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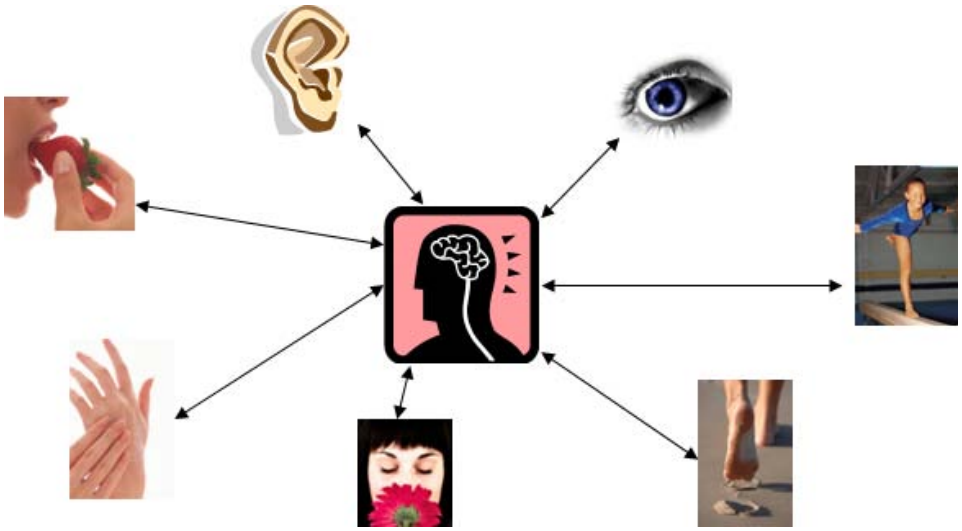
An Introduction to the use of Sensory Approaches in Mental Health Care



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Structure:

- The module titles are written across the top of the screen.
- The subsections of each module will appear on the left hand side as you choose a module.

Navigation:

- You can click on a module title at the top and then click on an item in the left hand list of subsections.
- Alternatively, you can go to the site map to see all of the headings and choose those that are of interest.

Activities and examples:

You will find useful practice tips and challenges, consumer stories, resources and more. Some of this information appears on the page, while others will appear as you click on the icon or the coloured writing.

PDF print outs:

Please click here to download a printable version of this module.

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to introduction to sensory approaches

The ability of mental health consumers to impact on their wellbeing by using Sensory Approaches is an exciting and innovative area of contemporary practice within mental health services.

This learning module will provide you with an introduction to sensory approaches and their application within Hospital and Health Service Mental Health Services.

At the end of this module you will be more aware of how to assist consumers to work towards optimum levels of functioning as they learn how to calm and alert themselves through the use of sensory based approaches.

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Learning objectives

The key learning objectives for this program are to:

- Develop an awareness of ***sensory approaches*** as a framework for working with people with mental illness.
- Understand why ***sensory approaches*** are important in mental health practice.
- Identify behaviours or clues which may indicate a person is experiencing difficulties with ***sensory processes***.
- Know when to refer a consumer to an experienced ***sensory approach*** clinician.
- Develop an awareness of ***sensory strategies*** that may be used to support someone whose ***sensory processing difficulties*** are impacting on their life.
- Develop awareness of how ***sensory approaches*** can support a consumer in their recovery.

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"Sensory Approaches" is an overarching term used to describe a range of strategies that people can use to help them regulate their sensory system to enable them to function at their best.

We all utilise sensory approaches daily as a healthy response to life stressors, and we often may not realise that we are doing so.

Think about what you commonly do to calm yourself down at the end of a stressful day. You may do some exercise, have a soak in a warm bath, listen to music you find relaxing, or cuddle a pet.

Alternatively you may use different strategies to alert yourself if you are feeling lethargic and need to 'rev up' to focus on a task at hand. You may go for a brisk walk, 'doodle' on a note pad, have a cup of coffee or chew gum. All of these strategies are sensory based approaches.

What about you?

Please make notes about your preferences to refer to later!

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Introduction to the senses

“The experience of being human is embedded in sensory events of everyday life” (Dunn, 2001, p. 608)

An important step in being able to utilise sensory approaches is to understand our seven senses.

Our senses are the avenue through which we receive input about ourselves and the world around us. You may be very familiar with touch, taste, sight, smell and sound, but what about proprioception (our position sense), and the vestibular (movement) sense? These may be less familiar. Also, the impact of the senses may not be as straight forward as you first imagine.

We all process information through our senses differently and we all have preferences for the type and amount of sensory input that helps us function at our best. These preferences can fluctuate over time and will also be influenced by arousal states and the impact of trauma.

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Introduction to sensory approaches in practice

Sensory Approaches can be used in many ways in practice. They can be used to enhance safety, to aid in engaging consumers and building therapeutic relationships, and as part of assessments and interventions which may target a range of different treatment goals. They also take in to account the person with their unique preferences and needs, as well as the environments and the activities that person may engage in.

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Author: Sue Holley, Queensland Health.

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  - Michelle Taylor, Chair of the Mental Health Occupational Therapy Sensory Approaches Clinical Collaborative in Queensland.

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As a result of working through this e-learning program you will have:

- developed an awareness of ***sensory approaches*** as a framework for working with people with mental illness.
- better understanding why ***sensory approaches*** are important in mental health practice.
- identified behaviours or clues which may indicate a person is experiencing difficulties with ***sensory processes***.
- knowledge of when to refer a consumer to an experienced ***sensory approach*** clinician.
- developed an awareness of ***sensory strategies*** that may be used to support someone whose ***sensory processing difficulties*** are impacting on their life.
- developed awareness of how ***sensory approches*** can support a consumer in their recovery.

If you would like further information on Sensory Approaches in Hospital and Health Services contact:

- The Occupational Therapist in your team.

  If you don't have an OT in your team, contact the Mental Health Occupational Therapy Sensory Approaches Clinical Collaborative via OT_Sensory_Approches_Collaborative@health.qld.gov.au.

