



FACT SHEET

FOR:
MENTAL HEALTH
CLINICIANS
YOUNG PEOPLE,
FAMILY AND
FRIENDS

SENSORY PROCESSING AND USING THE SENSORY TOOLKIT

INTRODUCTION AND PURPOSE

A sensory toolkit is a collaboratively designed set of sensory strategies that can help young people regulate arousal, reduce distress, and support increased engagement and sustained participation in their daily life. These concepts are grounded in a strength-based, neuro-affirming approach. Neuro-affirming sensory work focuses on understanding and working collaboratively with the young person regarding their sensory needs. It acknowledges that sensory preferences are a part of who the person is, rather than a problem or deficit. Working on sensory needs should aim to support quality of life and can inform other goals of intervention, for example, stress management or school engagement.

Sensory processing differences impact 5 – 15 per cent of the general population (1). However, all people have different experiences when it comes to sensory processing and thus it is important to note that sensory differences are not specific to autism or other neurodivergent experiences (1). Sensory differences occur in 10 – 55 per cent of children (under 18) without a diagnosis, reflecting the spectrum of human neurodiversity. This prevalence is even more common, between 40 – 88 per cent, among neurodivergent children with various diagnoses. Not all young people with a diagnosis of neurodivergence will experience sensory processing differences (2).

Supporting individuals with their sensory processing has often been a task associated with occupational therapists. This fact sheet provides information and recommendations for use within multi-disciplinary teams on how to implement and incorporate sensory preferences into routine care whilst employing a neuro-affirming lens. Mental health services need to recognise sensory processing differences in neurodivergent people accessing care, to provide an accessible and supportive experience. In addition, many



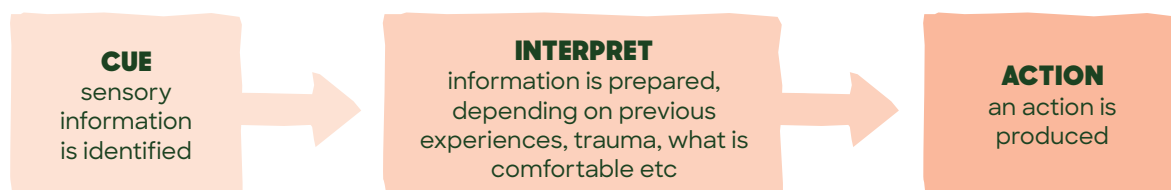
mental health settings do not have access to occupational therapists, making it essential that all disciplines have at least a basic understanding of sensory processing.

A range of sensory toolkits, checklist and questionnaires currently exist, which provide clinicians opportunities to explore sensory preferences with a young person. The purpose of this fact sheet is to provide an overview of sensory processing, outline ways to explore sensory preferences with a young person and offer guidance on using Orygen's Sensory Toolkit to support young people.

