Special Interest Section Quarterly
Mental Health
Sponsored in part by Pacific University
Volume 29, Number 4 • December 2006
Published by The American Occupational Therapy Association, Inc.

Creating Sensory Rooms: Environmental Enhancements for Acute Inpatient Mental Health Settings

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An increased focus on doing and performance, the domination of the medical model, and the fast-paced nature of the workplace are some of the primary factors contributing to an overall reduction in the focus on the therapeutic value of the physical environment in occupational therapy practice (Rowles, 1991; Stewart & Law, 2003). It is within the occupational therapist's scope of practice to assist in creating environments of care in which staff and consumers feel comfortable and supported. Therefore, we must ask ourselves whether mental health environments of care support nurturance, wellness, and recovery as universal themes (Champagne, 2003). Further, in demonstrating the active creation and therapeutic use of the physical environment to positively influence performance skills and patterns, consumers increasingly may become aware of the importance of considering contextual elements as an essential part of the treatment and discharge planning processes (for home, work, and school applications). Hence, the occupational therapist's role in environmental design and enhancement is quintessential in mental health. Additionally, it must be recognized that in settings based on the medical model, this approach requires much more than merely redecorating.

Hasselkus (2002) elaborated on the differences between space and place and stated that one of the primary differences is *meaning*—both private and shared. The term *space* alludes to neutrality and physical boundaries, whereas the term *place* emerges from the meaningful experiences and memories created within. In this way, a therapeutic place enables therapeutic experiences (occupations) and facilitates a safe sense of containment and the emergence of meaning (Hasselkus, 2002). Thus, in all areas of practice, including mental health, the importance of place must not be avoided or minimized. Rather, thoughtfulness in the use of space and place is essential. Whether beginning this journey through the creation of specialized rooms where place is a specific focus (a sensory room), through therapeutic gardens (Furgeson, 2003) rich in cultural symbolism, or in taking such steps throughout an entire health care organization, the potential opportunities for enhancing the ability to offer person-centered and recovery-focused therapeutic places in health care settings are endless.

It is important to point out that all therapeutic places will differ when developed collaboratively with the interdisciplinary staff and consumers of each organization. Although furnishings, activities, themes, and equipment may be common across similar settings (Hulsegge & Verheul, 1987; Pinkney, 2000), incorporating ongoing staff and consumer feedback will ensure site-specific individuality and its evolution over time (Champagne & Stromberg, 2004). For some, introducing organized carts, baskets, and bins of meaningful items into the programming may be first steps in this process. This article focuses on the general process of creating a therapeutic place, commonly known as a sensory room, emphasizing the value and necessity of collaboration in its initial development and ongoing evolution over time.

Why Now?

The President's New Freedom Commission on Mental Health (2003) has called for consumer-driven services and excellence in the delivery of all aspects of mental health care services. This initiative has kicked off multiple large-scale national efforts to assist mental health organizations in becoming more person centered and in offering evidence-based and innovative methods of care safely and responsibly (National Executive Training Institute [NETI], 2003). More specifically, federal and state mental health organizations, such as the National Association for State Mental Health Program Directors and the Massachusetts State Department of Mental Health (DMH), strongly recommend and support the creative use of person-centered, trauma-informed, sensory approaches as pivotal in transforming the culture of care (Champagne & Stromberg, 2004; NETI 2003). Trauma-informed care requires an understanding of the profound influence and high prevalence of trauma among consumers of mental health care services and the potential influence of environments of care (Jennings, 1998). Given that between 51% and 98% of mental health consumers have significant trauma histories (Meuser et al., 1998), environments of care must be trauma-informed to enable occupational performance and recovery.

One example of sensory approaches in mental health is the enhancement of the physical environment of care through the skilled creation and use of sensory rooms (Champagne & Stromberg, 2004; NETI 2003). A recent quality improvement study demonstrated that 89% of consumers reported decreased perceptions of distress after the use of the sensory room in one acute inpatient mental health care setting (Champagne & Stromberg, 2004). Further, it is believed that such initiatives, when successful, may decrease the need for restraint and seclusion across mental health care settings (Champagne & Stromberg, 2004; NETI 2003). In fact, the Massachusetts State DMH so strongly supports this premise that it has included the addition of sensory approaches into the state's code of regulations for the DMH (Code of Massachusetts, 2006) as part of its licensure requirements.

