic Report to the UN Committee on the Rights of the Child* (HM Government 2014) suggests that the government has done much to promote the provision of play opportunities throughout the UK and takes the fulfilment of its obligations in terms of article 31 seriously. This is reflected within each of the four home nations. Wales has become the first country in the world to specifically legislate for play, making local authorities assess 'the sufficiency of play and recreational opportunities' within their local areas (HM Government 2014; Powys Teaching Local Health Board 2012). The Scottish Government (2013a) has published its first national *Play Strategy* (HM Government 2014) and Northern Ireland has also published a *Play and Leisure Policy Statement* (HM Government 2014; Office of the First Minister and Deputy First Minister 2011). Spending on play in England from 2008 to 2011 exceeded £200 million (HM Government 2014) following commitments made in the *Play Strategy for England* (Department for Children, Schools and Families 2008). Since then, England's flagship *Play Strategy* appears to have been 'abandoned' by the coalition government (Play England 2013) and there are no plans to provide any alternative measures (Voce 2014).

Speaking at the *4 Nations Play Policy Symposium: Playing the Long Game* which was attended by all four of the home nations from the UK looking specifically at policy and strategy development for play in relation to article 31, Casey (2012, cited by Play Wales et al 2012, p.6) who is President of the International Play Association (IPA) stated that "Article 31 has become known as the most overlooked, misunderstood and neglected article in the UNCRC". This highlights a perceived weakness of the UNCRC articulated by Nixon (n.d., cited by Robinson 2010), namely the need for adults to enable children to fulfil their rights. If adults are not aware of children's' rights or the circumstances in which children may require additional help or support, then adults cannot enable the fulfilment of children's rights under article 31.

The 4 Nations Play Policy Symposium: Playing the Long Game was an opportunity for debate and discussion that would help inform the UK governments' response to the *United Nations Convention on the Rights of the Child (UNCRC) General Comment to support Article 31* (Play Wales et al 2012). Representation included each nation's play agency or charity that is dedicated to the promotion of children's

right to play under article 31 of the UNCRC (Playboard Northern Ireland 2014; Play Wales 2014b; Play England 2013; Play Scotland 2012). Although the benefits of play for health, wellbeing and overall development were widely acknowledged on the day, what is noticeable is the absence of reference to the needs of children who are ill or in hospital. Looking at the delegate list, there was no specific representation from the health sector (Play Wales et al 2012) which may explain why this vital area of provision was seemingly overlooked.

There is minimal if any reference to children and young people who are ill, in hospital or have chronic long term conditions in the documentation detailing the policy context surrounding article 31 from the UK government or the four home nations (HM Government 2014; Play Wales 2014b; Scottish Government 2013a; Play England 2013). This provides a classic example of one of the concerns raised by the Committee on the Rights of the Child (2013a), whereby States “have largely focused on children’s physical activity and not embraced all components of the article” (International Play Association 2013d). The Scottish Government (2013b) principle stating that all children and young people should be enabled to realise their right to play does recognise the role of ‘therapeutic and specialist settings’ within communities but does not specifically mention play in hospital or healthcare community settings.

Only Northern Ireland makes a specific statement on the needs of children who are sick, stating that:-

“It is essential that the needs of sick children both in hospital and in the community are also recognised and the expertise of Play Specialists in delivering the role and working with both children and their families actively encouraged” (Office for the First Minister and Deputy First Minister 2011, p.9).

The national play agencies and charities have identified that children in hospital may need extra support to fulfil their rights to play.

“Play and play work practice is used throughout hospitals and other places caring for children to increase their enjoyment, aid their recovery and support both their physical and mental health”

Getting it Right for Play: The Power of Play: an evidence base (Play Scotland 2012, p.21).

“When children are admitted to hospital, they are at their most vulnerable. They are not only ill, but are also separated from their friends and familiar surroundings. Facilitating opportunities for playing in hospital” [the benefits and contribution to wellbeing are then listed]. *Play: health and wellbeing* (Play Wales 2012, p.6).