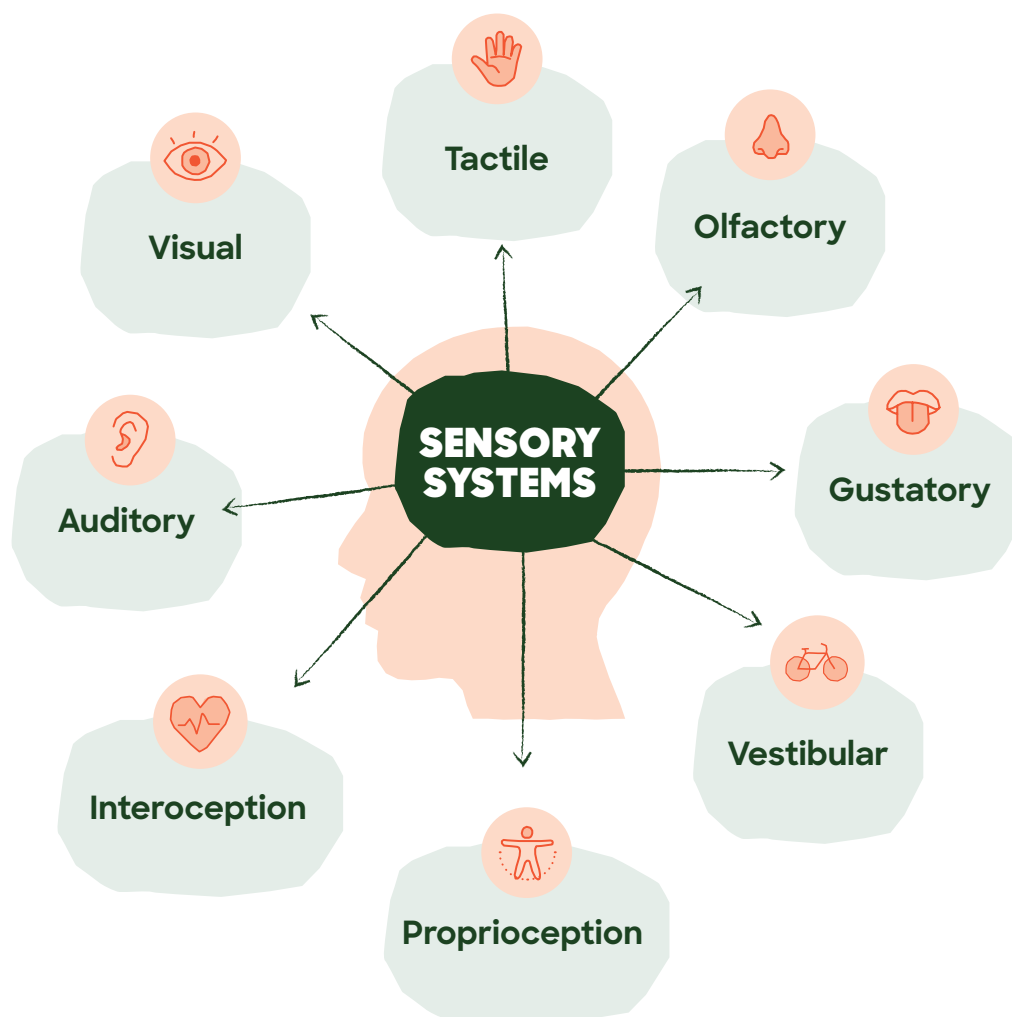
"It's not a one-size-fits-all, and you may find similarity with a sensory method, but you don't have to exactly match it."

YOUNG PERSON

SENSORY PROCESSING



The below visual displays all the sensory systems.



There are many definitions of sensory processing. Common terms include sensory integration and sensory modulation. Some individuals may use these terms interchangeably, however, there are some differences and research suggests that sensory modulation is better conceptualised as a subcategory of sensory processing (3). Sensory modulation can be defined as, “A twofold process. It originates in the central nervous system as the neurological ability to regulate and process sensory stimuli; this subsequently offers the individual an opportunity to respond behaviourally to the stimulus.” (3).

Additionally, Sensory Integration is a term first coined by Jean Ayres, an American occupational therapist and psychologist. She developed Sensory Integration Theory as a way to describe how difficulties in making sense of sensory information from the body and environment are linked to challenges in academic or motor learning (4). Sensory Integration Therapy was then developed, which uses clinical reasoning, current evidence and client outcomes to create holistic, individualised interventions instead of single stand-alone sensory strategies (4).

Sensory processing can be explained as, “the ability to register and modulate sensory information and to organise this sensory input to execute adaptive responses to situational demands and thus successfully engage in daily occupations” (5). Sensory processing differences are an important consideration for neurodivergent young people. Varied sensory needs are frequently experienced by young people presenting to mental health services with anxiety, trauma histories, changes in mood or psychotic experiences. Sensory differences are often observed by others as unique ways of interpreting, noticing, or integrating sensory input across sensory systems.

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“I find sensory toolkits useful at times when I am struggling to think of a way to meet a need especially when I am overwhelmed.”