Occupational therapists must remain aware of the local, state, and national initiatives contributing to significant changes in mental health practice. With this knowledge, we can rise to the challenge of taking a leadership role in creating innovative ways in which the profession can uniquely contribute. The occupational therapy process affords the ability to offer the skilled assistance that mental health organizations need to take this initiative forward, and the profession is being advocated as a

discipline that may greatly contribute to this collaborative mission, particularly within acute settings (NETI, 2003).

Sensory Room Development: Where To Begin?

There has been an increased focus on creating sensory rooms, particularly within acute inpatient mental health settings (Champagne, 2003, 2006; Champagne & Stromberg, 2004). Although the development and use of sensory rooms for persons with pervasive developmental disabilities and older persons (Snoezelen) is not a novel approach (Hulsegge & Verheul, 1987; Moffat, Barker, & Pinkney, 1993), application to adult inpatient acute mental health and forensic settings more recently has been established (Champagne, 2003). Change is not a linear process, and endless ways to begin exist, but many who have gone through this creative process have used general courses of action. The following guidelines may assist in the overall planning, development, and implementation of the therapeutic places known as sensory rooms.

Phase One: Research

To engage in evidence-based practice, it is important to begin by performing a literature review (Creswell, 2003). Initial topics of exploration may include environmental enhancements and sensory rooms in mental health care services. The literature review must not solely remain within the occupational therapy literature; much can be gained through investigating research conducted both within and outside of mental health care services. With this knowledge, it is possible to begin developing a plan and ultimately a project proposal (Creswell, 2003), which will assist in obtaining the administrative support necessary to continue with the project.

Creating a project proposal is an intensive process, especially given the needs of physical space, funding, and staff and consumer involvement. The proposal must include the general idea; potential benefits; an estimate of the initial costs; training needs; and plans for development, implementation, maintenance, and evaluation. It also should include a general timeframe and plan to review progress and to engage in furthering the project after it has been used and studied for a specified period.

When creating a sensory room that will be used by interdisciplinary staff, it is crucial to involve administrators, staff, and consumers in creating the proposal and throughout the entire process (Champagne & Stromberg, 2004). Such an approach will help to capture the creative energy and ideas of many, rather than those of just one or a few, and contribute to the space becoming more meaningful to all who will be using it. Involving direct care staff throughout the entire process helps to safely and responsibly ensure the room's availability to consumers across all shifts. However, if the sensory room is to be created and used solely for occupational therapy service delivery, it is important to create a plan that includes the types of equipment and surroundings that will best facilitate the specific types of services to be delivered within the space. Consumer involvement will help identify the kinds of services, equipment, and set up preferred.

Mental Health
Special Interest Section Quarterly

(ISSN 1093-7226)

Chairperson: Lisa Mahaffey
Editor: Brian B. Holmquist
Communications Manager: Andrea Brachtesende

Published quarterly by The American Occupational Therapy Association, Inc., 4720 Montgomery Lane, Bethesda, MD 20814-3425; ajotsis@aota.org (e-mail). Periodicals postage paid at Bethesda, MD. POSTMASTER: Send address changes to *Mental Health Special Interest Section Quarterly*, AOTA, PO Box 31220, Bethesda, MD 20824-1220. Annual membership dues are $225 for OTs, $131 for OTAs, $75 for Student-Plus members, and $53 for Standard Student members. All *SIS Quarterlies* are available to members at www.aota.org. The opinions and positions stated by the contributors are those of the authors and not necessarily those of the editor or AOTA. Sponsorship is accepted on the basis of conformity with AOTA standards. Acceptance of sponsorship does not imply endorsement, official attitude, or position of the editor or AOTA.

Phase Two: Green Means Go!