The following websites may also be useful:

- Occupational Therapy Innovations (Tina Champagne): www.ot-innovations.com.
- The Sensory Connection Program (Karen Moore): www.sensoryconnectionprogram.com/index.php.
- The Alert Program – How does your Engine Run?: www.alertprogram.com/index.php.

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- If you agreed to participate in the sensory approaches e-learning research, please complete the post evaluation here.
- If you did not agree to participate in the sensory approaches e-learning research, please complete the post evaluation here.

Thank you for completing these evaluations, we appreciate your input.

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Sensory Approaches…..that all sounds straightforward, so why would I need to learn about how to utilise these strategies with people with mental health issues?

Every individual is unique in terms of their sensory needs and sensory preferences. Many people with mental health problems experience difficulties in being able to utilise healthy sensory strategies when in distress as they are unaware of their particular sensory needs or stress responses (Champagne & Stromberg, 2004).

Over time, people with poor understanding of the impact of sensory preferences may be experiencing poor outcomes as they may have learnt to:

- utilise unhealthy responses (such as the use of drugs or alcohol); or
- behaved in a certain way (such as becoming agitated and aggressive, or avoiding particular situations).

In addition, in acute inpatient enviornments as a result of safety and treatment concerns related to consumers, people may not have regular access to the means or strategies of preferred sensory resources.

Using a sensory based “lens” provides an alternative way to view and understand what is happening for a person when they are in distress, or when they are engaged in seemingly ‘maladaptive’ or ‘difficult’ behaviours’ (yelling, crying, agitation, pacing, fearful responses, clinging, self-harming, avoidant behaviours and so on).

The application of sensory approaches allows us to help people understand their own sensory needs and preferences so that they can respond in a healthy and more adaptive way. This is one of many approaches used in conjunction with a clinical team.

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Evidence

Evidence shows that sensory approaches support consumers of mental health services to:

- Decrease self-harming behaviour.
- Improve interpersonal skills.
- Improve ability to manage distress.
- Create safe environments in which to engage in meaningful activities, roles and routines (Te Pou, 2011; Champagne, Koomar & Olsen, 2010).
- Sensory approaches support the reduction of seclusion and restraint (Te Pou, 2011) and are a helpful intervention for consumers with trauma histories (LeBel et al, 2010).

Sensory approaches are consumer focussed, recovery based strategies that are empowering for both consumers and staff. Within this approach consumers learn about their own needs and preferences and learn strategies for dealing with perceivably difficult and stressful situations (Te Pou, 2011).

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Theoretical foundation

The theoretical foundations of sensory approaches stem from the fields of:

- Sensory processing.
- Arousal and stress responses.
- Regulation.

Each of these areas will be explored in the section on Sensory Processing.

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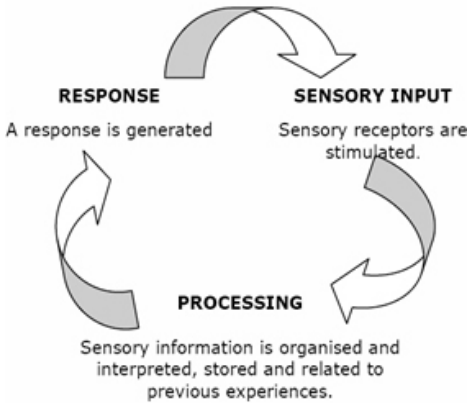
Sensory processing

Sensory Processing is a term that refers to the way the nervous system receives messages from the senses and turns them into appropriate responses to internal and environmental demands. It is the way we understand what is happening within our bodies and in the world around us.

The brain receives countless pieces of information from our senses at any given moment. It filters this information, deciding what information is important and should be responded to, and what information is not so important, and can be disregarded. For example sensory processing enables you to focus on a task at work, while allowing you to not be distracted by every piece of background noise. However, if your brain decides that a certain noise is important, for example a loud bang in the room next to you, or the sound of a distressed child, then sensory processing allows you to be distracted from your task and respond to this information.

Difficulties occur when there are problems in the way this process occurs. The resulting condition is termed “Sensory Processing Disorder”.



Williamson, (2008)

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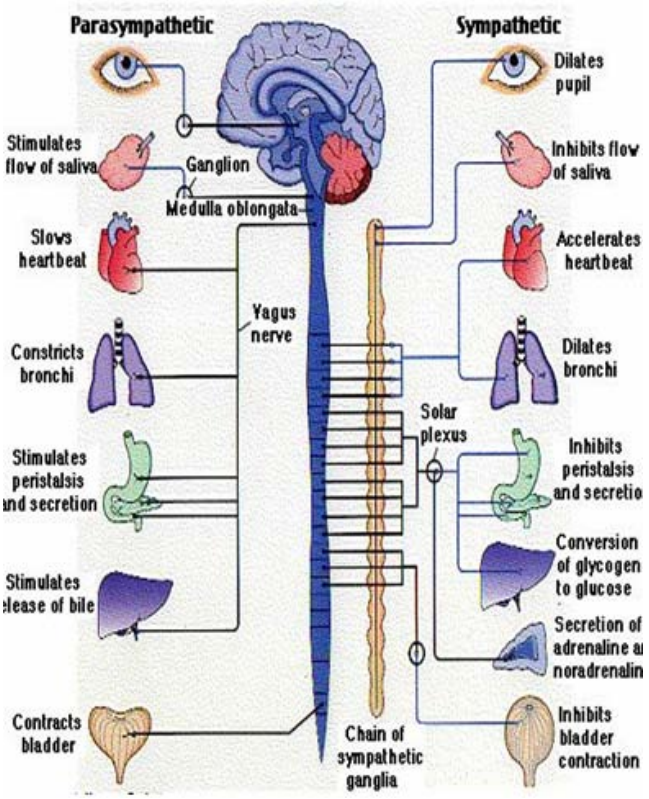
Arousal is a complex nervous system response involving the interaction between a number of systems including the Autonomic Nervous System (ANS). The ANS includes the sympathetic and parasympathetic systems. In simple terms arousal is your body's level of "awakeness" or alertness to be able to respond to stimuli internally and from our environment.