YOUNG PERSON



SENSORY SYSTEMS

There are five senses that most people would be aware of: visual, auditory, gustatory (taste), olfactory (smell) and tactile (touch). Other than these five senses, there are three additional senses that support functioning: proprioceptive, interoceptive and vestibular. These senses can be understood by recognising that the first five detect information from the external environment, while the three additional senses interpret cues from within the body (6–8).

External senses:

- Auditory/sound
- Visual/sight
- Tactile/touch (e.g. deep pressure, which can be described as the “sensation produced when an individual is hugged, squeezed, stroked, or held”) (9). Examples of other tactile or touch could include temperature, pressure, pain and vibration.
- Olfactory/smell
- Gustatory/taste

Internal senses:

- Proprioceptive/body awareness – input to the muscles and joints that frames body’s awareness.
- Vestibular – movement and balance
- Interoceptive/internal sensations – bodily feelings such as going to the toilet, hunger/thirst, temperature, pain and anger.

WHY SHOULD WE CONSIDER SENSORY PROCESSING IN PRACTICE?

- To foster emotional safety, comfort, and authentic participation.
- To create a positive, warm, hopeful, calming and wellbeing orientated therapeutic environment.
- To encourage understanding and use of strategies for grounding, orientating, self-soothing, and managing stress.
- To encourage self-awareness, understanding, and learning triggers and identifying sensory preferences/strategies.
- To assist in developing autonomy, choice and control.
- To assist in preventing or de-escalating the use of restrictive interventions.
- Regulation supports engagement, connection, and participation across all areas of life – and sensory experiences can influence this in dynamic ways.

SENSORY STYLES

Every individual's brain takes in sensory information in its own way. These differences are part of being human. Sensory processing can be assessed by an occupational therapist however it is important for all professionals to understand sensory processing when working with young people presenting in mental health services. Sensory processing differences are common in young people experiencing a range of mental health conditions, and even more so for neurodivergent individuals. Mental health professionals can incorporate sensory techniques to support person-centred, holistic and neuro-affirming care.

There are different ways that occupational therapists can assess sensory processing. One way that sensory processing can be understood is through considering four main categories: low registration, sensation seeking, sensory sensitive, sensory avoiding (10). The key areas that are considered during assessment provide information around the ways that individuals interpret and process sensory stimuli (4), (11).

It is common for individuals to experience variation across their sensory preferences and processing experiences, e.g. difficulty noticing hunger cues but also sensitive to noise. Each person has a profile that is unique to them and doesn't follow any pattern or 'rule'. Therefore, being flexible and responsive to each individual's sensory needs is essential, guided by what a person communicates and how they experience their environment.

The four main categories of sensory processing help an individual to understand how their brain takes in sensory information. This information can help an individual understand their own preferences and use the information to support their engagement and participation in different environments. Please note that there are many different assessments used to assess sensory processing however the categories below have been drawn from one of the most commonly used sensory assessments in mental health.

- **Low Registration:** Some individuals have a high threshold for sensory information, meaning they take more time to notice sensory information or may need more intense input to notice it. This means a person might not immediately notice their name being called or what's happening around them straight away.
- **Sensation Seeking:** Some individuals need lots of sensory input to feel calm, focused, or alert. Individuals may show a preference for moving, making noise, touching things or being active. These individuals will often seek out higher levels of sensory input to support regulation and engagement.
- **Sensory Sensitive:** Some individuals have a lower threshold for sensory information and notice input very quickly and very strongly. Sounds, lights or textures can feel intense or overwhelming. This also means they often notice details that others miss.
- **Sensation Avoiding:** Some individuals notice sensory input quickly and work hard to stay comfortable. They might like routines, quiet spaces, or controlling their environment. These individuals benefit from sensory input that is personalised and predictable (10).



NEURO-AFFIRMING PRINCIPLES

When considering a young person's sensory preferences, it is important to incorporate a neuro-affirming perspective. A neuro-affirming lens aims to support and encourage an understanding of sensory needs and allows for collaborative care and joint decision-making when working with young people. Neuro-affirming care benefits all young people, not just individuals with identified neurodivergence.