After obtaining the green light to begin developing the space, the next step is to form an interdisciplinary committee to work on the project. This committee will formalize the plans and timelines for development and provide ongoing opportunities for staff and consumer collaboration. Integrating both staff and consumers into the interdisciplinary committee, using surveys, and conducting a needs assessment are ways of involving staff and consumers. Administrative representation is strongly suggested within this committee to elicit leadership's involvement and support from the onset and throughout the course of the project. This support is particularly necessary within organizations requiring a significant culture change to embrace a person-centered model of care.

Choosing and obtaining a suitable location typically are the next steps and may be challenging. Maximize the potential of this future therapeutic place by considering the following: window(s), temperature control, noise level, electrical accessibility, color, room arrangement, lighting, ventilation, room size, structural details, furniture, and flooring (Champagne, 2006). Choose the space with the most flexibility given the nature of the various activities that may transpire within. Many settings have few options to choose from, but when considered a priority project, administration will be more likely to create options and provide the assistance necessary in this early phase. Offices may need to be relocated or storage spaces rearranged, and administrators are key in making changes of this magnitude.

Phase Three: Collaborative Preparation

Before ordering anything, consider the population's unique needs and requests, and investigate specific rules and regulations of your setting. Some settings are latex free, and most have strict fire codes. Usually, electrical requirements, general safety concerns, and infection control considerations exist. Further, consider whether the room will be sectioned off into different thematic areas, contain one overall theme, and whether the theme(s) will change periodically with the seasons or programming. Often, it is advantageous to consider the room's versatility when designed for use with both group and individual sessions. Creating an initial plan and a priority list of "must haves" and incorporating ideas obtained through the literature review and from staff and consumers typically follow. Developing a "wish list" for future reference also is useful.

Policy and procedure development is necessary and must address the general cleaning and use guidelines for the room and its equipment. Another consideration when ordering items and creating policies and procedures is whether the room will be locked or unlocked. Exposed electrical cords and equipment or furnishings that could be used to injure one's self or others are some of the many safety considerations that may lead to the decision to keep a sensory room locked unless supervised.

Mandatory staff trainings, in-services, and modeling opportunities must accompany the initiation of any new therapeutic approach, and the sensory room and the kinds of treatment exchanges that may occur within it are no exception. Staff trainings generally include the unit's mission and philosophy of care, a review of the centrality of the therapeutic use of self, sensory modulation, an introduction to the equipment contained within the room, integrative treatment approaches used, interdisciplinary roles, safety considerations, contraindications, and policies and procedures for use of the sensory room. Depending on the skill levels of the staff, additional topics may need to be included, and further trainings may be necessary. One example is an in-service on the correlations between trauma-informed care and sensory modulation. Administrators must be included in planning the trainings and in ensuring that all staff members demonstrate competency to provide the specific interventions each discipline is expected to deliver across the various populations served and levels of care.

Phase Four: The Emergence of Place

Sensory rooms afford an organized context for engaging in self-organizing and nurturing interventions for prevention purposes and in times of

distress. The goal of a sensory room is to offer a comforting, therapeutic place to promote health, resilience, and healing. When successful, the availability and use of such a therapeutic place typically is a very meaningful experience. Additionally, a common rule in the use of sensory rooms is to use them only in ways that will not influence the development of negative associations (e.g., do not use it for restraint application or for seclusion; do not use the space to give "bad" news, unless the person is told it will be a difficult session, and he or she chooses the room as the place to work though hearing the difficult news).

The arrangement of all of the therapeutic equipment and furnishings must be thoughtful, complementary, safe, and functional. According to Cooper and Day (2003), research obtained from the areas of environmental design may be useful when designing therapeutic environments of care. However, according to the principles of person-centered care, including staff and consumer ideas and preferences is key. Moreover, the many different types of sensory rooms created in mental health care settings are reflected in the different names they are given. Some of these include "Chillville," the "Zen Room," the "Sensory Modulation Room," the "Serenity Room," "Snoezelen," and the "Comfort Room."