Think about the body sensations you experience when you are stressed: your heart rate increases, your pupils become dilated and your palms become sweaty. This is due to the activation of your sympathetic nervous system. This is commonly referred to as the fight-flight response.

Your parasympathetic nervous system, slows your heart rate and stimulates your digestive organs to do their work when you are at rest or relaxed.



www.biocomtech.com/hrvscientific

Important to know

In terms of daily functioning, our body works best at optimal levels of arousal, a balance between states of calmness and alertness.

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Sensory processing disorder

"People with disorders that include unusual sensory processing patterns live a more intense version of life; they experience things more acutely or deeply" (Dunn, 2008, p. 9).

A person with Sensory Processing Disorder finds it difficult to process and act upon information received through the senses, which creates challenges in performing countless everyday tasks.

Dr A. Jean Ayers, an early pioneer in the identification and treatment of children with disorders in sensory processing, likened this process to being like a traffic officer directing the movement of cars.

When the flow of sensations are integrated, the brain can use these sensations to form meanings and learning.

When the flow is disorganised, Ayres (1979, p. 5) suggests "life can be like a rush hour traffic jam".

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Impact of sensory processing disorder

A person experiencing sensory processing disorder may find it difficult to discriminate sensory information that is 'important' and 'not important'. So for example they may:

- Find it difficult to concentrate on a task because they are distracted by all of the noises and sights around them.
- Alternatively they may need a lot of sensory input before they recognise that something is happening around them. For example, they may not become aware of someone talking to them until the person is standing right in front of them.

Much early work focussed on the presence of sensory processing disorder in children. These children may have presented with symptoms such as difficulties in motor co-ordination, behavioural problems, hyperactivity, learning difficulties and so on.

Important to know

More recent evidence suggests that disorders in sensory processing do not disappear in adolescence or adulthood, and in fact if untreated can have significant impact on a person's ability to function in everyday life (Dunn, 2001; Abernethy, 2010).

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- Avoid or not notice sensory stimulation

Important to know

Sensory processing difficulties are common in people with mental health issues.

Brown et al (2002) found that people with schizophrenia are more likely to avoid or miss sensory stimulation in their everyday life than those people without a mental health diagnosis.

People who use sensation avoiding behaviours tend to limit the sensory input they must deal with (Dunn, 2001). This enables them to feel less overwhelmed by unfamiliar sensory input, but it also means that they are more likely to withdraw from experiences of everyday life.

Those who miss sensory input are likely to miss a whole range of things going on around them, and may not pick up on subtle sensory cues, such as non-verbal signals in communication.

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- Sensory defensiveness

Abernethy (2010) identified a prevalence of sensory defensiveness in adult mental health populations.

Sensory defensiveness is defined as a tendency to react negatively or with alarm to sensory input which is generally considered harmless or non-irritating (Kinnealey et. al., 1995).

Symptoms of sensory defensiveness include:

- distress or aggression,
- misinterpretation of sensory input.
- fear.
- withdrawal.
- strong need for routine.
- self harming behaviour (Moore, 2010: The Sensory Connection Program website).

Abernethy reports that sensory defensiveness can have a detrimental effect on function, behaviour, emotions, and mental health. She also reports that the coping strategies that people develop to deal with sensory defensiveness add to the negative impact on their quality of life (avoidance of situations, limiting choices in regards to career, leisure, accommodation, friendships and intimate relationships).

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Sensory processing difficulties

- Evidence

Cheng and Boggett-Carsjens (2005) suggest that many children and youth presenting to services with affect regulation issues (such as anger and explosive rage) have sensory processing difficulties.

Lindley and McDaniel (2000), found that 80% of residents in an adolescent inpatient mental health facility experienced sensory processing issues, and identified that sensory issues in child and adolescent populations may present as:

- self-harm via an increased need for sensory input
- unpredictable explosions of emotions
- lack of interaction with the environment
- increased distractibility
- difficulty with transitions
- social isolation
- difficulty regulating activity levels

Important to know

It is highly likely therefore that many of the consumers you are working with experience difficulties with sensory processing. Sensory processing difficulties have a significant impact on a person's everyday functioning. As such it is important that all clinicians have some understanding of the way that sensory approaches can be used to support those consumers to minimise their distress and maximise their functioning.

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Why arousal is important

When our nervous system is operating at an optimum state of arousal we are able to perform at our best. Our arousal level fluctuates during a typical day based on our involvement in daily activities and what is going on within us and in the world around us. These fluctuations are normal.

However, there are times that a person's nervous system may be in a state of hyper or hypo arousal.

If someone is hyperaroused, they may present as fidgety, agitated or aggressive, labile (emotionally changeable) in mood, emotionally blunted almost 'frozen' in appearance, or even fearful. In this state the person's arousal will be too high to focus on many daily activities.

If a person is hypoaroused, their level of arousal is too low to function at their best. They may present as sleepy, lethargic, disinterested or slowed in their movements and responses.

Click on the practice tip below to find out more.

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Arousal and self regulation

Our bodies have the ability to attain, maintain and change arousal appropriately for a task or situation – this is termed self-regulation.

You may do this by utilising strategies to assist you to calm down if you are hyperaroused or alert you if you are hypoaroused. Think about the strategies you wrote down at the beginning of this learning module. You have already identified strategies that you use to self-regulate.

Different tasks require different levels of arousal and we may incorporate different strategies at different times to best suit our current level of arousal and the task at hand.

Many people with mental health problems have difficulties with this process of self-regulation. An inability to regulate arousal effectively is termed dysregulation.

Dysregulation in people with mental health problems may be as a result of sensory processing difficulties, and/or due to the impact of childhood or more recent trauma (Koomar, 2009; Champagne, 2010).