“Children and young people living away from home or visiting unfamiliar or controlled environments such as hospital... sometimes experience fear, anxiety and discomfort. For these children it is especially important to ensure they have good play opportunities facilitated by trained staff and volunteers” *The Charter for Children’s Play* (Play England 2009, p.3).

Advocacy needs to be translated into government policy.

- *What types of play occur within health service delivery?*

Play is complex (Henricks 2008) and there are a variety of differing applications of 'play' for children within health services. Distinguishing between the differing applications of play is important (Koller 2008; Glasper and Haggarty 2005; Mountain et al 2005).

Play within the health literature is most noticeably linked to physical health (Alexander et al 2014; International Play Association 2013a; Gleave and Cole-Hamilton 2012; Lester and Russell 2008) and the focus on promoting physical activities dominates the play landscape (HM Government 2014; Play Wales et al 2012; Play Scotland 2012; Play Wales 2012; Play England 2009). The agenda for children's health has been moving towards prevention (The Chief Medical Officer 2013; BMA Board of Science 2013) and physical activity is now being seen as a means of combating childhood problems such as obesity (HM Government 2014). This is demonstrated in The Chief Medical Officer's Report (2013) for 2012, which was dedicated to the health and wellbeing of children and young people. However, Brooks (2013) writing about the 'schools years' provided the only life stages chapter that specifically documented the role of play as play in its own right. The focus on physical activity is redefining the perception of play within health service provision and may be detrimental to the wider appreciation of play in the long run (Alexander et al 2014).

According to NHS Careers (2014a) "play has a special function in the hospital environment". There is descriptive coverage of child-centred play provision within the literature but this is generally linked to environmental considerations (Lambert et al 2014; Ekra 2012; Bayliss Robbins 2012; Randall and Hallowell 2012; Mathers et al 2011; Kirkelly 2011; Koller 2008; Coad and Coad 2008; Clift 2007). The contribution of the environment to health is well documented and the provision of age/stage appropriate play and recreation environments makes a significant difference to children's experience of health service delivery (European Association of Children in Hospital 2014; The Royal College of Radiologists et al 2012; Royal College of Nursing 2011b; Coates-Dutton and Cunningham-Burley 2009; Kennedy 2010; Department of Health 2006). The experience is enhanced when children are actively consulted in the design of health service environments (Lambert et al 2014; Coad and Coad 2008). Reciprocal determinism forms part of Bandura's Social Learning Theory and links the environment to our thinking and behaviour, which influences how we feel (Allen and Gordon 2011). This helps to explain how the environment contributes to children's feelings and subsequent behaviour, and why it is so important to see play reflected within the environment when children use health services (European Association for Children in Hospital 2014; 2012).

The other main area of play provision comes under the banner of 'therapeutic play'.

Play allows children to make sense of their world and explore personal experiences that have occurred (Committee on the Rights of the Child 2013a; Gleaves and Cole-Hamilton 2012; Duffin and Walker 2012; Lester and Russell 2008). Through the use of more focussed, adult directed play opportunities, play can allow children to

express their feelings and develop coping mechanisms to deal with traumatic or painful experiences (Barbour and Jun-Tai 2014; Weldon and Peck 2014; Macqueen et al 2012; Hubbuck 2009; Glasper and Haggarty 2006; Weaver and Groves 2005; Jun-Tai 200). Play Scotland (2012, p.17) contextualise this well:-

“...play provision for sick children... aims to safeguard their emotional well-being and the continuation of normal development, as well as help facilitate coping strategies for the stressful time of illness or hospitalisation”.

The use of play based techniques for preparing children for procedures is extensively covered in the literature, mainly through narrative accounts (Weldon and Peck 2014; Macqueen et al 2013; Knight and Gregory 2009; Jun-Tai 2008; Barry 2008; Wilmott 2007; Glasper and Haggarty 2006; Gaskell et al 2005; Maras 2003) and extensive coverage can also be found in many issues of the the Journal of the National Association of Health Play Specialists.