NEURODIVERSITY-AFFIRMING PRACTICE IS GROUNDED IN SEVERAL KEY PRINCIPLES

PRINCIPLES	CONSIDERATIONS
A commitment to ongoing learning about neurodivergence	Clinicians are encouraged to actively build and update lived-experience-informed and evidence-based knowledge of neurodivergence, including trauma-informed care, sensory needs, masking, and the impacts of non-affirming approaches across the lifespan. In addition to this, it is important to recognise the limits of clinical approaches and assessments and to prioritise Autistic-led/neurodivergent resources and refer/collaborate as needed.
Safety to be their authentic self	Create sensory-friendly therapeutic spaces, welcome stimming/movement, use client-preferred language/pronouns (i.e. identity first or person first language), support safe un-masking, and pace sessions to build trust at the individual's rate.
Finding the best way to communicate	Proactively adapt to individual communication styles (e.g. clear/direct language, visual/written aids, no pressure for eye contact – all dependent on the young person and their preferences), allow processing time, and involve families/carers/support people with consent where required.
Authenticity in practice	Be genuine and curious about the young person, be compassionate and reflective, relate as fellow humans within the context of a therapeutic setting, openly admit to any potential limitations ("I don't know"), welcome feedback, and repair with humility.
Validate lived experiences	Believe and value a young person's account of their own experiences, treat young people/families as experts in their own lives, challenge deficit-based assumptions, and recognise distress/sensory overwhelm.
Person-centred support	Collaboratively tailor goals, make accommodations and adaptations according to individual needs, strengths, and interests (e.g. predictable routine, low sensory environment, visual aids, talking about their passion).
Genuine acceptance and appreciation of the neurodivergent community	Embrace neurodivergence as a valid neuro-variance with strengths and culture, avoid pathologising, and actively counter ableism in practice and systems (12).

*For more information on neuro-affirming care, please refer to Orygen's [Neuro-affirming Care Resource](#).

DEFINITIONS

Below are some common terms and definitions that are often explored when looking through a neuro-affirming lens:



Neurodiversity

“Neurodiversity is the idea that all people have different ways of thinking and experiencing the world,” (13) explicit focus. Research questions included: (a. It recognises that neurological differences – such as autism and ADHD – are part of normal human diversity. The neurodiversity paradigm emphasises inclusion, respect, and appreciation of all neurotypes as equally valid ways of being.

Neurodivergent

This term describes individuals whose learning, thinking or functioning falls outside neurotypical social norms. Previously, neurodivergent individuals were viewed as having deficits and in some cases, this belief and approach to care still exists today. Neurodivergence covers a range of differences, not just autism and ADHD. Other examples that are often associated with neurodivergence include: learning and intellectual disabilities, dyslexia, dysgraphia, dyspraxia, speech and language differences, foetal alcohol syndrome, and acquired neurodivergence such as traumatic brain injury and post-traumatic stress disorder. Essentially, neurodivergence means a person’s brain works differently from what most people might expect (14). Many people identify as neurodivergent without a formal diagnosis based on their lived experiences and because of the significant systemic barriers that can limit access to assessment. Historically, research has underrepresented women, culturally diverse individuals, and gender-diverse people, which has contributed to narrower diagnostic frameworks and made neurodivergent experiences more difficult to recognise across different groups.

Autistic, AuDHD, ADHDer

Recent research on neurodiversity affirming language preferences “identity first” terms like “Autistic person” (capital A) because many Autistic people see autism as an intrinsic part of their identity, not something that they “have”. “AuDHD” and “ADHDer” are community terms for someone who experiences both autism and ADHD, or ADHD only (15).

Rejection Sensitivity Dysphoria (RSD)

This term refers to intense emotional distress which is caused by perceived or actual rejection, criticism, or disapproval. These experiences are often shaped by cumulative “biological and environmental factors” (16) rather than being an inherent trait of neurodivergent individuals. It is important to note that RSD is not recognised as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), however, it has helped many people make sense of their experiences by increasing self-awareness of triggers, reducing shame, and supporting effective coping strategies.