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Arousal and trauma

When a child experiences significant trauma there are changes to the way the brain develops. This will impact on the brain's ability to integrate sensory, emotional and cognitive information into a cohesive whole. As a result, a child with a trauma history is likely to experience difficulties in their arousal processes and their ability to self-regulate. These difficulties can extend into adulthood if untreated.

Common arousal patterns for people who have experienced trauma include:

- A pattern of hyperarousal for most of the day.
- This person will be highly sensitive to any sensory input and will find it very difficult to organise themselves and focus on individual tasks.

- A pattern of extreme fluctuations in arousal levels over the day.
- There are times in the day that the person is in the optimal state of arousal, but for much of the time is bouncing wildly between states of being hyper-aroused to being hypo-aroused.

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Tactile

"Touch receptors tell you about the edge of your body" (Dunn, 2009, p. 22).

The skin is the largest sense organ, and as such we get a large amount of sensory information from tactile receptors within our skin.

We have 2 types of touch receptors:

- Close to the surface of the skin *(light touch).*
- Deep in the skin *(deep pressure).*

This sense includes "to touch" and to "be touched", and also pain, vibration, temperature.

The functions of this sense are protective (alerts body to potential threats) and discriminative (discriminates between different kinds of tactile stimulation).

Our tactile sense also contributes to sense of body boundaries and body image.

Touch is a powerful sense in the establishment of bonding and relationships.

Light touch

- Picked up by receptors close to skin's surface/hair
- Often a faster response
- Elicits attention; alerting
- May provoke strong emotional response

Deep pressure touch

- Receptors are further under the surface of the skin
- Can be very calming
- Can be used to promote reality orientation (for people with psychosis or experiencing symptoms of dissociation/ detachment) stabilise mood, decrease inappropriate tactile seeking behaviours, ie touching others.

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Auditory - hearing

Our auditory sense is our sense of hearing.

It is interconnected with our vestibular (or movement system) and includes not only sound but also vibration.

Sound helps us to map space and distance, so for example you can discriminate between sounds that are close to you or sounds that are coming from far away. You also tell if sounds are moving towards or away from you.

Music, sound and rhythm can all be used to reduce stress (calm) or alternatively can be used to uplift (alert).

Our auditory system is also linked to social engagement. Muscles in the middle ear protect the inner ear from loud noises but allow for frequencies in the human voice to be discriminated. This allows for speech to be heard within the context of background noise. If these muscles are not working correctly, the nervous system can be bombarded with unwanted sound, and this ultimately can lead to social avoidance and withdrawal (Doman, 2008).

Hyper-sensitivity may look like:

Hypo-sensitivity may look like:

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Olfaction - smell

“Smell senses are primal and attached to our emotions” (Dunn, 2008 p. 26).

Our sense of smell is a primitive sensory system; we detect the smell of objects and the world through our noses.

Smell is closely linked to the emotional parts of our brains, and so sometimes smells can trigger emotions more quickly than other senses.

It is directly connected to the limbic system and as such is closely linked to the emotional parts of our brain. Therefore it can elicit emotions more quickly than other senses.

It is also linked with memory, so a smell can remind you of an event, a situation or a whole scene from a recent time or an earlier time in your life (for example childhood).

We often have a clear preference for desirable rather than undesirable smells.

Sense of smell has a strong link with trauma.

Hyper-sensitivity may look like:

Hypo-sensitivity may look like:

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Gustatory - taste and oral motor

Our oral senses include textures, temperatures and tastes: salty, sour, sweet, spicy.

We get a lot of sensory information from our mouths quickly.

People are often adamant about what they do and don't like in terms of taste and texture.

Co-ordination of movements and muscle tone (oral-motor) enables the ability to eat, swallow, breathe, blow and suck (drink through a straw, blow bubbles).

People seek oral motor stimulation to help with comfort, attention and overall organisation.

Smoking cigarettes is an oral-motor activity that may have comforting effects.

Hyper-sensitivity may look like:

Hypo-sensitivity may look like:

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Visual - sight

What we see.

Size, shape, colour of objects around us.

Peripheral vision is often alerting, this means we are alerted by seeing movement or something/someone in our peripheral vision.

The use of light can be activating (or alerting) and is used as a treatment modality for seasonal affective disorder.

Dimming or soft light, and particular colours of light (typically blue/green) can be calming.

We often have particular images or scenes that we find calming (fish tank, sunset scenes, familiar comforting place).

Hyper-sensitivity may look like:

Hypo-sensitivity may look like:

Dysfunction in visual discrimination may look like:

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Proprioception - position sense

Our position sense is derived primarily from receptors surrounding our muscles, tendons, ligaments and joints.

This sense helps us understand where our body parts are in space. For example if you have your eyes closed and move your arm straight up above your head – you know this is what your arm is doing without having to see it. Another example is to think about when you are driving a car, you are able to move your feet to the right pedal without looking at your feet, this is due to proprioception.

This sense also gives an indication of the amount of pressure applied to parts of our body as it activated when we move against resistance. For example, when you push with your hands against a wall or use weights at the gym.

Proprioception allows you to feel “grounded” within your body and your environment, by knowing where you are and what you are doing. It contributes to spatial awareness, body boundaries, body image and sense of movement.

Hyper-sensitivity may look like:

Hypo-sensitivity may look like:

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Vestibular - movement

This sense is derived largely from stimulation to the vestibular mechanisms of the inner ear. Vestibular stimulation occurs through changes in positioning and movement.

It allows you to tell how fast and in which direction your head is moving.

Vestibular stimulation also involves postural control mechanisms, and as such supports an individual's posture while they are concentrating on performing a task (Dunn, 1998).

Hyper-sensitivity may look like:

Hypo-sensitivity may look like:

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7 Senses in mental health

Consider a couple of key points that we have already learnt in this module:

- We all process information through our senses differently and we all have preferences for the type and amount of sensory input that helps us function at our best.
- These preferences can fluctuate over time and will also be influenced by arousal states and the impact of trauma.