Weir (2013) highlights the wishes of children for information relating to all aspects of their engagement with health services, including treatment and how it will be delivered. Play preparation can provide information about what is going to happen and enables children to explore and in turn understand hospital procedures in an age appropriate manner (Macqueen et al 2012). Depending on the age of the child, preparation may include the use of play with adapted dolls or teddies which may be pre-purchased (Duffin and Walker 2012) or adapted by the child themselves (Hubbuck 2009). It can also include playing with medical equipment, both real and pretend (Proczkowska-Bjorklund et al 2010). As a result, play preparation increases children's confidence and helps them have some degree of control when it comes to the actual procedure (Patient Experience Network 2013; Hubbuck 2009). It also enables shared decision making (Lambert et al 2014; Coyne and Kirwan 2012) and in some ways, challenges healthcare practitioners to “examine their assumptions about children's abilities and explore how children's own resourcefulness can be encouraged to support their efforts to cope with medical and health interventions which may cause pain or embarrassment or be de-humanizing” (Randall and Hallowell 2012, p.311).

Although preparation is valued by children and parents (So et al 2014; Craske et al 2013; Coyne and Kirwan 2012), published evidence to support its use is limited. Evidence from one audit was found (Craske et al 2013) but as preparation is considered to be a non-clinical activity (Healthcare Commission 2007), its efficacy is seldom measured (Uman et al 2013). It may be the consequences of when it is not available or when it is not used that provide the greatest testimony for its efficacy (Care Quality Commission 2014a; 2014b; Patient Experience Network 2013). However, there is a growing awareness that evidence in terms of cost effectiveness may be a more appropriate measure and provide a unique selling point for play service delivery (Petty 2013; O'Donnell 2013; White 2012; O'Donnell and Tonkin 2012). For example, in 2008-2009, University College Hospital in London provided preparation for children aged three to five years of age who were to undergo a six week course of radiotherapy. For the children, this resulted in reduced anxiety, less medication and enabled them to cope better with the treatment process. However, it also reduced the need for daily general anaesthesia from 71% to 22%, making a

significant reduction to the £18,500 associated with each course of treatment (Tonkin et al 2009).

The other main therapeutic play technique that was widely covered in the literature was distraction. Distraction can provide children with a coping strategy to use when undergoing medical procedures, and this needs to be tailored to the individual circumstances and needs of the child (Kennedy and Binns 2014; Weldon and Peck 2014; Macqueen et al 2012; Hubbuck 2009). Sixteen primary research studies covered the use of distraction techniques across the age range and these used a variety of resources, such as distraction cards, a kaleidoscope, bubbles, books and toys kept in a specially designed distraction box (Starlight 2014). Distraction activities can include singing, reading, playing a game, blowing bubbles etc. and can be used to pass the time while waiting or during a procedure itself as a means of optimizing pain control (Canbulat et al 2013).

Being able to cope with medical procedures is not only important 'at the time' but experiences as a child can have a long term consequences that impact on adult lives (Ekra et al 2012). This is particularly linked to procedures involving needles and the role of distraction as a non-pharmacologic means of pain control featured in five primary research studies. Needle play can be used to 'de-sensitise' children (Barbour and Jun-Tai 2014; Jelbert et al 2005) but Macqueen et al (2012) warn that this may need to involve more specialist support from a clinical psychologist. al

There was a significant amount of evidence available that looked at the efficacy of distraction. However, in a recent systematic review of 26 distraction and 7 hypnosis trails which clearly indicated the effectiveness of both techniques for reducing needle related pain and distress, it was noted that the quality of the evidence was low and this needed to be improved in the future (Birnie et al 2014).

Finally, play is also important for exploring children's experiences after they have undergone procedures, and this is explored through the use of post-procedural play. Only one study was found that covered post procedural play (Ullan et al 2014) and this was linked to the reduction in post-surgical pain as opposed to the exploration of how children feel after a procedure or treatment.