Pathological Demand Avoidance (PDA)

PDA refers to a neurodivergent profile in which everyday demands can trigger significant anxiety, distress and nervous system overload, leading to avoidance of those demands. This avoidance is not intentional opposition or lack of motivation, but rather a protective response to perceived loss of control or overwhelm (17). Some communities prefer the term Pervasive Drive for Autonomy, which avoids deficit-based language and better reflects the underlying need for safety and control. It is important to note that PDA is not recognised as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) but is a concept that has helped many individuals and families to make sense of their experiences and better manage distress and avoidance.

Double Empathy Theory

The Double Empathy Theory proposes that communication breakdowns between Autistic and non-Autistic people arise from mutual misunderstanding rather than a one-sided deficit (which is typically misattributed to Autistic people) (18). It argues that each group struggles to interpret the other’s intentions, emotional cues, and communication styles due to differences in lived experience and social expectations. This reframes social misunderstandings as a reciprocal mismatch in understanding, not an Autistic lack of empathy.

Executive Functioning

Executive functioning refers to the mental processes that support planning, organisation, task initiation, flexible thinking, emotional regulation, and working memory. Neurodivergent young people may experience differences in these areas due to variations in neurological processing, as well as increased **cognitive load** (the amount of mental effort required to manage tasks, sensory input, and social experiences) and **cognitive fatigue** (the exhaustion that follows sustained cognitive effort). These differences can make everyday activities – such as following multi-step instructions, transitioning between tasks, finishing activities, multi-tasking, or managing strong emotions – more challenging. A neuro-affirming approach recognises these capacity-based differences and focuses on reducing environmental demands, supporting regulation, and using strengths-based strategies to help young people participate meaningfully in their daily lives.

Masking

Masking is a term often utilised in the Autistic community to “describe the suppression of aspects of self and identity” in order to better fit in with neurotypical expectations and avoid stigma (19). Autistic people may consciously or unconsciously mask because they do not feel safe or comfortable expressing themselves openly, leading them to modify behaviours such as eye contact, facial expressions, or stimming movements.

Masking requires significant cognitive, emotional, and physical effort, often resulting in exhaustion, burnout, and reduced capacity to participate fully in meaningful activities or relationships. It can also affect a person’s sense of identity, contributing to feelings of disconnection, grief, or loss as individuals struggle to maintain a coherent sense of self (19).

Trauma-informed care

Autistic people experience significantly elevated rates of trauma (20). Therefore, to provide neuro-affirming care, it is imperative for clinicians to practice according to trauma informed care principles. Trauma-informed care:

- *realises* the widespread impact of trauma and understands potential paths for recovery.
- *recognises* the signs and symptoms of trauma in clients, families, staff and others involved with the system.
- *responds* by fully integrating knowledge about trauma into policies, procedures and practices.
- *seeks* to actively resist re-traumatisation (21).

Trauma-informed care seeks to provide an environment that encourages safety, trustworthiness and transparency, empowerment, collaboration and mutuality, voice and choice, and considers cultural, historical and gender issues (22).

Further information regarding [trauma and trauma informed care](#) can be found on the Orygen website.

“[Sensory processing] plays a big role in it, even like when you spend so much time in hospitals, they’re not, sensory friendly places. They’re lots of noise, lots of lights, you know, lots happening.”

YOUNG PERSON

USING THE TOOLKIT IN A MENTAL HEALTH SETTING

Disclaimer - the discussion points and recommendations in this document around supporting sensory needs are suggestions and should **not to be used as a 'one size fits all approach' as all individuals interpret sensory stimuli differently.*

There is strong evidence that when caregivers and educators are supported with sensory-informed training that aligns with a young person's preferences and goals, it can meaningfully support their regulation and participation (23,24). In a mental health service, this can look like:

- Embedding sensory tools in clinical spaces (waiting room, consult rooms, group rooms) with clear signage inviting young people to selfselect items, and having staff model how to use items.
- Offering brief, structured sensory checkins at the start of sessions (e.g. visual cues, arousal scales, checking in prior to appointments to understand level of support required) to plan how to make the space comfortable and supportive.
- Using sensory strategies proactively and responding to signs of sensory overload by pausing talking-based therapy and supporting nervous-system regulation (e.g. deep pressure, movement breaks or environmental adjustments).
- Consider referral to an occupational therapist if additional support regarding sensory processing needs is required.
- Consider development of a feedback form (either through the use of paper form, a text message or an app) to gain an understanding of the young person's experiences. It cements a commitment from the service to continually amend and adapt practice in order to build rapport and support the young person in meeting their sensory needs.