Phase Five: Shifting From Principle to Practice

A person-centered approach is necessary when using a sensory room or any sensory modalities. *Person-centeredness* is a buzzword in health care organizations, and many use this phrase only superficially. For some staff and administrators, a deeper approach to person-centeredness may be a significant shift and the centrality of the consumer in all aspects of care becomes the charge. Facilitating such a culture shift takes time, patience, ongoing modeling, and trainings. Over time, this shift is evidenced in many ways: Care becomes trauma-informed, more responsive, and recovery-focused. Crisis escalation is recognized early on, and staff members are more responsive before things get out of control or become dangerous. Before long, staff and consumers may begin suggesting ideas for making the rest of the unit more "sensory friendly."

Phase Six: Quality Improvement Studies, Research, and Changes Over Time

After staff use the sensory room for a specified period and are skilled in implementing therapeutic interventions, it is time to engage in quality improvement or research studies that evaluate consumer and staff satisfaction. Truly meaningful places are not static and must evolve as the times, needs, and practices change; thus, the creative nature of the sensory room must evolve along with the therapeutic processes exchanged within it. This ongoing reassessment is quintessential to it remaining a meaningful and nurturing enhancement rather than dissipating over time as a mere trend. When the purpose and value are well understood, the sensory room and approaches are not considered trends. The value and meaning of sensory rooms will become established and enriched over time only if consumers and staff continue to find them meaningful. Meaning does not reside within objects or spaces but within each person; thus, the evolution of the sensory room *must* be a collaborative and ongoing project.

Conclusion

Although we cannot control or determine the natural phenomena that emerge within therapeutic places, we can collaboratively choose and introduce environmental enhancements and activities that may help to facilitate the process of healing. Plants, music selections, instruments, natural lighting, artwork, scented lotions, assorted tactile manipulatives, a weighted blanket, health-related reading selections, and a variety of comfortable chairs are examples of sensory room essentials that often afford a more nurturing, person-centered, and recovery-focused environment.

Occupational therapy practitioners must become more active in collaboratively creating, expanding, and promoting the use of sensory rooms and other environmental enhancements across mental health care settings not only because of the national and state initiatives currently in progress, but *primarily* because of the nurturing and healing opportunities these enhancements afford. The skilled and responsible creation and use of therapeutic places (sensory rooms) has the potential to positively influence the process of self-organization and recovery (occupation as means). In this way, occupational therapy practitioners promote a deeper appreciation of the meaning of person-centeredness and the role of the environment, while facilitating the consumer's ability to more safely and functionally participate in meaningful life activities (occupation as ends). ■

Sensory Room Equipment Considerations

General Categorization	Equipment Examples
Tactile	Stress balls; Koosh® balls; Wikki Stix®; books and magazines; arts-and-crafts supplies; putty; clay; rubbing stones; T-foam cubes; therapy brushes; beanbags; musical instruments; chalkboard and chalk; massage tools; vibrating gadgets; weighted lap pads, blankets, and vests; seasonal nature items (pumpkins, gourds, pine cones, flowers); beads; puzzles
Visual	TV, DVD/VCR player, wall or ceiling projectors, lighted ceiling effects, wall tapestry, books and magazines, laminated scenic pictures, posters, wall mural, colors and textures of wall paints and coverings, mobiles, wind chimes, rock waterfall, fish tank, bubble lamp, water toys, bubbles, glitter wands, colored scarves, target games, Simon™ game, light box
Auditory	Headphones, portable music player, stereo, assorted music selections, musical instruments, singing bowl, karaoke machine, videos, sound machine, rain stick
Olfactory	Scented candles, scented lotions and powders, linen sprays, aromatic beads, aromatherapy diffuser, cut flowers, cinnamon sticks, eucalyptus leaves, lavender buds, potpourri
Gustatory	Individually wrapped hot balls, sour candies, crunchy and chewy foods, sugar-free gum, strong mints
Body awareness, movement, and balance	Weighted blankets, blanket wraps, weighted lap pad, weighted stuffed animals, ankle weights, therapeutic brushing, vibration, self-massage, assorted seat cushions, rocking chair and glider rocker, beanbag chair, yoga videos and mats, therapy balls, medicine balls, a rock climbing wall, vibrating seating equipment
Other	Air purifier, locked cabinet, window treatments (blinds, shades, curtains), natural lighting, full spectrum lighting, book shelf, texturized wall coverings, chalkboard paint, electrical outlets and covers for when not in use

Note. All experiences are multi-sensory, and there is much overlap in the categorizations and equipment examples listed. This list is for introductory purposes and is not all inclusive.