You identified personal preferences and strategies in the first “Think About You” activity. These materials have challenged you to consider the strategies that you use most commonly to assist you to calm or alert.

"All health care providers should imagine, for a moment, feeling overwhelmed, unsafe and bombarded by unfamiliar stimuli, and imagine entering a complex and overstimulating health care setting" (Champagne & Stromberg, 2004: p.36)

Practice challenge

When we look at what might be happening for our consumers in this situation with a sensory "lens", we are likely to understand their behaviours in a different way. Sensory approaches can be used with consumers who may be in a state of crisis to alleviate their feelings of distress.

Now imagine for a moment that you are acutely unwell and have been admitted to an acute inpatient mental health unit. You are in a new and confronting environment which offers limited personal choice and control.

How would you feel?

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About this section

As we discuss each sense, you will be prompted by a number of questions to build up a picture of your own sensory preferences. Please take the time to do this in the 'What about you" sections. Understanding your own preferences is an important component of being able to view what is happening for you and the people around you with a sensory 'lens'. Being able to apply this sensory lens will assist you to utilise sensory approaches in your work with people with mental health issues.

Within each sense you will also have the opportunity to:

- Explore types of activities that can be used to activate this sense.
- Identify behaviours a person may exhibit if they are hyper (over) or hypo (under) sensitive to input from this sense.
- Read an example of how a targeted sensory approach has been utilised to help a person with mental health issues.

It is important to note that while we are focussing on each sense separately, our experience is always multi-sensory, that means all experiences involve input from a number of senses. However, for each individual there will be times and situations where targeted input from a particular sense will be more helpful to them to achieve an optimum state of functioning.

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Tactile – hyper/hypo

Poor tactile discrimination means difficulty with distinguishing, comparing and contrasting different textures/surfaces by touch. An example may be:

- An example may be reaching into your pocket and being unable to discriminate between your car key and money.
- Being unable to find an item in a crowded drawer by touch alone.

Hyper-sensitivity to tactile stimulation may look like:

- "Fight or flight" response to touch.
- Does not like to be touched.
- Does not like messy foods or art activities.
- Dislikes self-care tasks for example cleaning teeth, brushing hair.
- Dislikes labels / seams on clothes.

Hypo-sensitivity to tactile stimulation may look like:

- Touches people or objects constantly.
- Seems unaware of touch unless intense or seen visually.
- Poor body awareness.
- Sloppy/messy eater.
- Invades other's space.
- May hurt people/animals with too much force without awareness.

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Tactile in practice

Activities include:

- “Fidget” toys of a variety of textures, surfaces. These toys can be squeezed, manipulated, stretched.
- Blankets or toys made with different fabrics and different textures.
- Puzzles, games.
- Manicure, pedicure, massage, self-care activities.
- Hand held massager.
- Art, craft, play doh, clay.
- Pets.
- Knitting, crotchet.
- Cooking, gardening.

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Auditory in practice

Activities include:

- Music.
- Rain.
- Ocean sounds.
- Sound of a fan.
- Humming, whistling.
- Relaxation CDs.

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Olfaction in practice

Activities include:

- Scented oils /lotions.
- Scented candles.
- Flowers.
- Cooking.
- Freshly cut grass.
- Fresh linen.
- Herbal tea.
- Scent of a favourite blanket or toy.

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Gustatory in practice

Activities include:

- Exploration of foods that may calm (typically drink of warm milk, sucking on a sweet lolly/lollipop) or alert (typically sour lollies, liquorish, lemon/lime, strong mints, crunchy foods).
- Chewing gum.
- Blowing bubbles.
- Foods of different textures.
- Incorporating stronger or less strong tastes (spice, sweetness etc).

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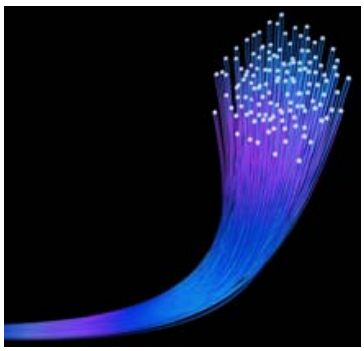
Visual in practice

Activities include:

- Coloured glasses.
- Scenic pictures or coffee table books.
- Posters, wall decals, murals.
- Photos.
- Colours and decor of the environment can be used to alert or calm.
- Lighting, lamps, fibre optic items, 'lava' lamps.
- Puzzles.
- Looking at a fish tank.
- Sunset or sunrise.
- Limit clutter on desk or provide visually stimulating items.



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Activities include:

- Trampoline, skipping, exercise bike.
- Jumping, stomping.
- Climbing, playground equipment, rock climbing wall.
- Sports, obstacle course.
- Tug of war games.
- Stress balls, exercise bands, exercise equipment.
- Games with clapping.
- Clay work, putty, play doh.
- Hand exercisers.
- Chair push-ups.
- Gardening / digging.
- Yoga.
- Wheelchair mobility.

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Vestibular in practice

Activities include:

- Sports, exercise.
- Trampoline.
- Spinning, skipping.
- Rocking chair.
- Glider.
- Balance activities.

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Practice Challenge

"All health care providers should imagine, for a moment, feeling overwhelmed, unsafe and bombarded by unfamiliar stimuli, and imagine entering a complex and overstimulating health care setting"

(Champagne & Stromberg, 2004: p.36)

Consider some of the behaviours you may have noticed in health care settings (eg. pacing, restlessness, demanding behaviours). Now try and apply a sensory "lens" to these behaviours. What may be an alternative explanation for these behaviours? What might be happening for this person?

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Therapeutic use of self

Therapeutic use of self with a sensory lens involves:

- Thinking about how we use our voice, approach, body language, body positioning in any contact we have with a consumer.
- Clinicians can support consumers by a process of co-regulation.
- Being responsive to the consumer's sensory needs and preferences.
- Listening to what consumers are telling us both verbally and behaviorally in terms of their own sensory needs and preferences.
- Using appropriate self-disclosure regarding sensory preferences and strategies to normalise the process.
- Using sensory strategies to build rapport and trust, and create a safe space for the consumer to self-soothe and recover.