- *Who supports play provision within the health service?*

Play Services within hospital settings are well established and many hospital websites have a web page describing the rationale for play and the services offered i.e. Central Manchester University Hospitals (2014). However, there is confusion between the differing job roles and titles used, particularly between play specialists and play therapists, and these may be used interchangeably (Care Quality Commission 2014a). They are distinct areas of practice, as presented in *A textbook of Children and Young People's Nursing* which has two chapters covering play - 'preparation for children' which is the traditional HPS role (Glasper and Haggarty 2006) and the role of therapeutic play which is more akin to the role of play therapists (Mountain et al 2006).

There are a variety of staff, such as Health Play Specialists, play workers, youth workers, and nurseries nurses who offer play and recreational activities and these

are often defined by the age of the child. Age and developmental stage is a major contextual consideration when discussing play provision (Weldon and Peck 2014; National Association of Health Play Specialists 2013; Hubbuck 2009) as play needs change as children grow older. Therefore, play provision needs to cover the whole age range (Weil 2013) from neonates (So 2014; Brindle 2006) through the early years (Lambert et al 2014), school age children (Coyne and Kirwan 2012; Ekra et al 2012; Aldiss et al 2009) and adolescents (McKane 2008; Clift et al 2007). Each age range presents its own unique requirements and a sound knowledge and understanding of child development that can be applied flexibly for optimum provision is needed (Lovett et al 2014; Fairburn 2013; National Association of Health Play Specialists 2013; Brown 2012; Macqueen et al 2012; Hubbuck 2009). For example, young children may find spontaneous play difficult, especially if they are unwell (Weaver and Groves 2005) so additional support will be needed to enable them to engage with play opportunities being offered. This is also important for young people, who need to be given recreational space and activities that are tailored to meet their individual needs (Lambert et al 2014; Care Quality Commission 2014a; 2914b; DH – Children and Young People 2011; Kennedy 2012). The primary school age range (5-12 years of age) is represented most in the literature with a significant majority of primary research studies focussed in this age range.

For children who are ill and also have a developmental disability such as autism, flexibility will be needed. Kennedy and Binns (2014, p.2) note that an understanding of developmental delay will enable adaptation of play provision in response to a “reduced ability to play [and] inability to communicate through play” to ensure the child’s individual needs are met.

Qualified and registered Health Play Specialists “lead playful activities and use play as [a] therapeutic tool” (NHS Careers 2014a). HPS are recognised as valued members of the multi-disciplinary team (Freeman 2014; Macqueen et al 2012) and when present, they help to deliver a high quality patient experience (Patient Experience Network 2013; Healthcare Commission 2007). However, little is known about this professional group of practitioners (Nuttall 2013; Ware 2007). HPS liaise with all levels of clinical staff and are considered to have good relational agency as they advocate for the child and promote their rights to play across professional boundaries NHS Career Framework bands (Nuttall 2013). HPS undergo extensive training in the provision of age and developmentally appropriate play (Healthcare Play Specialist Education Trust 2014) and this is shared with other members of the multi-disciplinary team (Kayes 2005) through skill-sharing and peer education, including shadowing and taught sessions (Lawes et al 2008). This sharing of play based practice is really important for raising awareness of the value of play and how it can enhance the patient experience (Kennedy 2010). Once other health practitioners are aware of how play can help, they often become advocates for play services and the need for play. Play specialist input often appears in practice standards and guidelines (The Royal College of Anaesthetists 2014; British Association of Paediatric Surgeons 2013; Williams 2013; The Royal College of Radiologists, Society and College of Radiographers, Children’s Cancer and Leukaemia Group 2012; Royal College of Nursing 2011b; Society and College of

Radiographers 2009). A good example of this comes through the Teddy Bear Hospital, which is a European Medical Student's Association Project for children between 3-12 years of age. Medical students run role play sessions for children who bring their sick teddy to see the doctor. The child acts as the parent and they are encouraged to talk about their fears through the medium of play. This provides experiential learning from both sides and enables medical students to gain "knowledge of working with young children and handling sensitive discussions" (Victorine et al n.d., p.8).

