Note to all: in development and editing - will finalise after group edits

Key atm:

areas in yellow for you to add your own data -

areas in red examples of own ‘story’ example.

Email to: [professional.enquiries@rcot.co.uk](mailto:professional.enquiries@rcot.co.uk)

Dear Royal College of Occupational Therapists,

My name is XXX, RCOT number XXX. I am a member of XXX specialist section, XXX forum and XXX regional group.

I practice occupational therapy using a range of approaches, models and frameworks to support my holistic and client-centred practice; choosing from those that best meet my clients’ needs. These include but are not limited to;

(delete/add to those that apply)

* Ayres’ Sensory Integration
* Sensory-based interventions
* Co-op
* MOHO
* PEO
* Bobath/NDT
* Sensory Attachment Intervention
* Trauma informed care
* DBT etc
* Intensive interaction
* Solution Focussed Therapy
* Motivational Interviewing
* Coaching and education strategies
* DIR Floortime
* Top-down approaches
* Environmental adaptations and modifications
* Occupational performance coaching
* DDDM???

Additionally I am also trained in the use of a range of assessment and intervention tools and methods, some taught at undergraduate level and others at postgraduate level:

(delete/add to those that apply)

* Hand therapy and splinting
* Sensory Integration and Praxis Test
* Evaluation in Ayres’ Sensory Integration (i*n development - norms currently being collected as part of an international research collaborative Goal 3 of the 202 Vision*.)
* Ayres’ Clinical Observations
* Fidelity Rating - Ayres’ Sensory Integration
* Assessment of Motor and Process Skills
* Developmental, Motor and co-odination assessments: MABC2, BOT2, MFUN, VMI, Peabody, Bayley scales, GOAL etc
* Occupation focused tools; MOHO tools eg MOHOST, SCOPE, OSA, COSA, ACIS, OCAIRS, MOHO ExPLOR, ABAS2, REAL, Vineland, VDT MOCA, REAL
* Perceptual and Memory Assessments eg Rivermeads, Allens, COTNAB etc

I have read the recently released ‘RCOT Informed View Sensory Integration and Sensory-Based Interventions’ and ‘Evidence Spotlight: Sensory integration and Sensory-Based Interventions – Children & Young People’. I am very concerned and disappointed that the document has stated that the evidence for Ayres Sensory Integration (ASI) is limited and inconclusive.

While we concur with the evidence that has been quoted in both of the publications, Schaaf 2018 states *“Child outcomes in play, sensory-motor, and language skills and reduced caregiver assistance with social skills had emerging but insufficient evidence…”*, in addition to the conclusions drawn and therefore published in the RCOT Informed View and Evidence Spotlight, this Systematic Review also states *“…the evidence is strong that ASI intervention demonstrates positive outcomes for improving individually generated goals of functioning and participation as measured by Goal Attainment Scaling for children with autism. Moderate evidence supported improvements in impairment-level outcomes of improvement in autistic behaviors and skills-based outcomes of reduction in caregiver assistance with self-care activities.” It is imperative to highlight that the evidence is clearly compelling and therefore the documents* sadly undermine the integrity and validity of ASI.

The evidence base is not only growing, it is undoubtedly conclusive (Hume et al 2021, Porter Institute 2019 and Schoen et al 2018). The evidence within these peer reviewed publications demonstrates positive occupational gains. My concern, and that of the community of practice of therapists doing Ayres’ SI in this country and abroad will result in children and adults unable to access this therapeutic approach as part of occupational therapy service provision.

NICE guidelines and the Children’s Framework state “professions have to provide up-to-date evidence-based assessments and interventions.” and the The National Framework for Children and Young People's. **[**<https://www.nice.org.uk/guidance/cg170/evidence/autism-managment-of-autism-in-childrenand-young-people-full-guideline-248641453> last accessed 09/02/2021**]**

The NICE GUIDANCE for Autism spectrum disorder in adults: diagnosis and management includes references to both assessments and interventions addressing sensory differences and accommodating for these via comprehensive assessment.

**[**<https://www.nice.org.uk/guidance/CG142/chapter/guidance#principles-for-working-with-adults-with-autism-and-their-families-partners-and-carers> - last accessed 09/02/2021**]**

As an Occupational Therapist who uses ASI as one of the tools available to me, I am disappointed that the documents do not outline the requirement of specialist knowledge and skills that are required in some cases to support individuals who have significant sensory processing and integration as well as praxis difficulties which have a significant impact on occupational performance. Occupational Therapists are trained in many areas, however there are times when specialists are required in order to meet the needs of our clients. This specialist further education should reflect the learning needs of the therapist, providing targeted and specific training at the just right level to be able to deliver the specialist and complex assessment and intervention skills and clinical reasoning required by teams supporting clients with complex clinical presentations and behaviours, requiring differential diagnosis and in depth functional analysis, as per NICE Guidelines.