The most important tool you have is YOURSELF and this should be your starting point.

What about you?

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Assessment

Assessment tools that support the utilisation of Sensory Approaches may be formal or informal.

Formal

The Sensory Profile measures (Dunn, 1999) provide information about sensory processing patterns and behaviours, and are the most commonly used formal assessment tools in this area.

Warning! These formal assessments are standardised and require training to administer and interpret.

There are different assessments for infant/toddlers, children 3 – 10 years of age, and adolescents/adults.

If you would like more information about this assessment tool, talk to a clinican with experience and training in this area.

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Interventions

There are many ways Sensory Approaches can be used as interventions, and this will depend on the goals of treatment. A general goal of interventions is to optimise a person's level of arousal so that they can feel safe and function at their full potential. Interventions can focus on personal and carer awareness, environments and meaningful activities.

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Warning signs: slow down or stop!!!!

These are possible signs that a person is having difficulty tolerating an activity:

- Anxiety.
- Excuses.
- Confusion.
- Irritability.
- Resistance to activity.
- Defensive behaviors.
- Lightheadedness.
- Increased perspiration.
- Flushing or pallor.
- Shortness of breath.
- Crying.
- Nausea.
- Fearful expression.
- Angry.
- Paranoia.

(Champagne, 2010)

Competency based training is required to use weighted modalities especially weighted blankets.

Training is required to use sensory rooms "…training for clinical and direct care staff in the use of multisensory rooms and sensorimotor approaches is necessary and best accomplished in consultation with an occupational therapist" (Champagne & Stromberg, 2004, p.42)

The development of relevant policies and procedures is necessary to guide the safe and appropriate use of sensory approaches (Champagne & Stromberg, 2004).

1. A reminder that while the senses can be useful to soothe people they can also be triggers. For example, a smell can be a powerful reminder of a past trauma. It is important for clinicians to be mindful of this, to make consumers aware of this, to constantly observe for any signs of distress, and to encourage self-direction.

2. If the consumer is becoming distressed, once they have 'slowed down or stopped' it will be important to continue to observe them, to ensure their distress is relieved and you may wish to consider providing other options to self soothe. It is important to report this observation of heightened distress in response to certain stimuli to the team.

3. Remember that the consumer is the best expert on their preferences and what is working or not working for them.

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Meet Susan.

Susan's example will demonstrates how an awareness of sensory preferences and interventions can create positive, short and long term outcomes for a consumer.

Susan is a 32 year old woman with schizoaffective disorder and borderline personality traits. She is frequently admitted to the mental health inpatient unit due to increased self harming (hitting and punching herself), poor coping in the community and increased psychotic symptoms including hearing voices. When Susan is experiencing the above self harming behaviours this can often escalate to hitting and punching other people and during inpatient admissions this has led to seclusion in the past. Susan has a history of trauma including being physically assaulted during her childhood.

During a recent admission Susan's nurse who had prior training in sensory modulation discussed her behaviours with the occupational therapist who commented that Susan may engage in these behaviours due to a sensory processing problem. Susan's nurse showed Susan the Sensory Room and completed a safety tool with her which explored:

- Reasons for distress
- Signs I am becoming distressed
- Sensory items I find calming
- Sensory items I find alerting
- I will use my sensory items when….

When Susan was in the Sensory Room she identified that sitting in the rocking chair with her eyes closed and with the relaxation music on and having soft tactile items such as soft toys and stress balls were very calming for her. She identified that items that had bright lights or which flashed were very alerting for her. Susan and her nurse discussed the possibility of Susan using the items she'd identified as calming at times when she was feeling distressed and anxious and discussed how using calming strategies on a regular basis could help to reduce feelings of stress and anxiety overall.

Susan put a copy of her safety tool on the wall beside her bed and her nurse put a copy in the chart and mentioned it at the nursing handover. Over the next couple of days Susan used her calming items in the Sensory Room regularly and the nursing staff prompted her to use them at times when they saw Susan displaying the signs of distress she had identified on her safety tool.

Upon her discharge to the community staff discussed with Susan that her admission had been shorter than on previous occasions and that she had not required PRN medication or seclusion for aggressive behaviour. Susan and the staff identified that using the sensory approach had helped Susan to better understand her own behaviours and what she could do about them for herself. They also discussed ways Susan could continue to use her calming sensory approaches at her own home.

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Meet Matthew.

Mathew is a 26 year old man with schizophrenia treated in the community. Since his early 20s Mathew has been using large amounts of alcohol and cannabis on a daily basis. On a number of occasions his substance use has resulted in an increase in psychotic symptoms and hospital admission. Mathew indicated to his case manager that he is interested in cutting down his substance use because he feels that in recent years he has no energy, his life is becoming increasingly chaotic and he does not want to go back to hospital. Mathew would like to get a job, possibly in landscape gardening.

When Mathew was in hospital last he was asked to complete a safety tool by his nurse. His case manager reviewed his Safety Tool and noted that Mathew liked to use strategies such as going for a walk or using a stress ball to deal with stress while on the ward. Mathew's case manager completed a Motivational Interview. One of the things this revealed was that Mathew was using cannabis and alcohol to cope with feelings of anxiety, and that he turned to these substances exclusively to help him to calm down and to feel less paranoid. This was a particular problem at night time and he had a routine of using cannabis before bed as part of a pre-sleep routine.

Mathew's case manager consulted an occupational therapist and together they explored Mathew's sensory preferences using a range of sensory items with a self-rating tool. Mathew identified a variety of activities that helped him to feel less anxious and more grounded. An example of an item that he found calming was mandarin oil. An example of an item that he found alerting was the wrist weights. It was noted that Mathew responded very positively to proprioceptive input and activities such as gardening, walking, chewing gum, stress balls, weights and physical work were identified. The occupational therapist developed a Sensory Kit which Mathew named his Chill Kit. The Sensory Kit contained items and cues (such as photos or checklists) for a range of sensory-based activities that Mathew could do when he wanted to 'chill' without the use of a substance.