Nursery Nurses are sometimes employed to work alongside HPS as part of the play and they generally work with children under the age of five years. Their role includes the coordination of play for the child and their siblings, as well as the use of play as a means of communication (NHS Careers 2014b). At the other end of the age spectrum, youth workers may also be considered part of the play team, as they assist young people to build coping strategies and to find ways of dealing with the effects of illness and hospitalisation. This may involve one-to-one meetings or group work and can occur within a variety of settings (Renal 2014). Play opportunities are increasingly being offered within the community as part of hospice and family support services (Warren, cited Tonkin 2014; Action for Sick Children Scotland 2011) and visits to schools (Mayer 2006). There are also teams of specialist carers who work with families in a variety of settings (home, school, community) and incorporate play within respite provision for children with complex health needs, through planned or spontaneous play opportunities (Kirby, cited Tonkin 2014).

All play staff are considered to be non-clinical and as such, their contribution to clinical outcomes is not always recognised (Kennedy 2010; Healthcare Commission 2007). However, their contribution to clinical procedures can make the outcomes more effective, efficient and more pleasant for all concerned. Children are aware of this, and while commenting on their experiences of health care provision, they noted that "happy staff = happy patients... the patient experience is inextricably linked to staff experience. This has the potential effect of multiplying the benefits of getting it right – but it works equally in the opposite direction" (Patient Experience Network 2013, p.11).

- *What is the evidence base for providing play within health service provision?*

Play for sick children is often considered to be a luxury and play service provision has to compete for funding from an overstretched NHS budget (Webster 2000). With the growing emphasis on the need to provide evidence of what works as part of the decision making process (Department of Health 2013), play services within the health sector are under threat (Tonkin and Jun-Tai 2014). At a time of austerity and fiscal restraint, play slips down the policy agenda and "this right [31] is often overlooked when adult agendas are given priority over the needs of children" (PlayBoard n.d., p4). When this is linked to the drive for decision-making based on evidence of what works (Department of Health 2013) and the introduction of the commissioning of services which also requires evidence in terms of "...efficiency, effectiveness and value for money" (Royal College of Nursing 2011b, p.10) play has a problem.

Although evidence that demonstrates cost effectiveness or 'value for money' exists, mainly through time savings that have been made through the successful preparation of patients (Petty 2013; O'Donnell 2013; Tonkin et al 2009; Jelbert et al 2005), these figures are not easily accessible and are not generally publically available. This provides play services with perhaps their best opportunity to demonstrate their effectiveness, so they need to be collated and shared to a much wider audience. Walker (2006) provided a comprehensive tool for delivering and auditing quality play provision in hospitals, and this provides a good starting point to finally raise to the challenge Walker set down in 2004 to engage in research and audit which will "pay huge dividends for your own service and the profession as a whole" (Walker 2004, p.4).

Empirical evidence that documents the benefit of play is lacking (Lester and Russell 2008), and this is reflected across Europe as a whole (Whitebread 2012). Organisations that promote play do so on limited funding from their respective governments (Whitebread 2012). For example, Play Wales have recently been unsuccessful when applying for funding from the Welsh Government and unless this decision is overturned, their campaigning work will no longer continue (Play Wales 2014a).

Lester and Russell (2008) highlight this lack of empirical evidence within their review of the literature and state: -

"... there are problems in producing longitudinal research that shows clear statistical cause and effect of an activity as elemental, innate and ubiquitous as children's play. How the activity is in question to be defined accurately...how is it to be measured? What price a study group?" (Lester and Russell 2008 p.5).

Empirical evidence that makes the links between play and health is beginning to emerge but this focuses on enhanced functioning as a result of play, particularly in areas such as motor skills, cognition, social and neurological aspects (Whitebread 2012). However, in order to undertake such measurements, structured play opportunities need to be provided, and in many ways, this detracts from the value of play that is freely chosen and follows the interests of the child (Whitebread 2012).

When research has been undertaken, most noticeably looking at therapeutic play techniques such as distraction, the effectiveness of the technique has been confirmed but the research methodology and analysis has been questioned when these studies have been systematically reviewed (Uman et al 2013; Ranmal 2008). In both studies that were undertaken through the Cochrane Review process, the evidence was considered to be weak and recommendations included the development of more rigorous procedures for the production of evidence (Uman et al 2013; Ranmal 2008). This position has changed little and measuring the 'value' of play is even more problematic within the context of children's health services (Ullan et al 2104; Koller 2008) where its contribution to clinical outcomes cannot be quantified (Kennedy 2010).