Acknowledgments

I thank Kim Madden, Alison Berryman, Elizabeth McAnulty, and Brian Holmquist for their assistance in the revisions of this article.

References

Champagne, T. (2003). Creating nurturing environments and a culture of care. *Advance for Occupational Therapy, 19*(19), 50.

Champagne, T. (2006). *Sensory modulation & environment: Essential elements of occupation* (2nd ed.). Southampton, MA: Champagne Conferences & Consultation.

Champagne, T., & Stromberg, N. (2004). Sensory approaches in inpatient psychiatric settings: Innovative alternatives to seclusion and restraint. *Journal of Psychosocial Nursing, 42*(9), 35–44.

Cooper, B., & Day, K. (2003). Therapeutic design of environments for people with dementia. In L. Letts, P. Rigby, & D. Stewart (Eds.), *Using environments to enable occupational performance* (pp. 253–268). Thorofare, NJ: Slack.

Code of Massachusetts Regulations for the Department of Mental Health, 104 CMR 27.00 (2006).

Creswell, J. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Furgeson, M. (2003). *Healing gardens*. Retrieved August 24, 2006, from http://www.sustland.umn.edu/design/healinggardens.html

Hasselkus, B. (2002). *The meaning of everyday occupation*. Thorofare, NJ: Slack.

Hulsegge, J., & Verheul, A. (1987). *Snoezelen*. Chesterfield, UK: ROMPA.

Jennings, A. (1998). On being invisible in the mental health system. In B. L. Levin, A. K. Blanch, & A. Jennings (Eds.), *Women's mental health services: A public health perspective* (pp. 326–347). Thousand Oaks, CA: Sage.

Meuser, K., Goodman, L., Trumbetta, S., Rosenburg, S., Osher, F., Vidaver, R., et al. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66*, 493–499.

Moffat, N., Barker, P., & Pinkney, L. (1993). *Snoezelen: An experience for people with dementia*. Chesterfield: ROMPA.

National Executive Training Institute. (2003, August). *Training curriculum for the reduction of seclusion and restraint.* Alexandria, VA: National Association of State Mental Health Program Directors.

Pinkney, L. (2000). Assessment of the multi-sensory environment. *British Journal of Therapy and Rehabilitation, 7*(4), 158–162.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America: Final report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Department of Health and Human Services.

Rowles, G. (1991). Beyond performance. Being in place as a component of occupational therapy. *American Journal of Occupational Therapy, 45,* 265–271.

Stewart, D., & Law, M. (2003). The environment: Paradigms and practice in health. In L. Letts, P. Rigby, & D. Stewart (Eds.), *Using environments to enable occupational performance* (pp. 3–16). Thorofare, NJ: Slack.

Additional Resources

For more information on sensory room development, equipment, and resources, visit the following Web sites:

- ROMPA: www.rompa.com
- Flaghouse: www.flaghouse.com/whatissnoz.htm
- OT–Innovations for Psychosocial Practice: www.ot-innovations.com
- TFH Celestia USA: www.tfhusa.com
- Abilitations: www.abilitations.com/features/interactions.shtml
- The SPACE Centre: www.users.globalnet.co.uk/~fow/home.htm
- CCAR Services, Inc.: www.ccar.org/snoezln.htm
- Hirstwood Training: www.multi-sensory-room.co.uk

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Champagne, T. (2006, December). Creating sensory rooms: Environmental enhancements for acute inpatient mental health settings. *Mental Health Special Interest Section Quarterly, 29*(4), 1–4.

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