The occupational therapist recommended the use of the Sensory Kit as part of developing a regular daily routine for Mathew that incorporated his preferred sensory activities. An example is that each day Mathew would eat breakfast and then spend time doing an activity such as going for a walk, doing some house work or working in the garden instead of getting out of bed and smoking cannabis.

As the environment is an influence on substance use, it was recommended that Mathew kept his Chill Kit very visible and accessible on the coffee table in the lounge room where he would normally sit and smoke cannabis or drink alcohol. He was encouraged to use the kit if he experienced anxiety or cravings to use a substance. Before bed Mathew moved his Chill Kit to his bedside table. He used some of the items as part of a pre-sleep routine or if he woke in the night with restlessness or cravings. An example is that he placed a few drops of mandarin oil on his pillow to help him to feel calmer.

His case manager reinforced these routines and helped Mathew to continue to develop sensory strategies to add to his daily schedule and his Chill Kit.

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Informal

There are a range of informal assessment tools that do not require specialised training and can be utilised by clinicians with an introductory level of knowledge about sensory approaches.

These include:

- Safety tools.
- Self-rating tools.
- Safe exploration of sensory based activities.

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Safety tools

A number of inpatient mental health units use individualised safety tools which are developed by a consumer with support from staff prior to or during inpatient admissions.

Generally these tools are used as a crisis prevention or a crisis de-escalation strategy.

1. In the safety tool, the consumer identifies:
   - what they are like when they are well,
   - what situations cause them distress and
   - what warning signs might be a signal that they are becoming distressed.

2. The safety tool then identifies sensory based strategies that can be helpful during times of distress for calming or self -soothing.

3. As safety tool may also include information about the individual consumer's history of trauma and previous experiences of seclusion and restraint.

4. The safety tool can then identify alternative interventions to prevent any further episodes of seclusion.

As such, a safety tool is not only an assessment tool, but also a key Intervention tool.

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Self-rating tools

Self rating Tools are simple checklists and/or rating scales that a consumer can utilise with support of a staff member and /or family members to identify sensory based strategies that they find calming and/or alerting. The results of this can then be utilised to support the consumer to develop a greater understanding of sensory based strategies they can use to self-sooth and self-regulate.

The most simple version of this type of tool may simply prompt the consumer to identify calming and alerting activities based on discussion and thinking about previous experience. Another example would be a tool which asks the consumer to tick statements that identify particular sensory strategies that the consumer finds helpful.

Safe exploration of sensory based activities

Self-rating tools are often used in conjunction with education regarding sensory processes and preferences and a safe exploration of sensory based activities within a sensory room or with portable sensory equipment. The consumer would be encouraged to try a range of sensory activities and rate if they found these activities to be calming or alerting, and to what degree this is so based on a rating scale.

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Sensory awareness

Educate, educate, educate!

A key goal within sensory approaches is to support consumers to be more 'sensory' self-aware, so that they are able to be more self-sufficient in their own self-regulation processes, enabling them to move forward on their recovery journey.

Sensory awareness can be achieved by educating consumers and their families in the following:

- Fundamental information on the senses, sensory processes and their impact on thoughts, behaviours and functioning.
- Identification of the consumer's own sensory tendencies and preferences.
- Identification of the consumer's own calming and alerting strategies.
- Identification of the consumer's own warning signs.

The consumer then will be much better informed about ways they can use their own sensory approaches to function every day at their best!

A greater sensory awareness within the staff of mental health services enables us all to work in a more sensory friendly way, and view what is happening for us and the consumers we are working with, with a sensory lens.

"Take control and you help for a day.
Teach control and you help for a lifetime"
(Karen Moore, 2010)

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Sensory friendly environment

The physical environment has significant sensory impact on all of us.

The concept of sensory friendly environments is to create environments that offer diverse, meaningful and sensory rich opportunities (Champagne & Stromberg, 2004). The aim is for environments to be nurturing and recovery focussed, with opportunities to engage in a range of activities for self-regulating purposes.

Many mental health units are modifying the environment through the development of Sensory Rooms, or by looking at ways to make the overall environment more sensory friendly – for example through the use of wall decorations and furnishings, availability of quiet spaces for calming, presence of plants and items from home.

Community mental health settings can also consider sensory friendly environment options in waiting and appointment areas, for example having “home like” furnishings, play areas/toys for children, considering the choice of wall decoration, and availability of recovery focussed information.

Occupational Therapists are experts in the field of modifying the environment to support the best possible functioning. If you would like to know more, talk to the OT in your team!

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Risk and safety features

Case study 1

Case study 2

Sensory room

A number of mental health inpatient units in Queensland have sensory rooms.

Sensory Room is the name given to a safe space containing a range of sensory based tools activities for consumers to trial and explore, with the support and guidance of a staff member who is trained in sensory approaches.

The aim of a sensory room is to support consumers in their process of becoming more aware of their own sensory preferences, what alerts and calms them, and to identify ways to self-regulate and alleviate distress.

Sensory rooms are often used in the process of developing a personal Safety tool, or may be used by a staff member and a consumer in the early phase of a consumer indicating increased distress and as such can be considered a preventative and crisis de-escalation intervention as well. Sensory rooms provide the opportunity to facilitate the therapeutic alliance and promote self care, self-nurturance, resilience and recovery (Champagne, 2010).

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Sensory kit

A Sensory Kit contains items which have been personally chosen to support an individual to self-regulate.

A sensory kit may come in the form of a box, or bag, or a personal drawer that is kept in a designated place that contains items that the person finds helpful for calming and alerting purposes. It is crucial that the kit is individual and personalised based on the consumers own needs and preferences, and contains a range of items that can be used at different times and places.