Having demonstrated the value of play through the literature, the usual research methodologies in terms of 'comparing' a group that has play provision against a group that does not, would be unethical. Therefore, one of the major challenges that faces play provision in the future is the development of a tool that could be used to provide some evidence of efficacy. Perhaps a tool such as the Leuven Scale which looks at the degree of children's 'emotional wellbeing' and level of 'involvement' (Laevers 1997) could be utilised in the future. Although this is associated with early years practice in education, it can be applied to any age range and could be used to measure children's involvement in play related activities and the associated emotional wellbeing. The context of Laevers's (2005) work relates to the 'process' that occurs within deep learning as opposed to the outcomes and this reflects the current dilemma in terms of trying to 'measure' the process of play, as opposed to its outcome.

Ultimately, and irrespective of whether the evidence base in terms of efficacy and cost effectiveness is present, article 31 of the UNCRC clearly states that play is a right for all children and that States are obligated to fulfil their role in making this happen. Promoting the holistic nature of the UNCRC and the need to view all rights in relation to one another, specific links can be made to article 24 (Committee on the Rights of the Child 2013a). This promotes the right to, amongst other things, good quality healthcare (Unicef 2014) and good quality healthcare should include the delivery of play (Office of the First Minister and Deputy First Minister (2011). Interestingly, the Committee on the Rights of the Child (2013b) have also published General Comment 15 which covers article 24. Despite noting the 'indivisibility' of the rights, the need to provide play and recreation as stated in article 31 was not mentioned within this General Comment, although it was noted that health services should be organised around people's needs and expectations (Committee on the Rights of the Child 2013b). Children need and expect play to be provided as part of their health service experience (Lambert et al 2014; Coyne and Kirwan 2012; Ekra 2012; Action for Sick Children 2011).

"The sooner we attach the same importance to play as do children, the better will be the world we create for all of us" (Baillie, cited Scotland's Commissioner for Children and Young People 2014,p.13).

Limitations of the literature review

Henricks (2008, p.176) identifies that individuals will always reflect their own "disciplinary background, ideological commitments, and even personal 'taste'" when discussing play. This may influence the search strategy and subsequent use of literature (Aveyard 2010). For example, inclusion of all the health services disciplines who use play within their practice (i.e. occupational therapy or physiotherapy) is limited as the literature is not readily available through the search strategy undertaken. Using a 'scoping study' approach to review the literature is defined as a 'rapid' mapping of the literature (Arksey and O'Malley 2005) and the timescale for

undertaking this literature review meant this was a good method to use. However, it also means the broader, more holistic coverage of play within the health service which this review provides, has not used inclusion criteria aside of the 10 year time scale from 2004-2014, and a very broad range of sources have been reviewed.

Conclusion

Play is a universal right for all children and is fundamental to developing their holistic health and wellbeing. By raising awareness of the distinct needs of children who are ill or have chronic health needs, play related policy and strategies can enhance the provision of play within the context of health service delivery. However, the evidence base showing the efficacy of play needs to be developed and strengthened which in turn should encourage commissioning groups to allocate financial resources for this specialised area of provision. The UK government has done much to respond to the Committee on the Rights of the Child call for action in relation to article 31.

Acknowledgement of the significance of play and the provision of play for all children within health service provision will further enhance the government's reputation.