CORE COMPONENTS OF THE SENSORY TOOLKIT

When considering the sensory needs of a young person and how to implement a sensory toolkit within a mental health setting, it is important to prioritise rapport-building and creating a safe environment for the young person. Sensory needs may not be a comfortable topic of conversation for young people, especially if their needs are something that may be stigmatised or they have not had positive experiences when accessing mental health services in the past.

The toolkit has been specifically designed to explore sensory processing preferences within a mental health context, however could be extrapolated to a range of settings and could be even used as a personal tool, encouraging continued learning about oneself.

BEFORE WE BEGIN...

Consider the following:

- ✓ Before a young person attends a service, can information be collected to help understand the person's sensory preferences prior to their attendance? Young people may have questions about accessibility of the building or how stimulating the environment may be. This can often increase anxiety and concern if not addressed. This could be explored through initial contact via phone, email or text or through an intake form.
- ✓ Once this is considered, are there ways to communicate with the young person to ensure a smooth transition of support? Are there any simple sensory changes that could be implemented in the environment to support their needs?

The toolkit is separated into four sections or steps which include the following:

STEP 1

The first step explores each sensory experience (taste, smell, touch, visual, sound, proprioception, interoception and vestibular) and breaks down some ideas/recommendations and allows space for the young person and clinician to write down what is relevant for them in each sensory experience. It is important to note that young people are encouraged to come up with their

own ideas if the ideas presented on the page are not relevant to them. Clinicians are encouraged to consider additional recommendations and strategies if they deem this may be relevant to the young person. New recommendations and strategies should be trialled by the young person to see if they work.

STEP 2

The second step is about recognising an individual's sensory preferences within their environment. It explores four main questions that a young person can either fill out individually or can fill out with a clinician. They are as follows:

1. Are there any thoughts or feelings you have about coming to the service?

Some ideas that could support exploration of this question include:

- I feel anxious about coming to a new service.
- I've never been in this building before, and I'm worried about getting lost.
- I'm worried my clinician won't understand me.
- I'm worried my clinician will make me feel bad about my mental health.
- I don't know what to expect.
- I don't know what the experience will be like.
- I'm feeling hopeful.
- I'm looking forward to getting support.
- This question allows for openness, honesty and reflection from the clinician, and the young person to name the environmental, emotional, spiritual, mental and physical challenges that may arise when accessing a mental health service.
- In the toolkit, there are some prompts that have been developed that may be helpful for young people who require support with determining how they feel this topic. Often, conjuring ideas about thoughts and feelings may be incredibly challenging, particularly if young people have had previous negative experiences or experience alexithymia.

2. Is there anything you needed from mental health services before that you didn't receive?

- As discussed in the previous dot point, the toolkit recognises that young people may have had previous experiences in mental health settings and thus, recognising and naming this can often be helpful in ensuring that the young person has a more positive experience and the clinician is more aware of what may have not have been helpful in a previous setting.

3. What are my current strategies?

- All individuals have strategies they use to support their own mental health. It is important to utilise a strengths-based approach to acknowledge how an individual processes information and how they may manage each situation (24). Clinicians need to consider this when engaging talk therapies and recommending strategies to manage symptoms.