I am confounded and astonished by the point that states that ASI is all about remediating dysfunction and nervous system issues, rather than supporting and enhancing occupational performance to improve our clients quality of life. There are many ways we as Occupational Therapists support occupational performance through both bottom-up and top-down approaches. (which is flexible thinking)

See the attached Wall Model, clearly indicating how the senses inform occupational performance.

Graphical user interface

Description automatically generated

I am aware of the up to date evidence, as are all the other Occupational Therapists who are qualified in ASI, as we have to complete postgraduate level training which requires us to review the evidence.

Historically, Liverpool, Cardiff, Ulster University and now Sheffield Hallam University have all offered post graduate accreditation of education in Ayres’ Sensory Integration, including at master’s level, reflecting the expertise and complexity of clinical reasoning required to practice with some of the most complex clients with extreme dysregulation and high risk behaviours that are challenging, including trauma which significantly impacts upon their ability to engage in daily occupations, putting them at risk and overall has a debilitating consequence on their quality of life.

The impact of the 2015 Practice Briefing was far reaching, with the statement then dividing therapists, reducing post and service delivery models that included Ayres’ SI and preventing commissioners funding therapy that many children, young people and families (and also adults) required. The impact included OTs reporting other OTs for being unprofessional in choosing to use Ayres SI as part of their practice, including to the HCPC. Sadly and most worrying to highlight, most recently this statement was used to evidence decisions not to provide Ayres’ SI as an NHS service on behalf of social care to inform the adoption care planning for a young person with trauma, citing quotes dictated in a phone call from the new 2021 Evidence Spotlight and Informed View, stating their practice adhering to this guidance means they practice ethically. (my personalised bit - Kath Smith)

I know it is often quoted that there are more evidence-based options available, such as Occupational Performance Coaching, and the Co-op approach, however OTs utilise a combination of these approaches and others e.g. Sensory Ladders alongside ASI. Not all children and adults can access these very cognitive approaches, including those who are non-verbal, who have cognitive delays, who are unable to play or have profound physical and cognitive challenges.

As an Occupational Therapist using the theory and practice of Ayres’ Sensory Integration (and related approaches grounded in the theory), my holistic, person-centred rather than model dictated practice has allowed me to support and improve the quality of life of infants, children, teens, adults, older adults and their families and carers (across the lifespan). This includes from the level of poor awareness of anyone being present in the room, running in circles, humming a song, to being able to access a mainstream school (with support), begin to learn to hand write, toilet independently, feed independently, dress independently, scoot to school with their peers, and play at break cooperatively.

(Add a case study anonymised PRACTICE EXAMPLE or other commentary).

As part of my occupational therapy practice, the use of Ayres’ SI first has enabled clients to engage in top-down approaches – with colleagues often commenting it gets people talking therapy or top-down therapy ready, including supporting and enhancing self-regulation.

OTs in the UK are using ASI as one of the tools in their toolkit. Why is this approach continually being highlighted as controversial? I would like to conclude that it is no longer as the recent evidence (Hume et al 2021, Porter Institute 2019 and Schoen et al 2018) is now being recognised by others, practiced daily and demanded by families/adults. There are no other treatment approaches which treated in this way within our profession which I am proud to say

Both RCOT publications seem to suggest that Therapists practicing Ayres' SI use one to one therapy in a clinic setting in isolation from other occupational therapy practice. In 2021 the expectation is that Occupational Therapists who have comprehensive education in assessment and intervention using the theory and practice of Ayres’ SI will provide: or add DDDM here??

* Psycho-education for the person, their family and carers e.g. sensory training delivered by most NHS Trusts as part of neurodevelopmental pathways / universal provision.
* Top-down cognitive strategies and methods of assessment and intervention where the client is able to engage in this way e.g. sensory ladders, diary sheets, creating GAS or other SMART Goals together including for example COPM.
* Consultation with the multidisciplinary team around the person and their carers
* Coaching and skill development of parents and people with sensory integration difficulties including chain analysis
* Environmental adaptations for home, school and at work for children and adults that specifically address sensory processing difficulties and facilitate adaptive behaviour and engagement in all functional skills. Therapists working in local Authorities that have additional training in ASI theory are in an ideal position to assist in providing such environments through disabled Facilities Grants.
* Minimising risk to carers and clients through provision of risk assessments, moving and handling care plans and 24 hour postural plans of those with complex medical needs that will ultimately have difficulties in sensory processing and knowledge of correct positioning to address those needs is essential.
* Outcome measurement, including the measurement of proximal goals and outcomes e.g. sensory motor, as well as, occupation focussed distal goals and outcomes e.g. MOHO, ABAS2, QoLI etc. These distal occupation focussed goals are core to our profession.
* Individual one to one therapy in a clinic, at home, on a unit, outdoors - wherever it is possible to develop the ability to process and integrate sensation for use in everyday life so that the person can take in and make sense of and respond appropriately, in an adaptive way to daily challenges.