Recommendations

- The significance of providing children's play opportunities under article 31 of the UNCRC needs to be promoted as part of routine health service delivery
- The inclusion of play opportunities for children using health service provision needs to be incorporated within the policy framework of the UK government and the devolved governments of the home nations
- Commissioning groups need to be challenged to show how they support, promote and protect children's right to play under article 31
- Research that demonstrates the efficacy of play within the health sector is needed but this needs to be carefully planned to ensure academic rigour that will stand up to scrutiny

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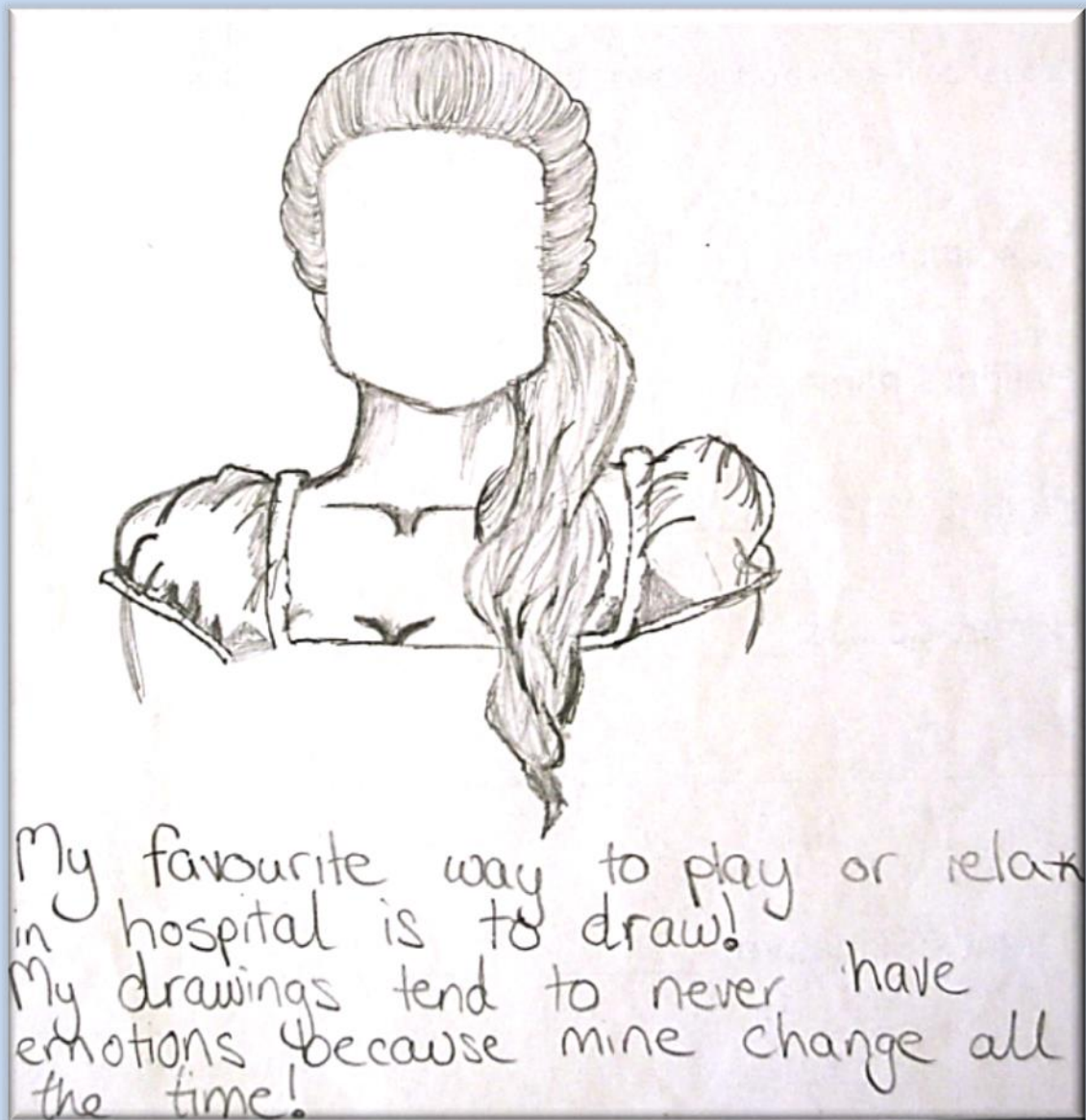
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My favourite way to play or relax in hospital is to....

Drawn by Annie Barter

Winner of the national art competition run by children's charity Starlight Children's Foundation supporters of National Play in Hospital Week 2014

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