Sensory kits are used for both preventative and crisis de-escalation purposes.

It is recommended that you undertake further training beyond this introductory information before engaging in the development of sensory kits with consumers. Talk to the occupational therapist in your team, or your supervisor about how to access further training.

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Suggestions for specific mental health issues

The following suggestions may be helpful for consumers with particular mental health conditions or issues. However, be aware that these are suggestions only, and as with all sensory approaches it is important to consider individual differences and always check with the consumer you are working with.

- Anxiety or Agitation.
- Mania.
- Psychosis.
- Depression.
- PTSD/ Trauma history.

Strategies shown in italics require training. Seek assistance from an appropriate professional.

Site Map

TRIAL

Queensland Government

Royal Brisbane & Women's Hospital

Metro North Mental Health RBWH

SAFETY TOOL

(Affix patient identification label here)

URN:

Family Name: Mathew

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

The aim of this **SAFETY TOOL** is to:

- Help us better understand your needs
- Identify ways to keep you safe and in control of stressful situations during your hospital stay.

The information you provide will help us manage your care. A copy of this Safety Tool will be kept in your chart and a copy will be given to you.

Please tick the relevant options relating to **Triggers, Warning Signs and Coping Strategies**. If you select more than **5** options in any category, please also circle the **5 that are most important.**

Triggers: What are some of the things that make it more difficult for you when you are already upset?	
☒ Loud noise	☐ Bedroom door being open
☐ Being touched	☒ Too much stimulation
☐ Being isolated	☐ Not enough things to do
☐ Yelling or arguments	☒ Auditory or visual hallucinations
☒ Being around men / women	☐ Needs not being acknowledged
☐ Privacy not being respected	☐ Being restrained
☐ Rules	☐ Feeling threatened
☐ Darkness	☒ Feeling patronised
☐ Bright lights / lights shone in eyes	☐ Broken promises
☐ Particular times of the day (When?)	☐ Nightmares or distressing thoughts (What?) .....
☐ Particular times of the year (When?)	☐ Not having control or input (Please explain) .....
☐ Contact with particular people (Who?)	☐ Other: (Please describe) ....

Warning Signs: What are some of the things that indicate that you are becoming angry or very upset? Tick each "warning sign" that you recognise.		
☐ Crying	☐ Being rude or loud	☐ Shortness of breath
☐ Racing thoughts	☐ Rocking	☐ Swearing
☐ Shaking	☐ Sweating	☐ Laughing loudly
☐ Inability to sit still	☐ Clenching fists or teeth	☐ Racing heart
☒ Isolating myself	☒ Wringing hands	☒ Bouncing legs
☐ Singing	☒ Headache or tension in other parts of my body	☐ Having bad thoughts about myself or others
☒ Butterflies or sick feeling in the stomach	☐ Acting out of character (please explain)	☐ Other: (please list) ....

DO NOT WRITE IN THIS BINDING MARGIN

SAFETY TOOL

<MR OPD 195> <Date reviewed: 27/01/10>

Queensland Government

Royal Brisbane & Women's Hospital

METRO NORTH MENTAL HEALTH RBWH

SAFETY TOOL

(Affix patient identification label here)

URN:

Family Name:

Given Names: Mathew

Address:

Date of Birth: Sex: ☐ M ☐ F

Coping Strategies: Some strategies might help you to feel better when you are having a hard time and think you may lose control. Which of the following strategies do you think may help you?

☐ Asking for help	☐ Warm or cold drink	☐ Gentle stretching
☐ Deep breathing	☐ Sitting or lying down	☒ Time out
☐ Hot or cold shower	☒ Stress balls	☐ Muscle Relaxation
☐ Medication	☒ Walking in the ward	☐ A cool face cloth
☐ Talking with staff or peers	☒ Going for a walk with staff	☐ Rubber bands for wrists
☐ Writing in a diary or journal	☐ Time out with staff present	☒ Punching or hugging a pillow
☐ Dark room or dimmed lights	☐ Sitting by the nurses' station	☐ Wrapping up in a blanket
☐ Listening to music or a relaxation CD	☒ Exercise (what?) Not sure	☐ Doing a puzzle / game / activity (what?)
☐ Reading (what?)		

Other: (please list)

DO NOT WRITE IN THIS BINDING MARGIN

Comments: Is there anything else you would like to add which you think may be helpful? Has the Safety Tool raised any issues that you would like to discuss further?

Consumer Signature: M. Citizen Date: 2 / 11 / 12

Staff member to sign if assisting or discussing with consumer:

Name: Linda Nurse Designation: CN

Signature: L Nurse Date: 2 / 11 / 12

Thank you for completing THE SAFETY TOOL

My Sensory Preferences

MY NAME: Matthew DATE: 2/11/12

SENSORY AREA	What calms or soothes me	What alerts / energises me	What aggravates or distresses me
Visual		Television	
Sound / Hearing	Music		
Touching / Being touched	Massage		Wrist weights
Smelling	Mandarin Oil		
Tasting		Chewing gum	
Movement / Pressure	Stress ball		

Examples to assist exploration in each area:

1. VISUAL: Photos, TV / DVD, painting, drawing, reading, crafts, colours, nature, light / darkness, computer games
2. HEARING: TV, radio, CDs, nature sounds, silence, background noise, music, singing, talking books, volume, tone, accents
3. TOUCH: Firm or light touch on skin, massage, clothing, temperature, shower / bath, pets, handcrafts, sand, clay, textures
4. SMELLING: perfumes, essential oils, incense, herbal teas, nature smells such as scented plants, rainforest, mown grass
5. TASTING: Food, sweet / sour / salty, texture, cold / hot, lollies, milky
6. PRESSURE and MOVEMENT: Walking, jogging, running, sport, skipping, deep pressure massage, swinging, rocking in a hammock / rocking chair, dancing, using stress ball, lifting weights, yoga, zumba