4. How can my clinician help me feel more comfortable?

- The way that a clinician engages with a young person is imperative in the therapeutic relationship. A young person is an expert when it comes their lives and their own experiences and often allowing a young person to express themselves is a key part of building relationships and exploring their mental health in a more authentic way.
- There are some areas that clinicians can consider when assessing the environment, their approach and follow up appointments and how information is documented:
 - Observe the environment and name anything that may not be ideal and may not be able to be changed. Young people prefer authenticity and recognising this may provide an opportunity to 'break the ice'. For example: "I know that the clinic room environment isn't very inviting. We can't change that, but we can think about what we can bring to these sessions to help you feel more comfortable".
 - Based on what a young person shares, clinicians are encouraged to consider how information is best received and processed. Attending a new service can involve many new experiences, and people may benefit from information being shared in different ways. Thoughtful consideration of how information is presented, including offering alternative formats, can support understanding, comfort and participation.

STEP 3

The next step explores how we can take the sensory preferences identified in step 2 and extrapolate these in the young person's environment. It covers a range of common places that a young person may go to, including home, school, work and community spaces, and has another column for 'other' in case what has been listed is not relevant.

You may find that a young person may have difficulty making a choice about their sensory preferences. This is completely fine and can be used as a conversation starter. It is not a requirement for a young person to completely understand their needs but rather this tool can be used as a learning opportunity to engage and

experiment in their environment about what they may need for the future. The young person may use the ideas/suggestions as a starting point with the freedom to explore what works best for them, including trying something entirely different, i.e. if a young person sees a preference of being barefoot and they do not like that, then they can choose the opposite, such as 'prefers to wear shoes or socks'.

There is no right way or wrong way when using this tool. The most important part is creating space for open conversations about sensory preferences and encouraging people to explore what works best for them.

STEP 4

There is strong evidence that caregiver education and home-based sensory strategies (after caregiver training/coaching) improve functional performance and participation (24). In young people, evidence has demonstrated that focusing on participation and not symptom reduction often supports functional outcomes, which in turn support sensory strategies with life skills, emotional regulation and school/ community participation (24).

The toolkit explores three separate tables that support information sharing with the young person, should they choose to share this information. There are options to choose multiple individuals but there is no expectation that young people should share this information. It is up to the clinician and the young person to determine what is appropriate in this instance.

If a young person decides that they want to share their sensory preferences, the next table, titled *How do I want this communicated*, in the toolkit explores how the information could be shared. Please note that this is not an exhaustive list and should be further explored between clinician and young person. Not all information needs to be shared, so it is important to consider what is shared, as well as how.

Finally, the last table, titled *Are there parts of this document that I don't want shared?* explores any information a young person may not want to share. It is then up to the clinician and young person to explore how they communicate the information and share what is deemed important by the young person.



SENSORY CONSIDERATIONS AND ADAPTATIONS IN A MENTAL HEALTH SETTING

SENSE	ADAPTATIONS
Auditory (sound)	• Reduce background noise where possible (e.g. by installing soft furnishings, acoustic panels, door seals) and avoid loud televisions or music in shared spaces. Please note: it is also important to consider risk when setting up the environment to encourage neuro-affirming practice and to ensure that safety precautions for staff, young people and their families are also considered. • Where appropriate, consider whether music may support rapport-building by inviting the young person to share their preferences and, if welcomed, incorporating preferred background music into the therapeutic environment (for example, asking about their favourite band/artist and playing this in the environment). • Offer a range of noise-reducing options, such as access to quiet rooms, white-noise machines, or disposable earplugs, to support sound-sensitive individuals. Where appropriate, provide the option to use noise-cancelling headphones during assessments, provided this does not impact assessment results. • Consider other sensory inputs if sound is unable to be completely removed, including using visual supports, timers and cards to facilitate conversations. Over or under stimulation of a particular sense can occur and thus it is important to plan with a young person how they may best participate and communicate in these instances.
Visual (sight)	• Use softer, nonflickering lighting (warm, dimmable lights; minimal harsh fluorescents) and avoid very bright lights. In these cases, consider whether therapeutic support could be provided in another space such as another room or outdoors. • Consider the environment. Is the space visually demanding? Consider walls and noticeboards and determine what is necessary and essential to have on the walls and what isn't. Ensure that signage is clear (particularly for young people who have not visited the service before) and allow for the use of visual schedules (for collaborating around what the session will cover), cue cards or other visual supports are offered as alternate ways of communicating. • When providing recommendations, ask the young person and/or the family how best to present information and recommendations. I.e. would factsheets be appropriate, or would a more condensed visual tool be appropriate? Consider how the information is presented.
Tactile (touch)	• Provide a range of safe textures, like soft cushions, weighted blankets (please be mindful that weighted blankets need to be no more than 10 per cent of the person's body weight and are contraindicated for some medical diagnoses) or lap pads, weighted toys, fidget tools, or textured objects, for young people to use as they need. • Make sure everyday materials (chairs, blankets, flooring) are comfortable and not scratchy or irritating and keep options available for those who prefer minimal touch input. Enquire with the young person about their tactile preferences and discuss possible accommodations and explore what may not be altered.

SENSE	ADAPTATIONS
Olfactory (smell)	• Ask about olfactory preferences, discuss if there are accommodations that could occur, such as having non-scented tissues available during a session. • Consider aspects of the room, are there certain fragrances that are sprayed in the room and if so, are they able to be removed if required? • Consider wearing non-scented or lightly scented fragrance/body spray, especially if the young person has identified that it causes them discomfort or overwhelm.
Gustatory (taste)	• Provide access to plain, neutral-tasting water to encourage hydration without strong or unfamiliar tastes. Offer no more than two options and be sure to liaise with the young person about their preferences. • Allow for food to be present in the session if this is regulating and appropriate for the session. Consider allowing young people to bring preferred snacks or provide options that respect dietary restrictions and sensory preferences.
Vestibular (movement/ balance)	• Consider setting up the space to have different seating options, such as sturdy rocking chairs, balance balls (gym balls), or large cushions in a quiet corner for gentle forward-back or side-to-side rocking, which provides calming vestibular input. • Designate a clear, open path or opportunity for movement, where young people can walk, march in place, or do slow stretches (like reaching arms up and down) to activate vestibular sense safely indoors. • Incorporating movement into a session can be both regulating but also provide opportunities for break, facilitate impromptu discussion about strengths and interests and can support in reducing potential overwhelm. • Consider whether sessions need to take place exclusively within the clinic setting. Where appropriate, options such as a short walk or sitting outside may support comfort, promote variety in sessions, and increase engagement by offering a more relaxed and less demanding environment.
Proprioception (body-position awareness)	• Offer self-directed deep pressure via squeezing a stress ball or rolling up in a blanket for calming input, consider providing a weighted toy or blanket for additional input (keep in mind 10 per cent body weight rule and contraindications). • Play materials such as Theraputty that provide opportunities to strengthen hand muscles and provide tactile and proprioceptive feedback. This can also serve as a fidget toy option.
Interoception (internal body feelings)	• Guided activities that help young people notice their breath's rhythm and depth, such as slow breathing, belly breathing, progressive muscle relaxation or using apps or videos for breath tracking. • Short guided mindfulness or meditation exercises that encourage scanning attention through body parts to notice sensations (e.g., tension, warmth, heartbeat). • Encouraging regular check-ins with thirst and hunger signals, perhaps with prompts or journals to help young people notice and respond to basic body needs.

RELATED RESOURCES

- **Neuro-Affirming Care Factsheet** (Orygen, 2026).
- **Sensory Toolkit** (Orygen, 2026)

FURTHER INFORMATION

- Reframing Autism – an organisation lead by Autistic individuals: [Reframing Autism | Celebrating & nurturing Autistic identity](#)
- Yellow Ladybugs – [Yellow Ladybugs](#)
- Emerging minds – [Emerging Minds - Advancing Australian children's mental health](#)
- Raising Children Network – [Raising Children Network](#)
- Amaze – [Amaze – Creating an autism inclusive Australia](#)
- Aspect – [Aspect Australia | Autism Spectrum Australia \(Aspect\)](#)
- MySet (My Sensory Experiences Tool) – [MYSET \(My Sensory Experiences Tool\) - Autism Queensland](#)
- Ready Rocket – [Ready Rocket Resources](#)
- Tappy Digital Fidget Tool (app)

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