Data-driven decision making is a systematic approach to guide reasoning and decision making, using data to guide assessment and intervention, in order to address participation challenges and struggles in daily life.  
  
Schaaf and Mailloux 2015

[\*The evidence for the points above can clearly be seen in comprehensive Education Programmes about Ayres SI, including case study requirements for accreditation and as per ICEASI recommendations to ensure competency to practice. This addresses the very concerns you raise.]

This is not clear in these recently published documents, which fail to recognise that this therapy approach, unlike much of what Occupational Therapists do, has robust evidence to support its practice in discrete homogenous groups who clearly have identified sensory differences. Far from being a deficit-based approach as inferred, Ayres' SI when practised well\*, as part of a holistic occupational therapy intervention, promotes growth, learning and development necessary for occupational performance and participation in everyday life.

I hope you will listen to the Therapists using this approach, and the families who have worked with Therapists who use this as one of their approaches and reconsider your stance.

(add your own examples)

I know these are big examples and not all people/children have such drastic changes, but it is a treatment modality that supports occupational gains and positively impacts quality of life. I felt throughout the RCOT documents it was implying that when Occupational Therapists utilise an ASI approach they are not being occupation-focused, setting occupational goals, measuring outcomes effectively etc. From my experience Therapists trained in ASI do this incredibly well, they have clear and achievable occupational goals, they consistently use qualitative and quantitative data to measure progress, they provide support across environments, and most importantly they really listen to what the children, adults (and their families) want.

The final point I would like to raise is that in the RCOT Informed View 2021 a statement has been made based on the HCPC guidance pertaining to the scope of practice. The view states the following: *“Occupational Therapists are skilled professionals who are able to assess and assist people with sensory issues. Some occupational therapists may choose to undertake additional training in sensory interventions. The Health and Care Professions Council requires occupational therapists to ‘practice safely and effectively within their scope of practice’ and ‘draw on appropriate knowledge and skills to inform practice’ but it does not specify that a particular type or level of qualification in sensory interventions, for example Ayres Sensory Integration is expected of occupational therapists.”*

It is worth noting that the HCPC guidance does not specify any additional training in any areas of practice e.g. Ayres’ SI, hand therapy / splinting, or even in other professions.

Doctors are not required to have further training to be registered, however it is expected that they will complete specialist training and gain experience in their specific field. It is up to the professional to use their clinical judgment to ensure they practice ethically by only delivering services they are adequately trained to provide. It is unclear what RCOT’s understanding is of Ayres’ Sensory Integration when the term ‘sensory issues’ is used.

HCPC Guidance suggests that therapists should:

***Work within the limits of your knowledge and skills***

***Keep within your scope of practice***

*3.1 You must keep within your scope of practice by only practising in the areas you have appropriate knowledge, skills and experience for.*

*3.2 You must refer a service user to another practitioner if the care, treatment or other services they need are beyond your scope of practice. Standards of conduct, performance and ethics*

***Maintain and develop your knowledge and skills***

*3.3 You must keep your knowledge and skills up to date and relevant to your scope of practice through continuing professional development.*

*3.4 You must keep up to date with and follow the law, our guidance and other requirements relevant to your practice.*

*3.5 You must ask for feedback and use it to improve your practice.*

[<https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics> - last accessed 09/02/2021]

The informed view seems uninformed, with an evident lack of understanding of the impact of Sensory Integration function on motor skills, praxis, and therefore occupational performance. To be effective and have an impact on participation, sensory based interventions need to be targeted, specific, and meaningful. This can only happen when they form part of a holistic approach based on a comprehensive assessment. An example would be completing only a sensory-based subjective questionnaire to assess ‘sensory issues’, without the ability to adequately analyse the information contained in it and correlate it with other assessments and clinical observations, could be at the very least ineffective, and at the worst harmful.

I encourage you to reach out to your members, some of whom have left or are now considering leaving in response to appears to somewhat unhelpful publications, open for interpretation and possible misuse. It will be important to consult with the children, adults and families we work with and ask them for their experiences. It may be surprising how many Occupational Therapists utilise Ayres Sensory Integration as one of the many tools in their toolbox.

We would very much appreciate that RCOT would re-consider the publication of these documents without the most recent evidence and engage in a transparent process of consultation with members before documents that can jeopardise health, education and social care practice in this country and abroad.

Can statements like these issued go through a consultative process; to include users of services. It is for clients, for whom simple or top-down approaches do not work, we respectfully request re-consideration of your current positioning of Ayres’ SI.

Continued access to this therapeutic approach with a growing evidence base should remain a tool in the toolboxes of OT’s in the UK and abroad. Many OT’s who practice Ayres’ SI within their OT practice do so because they require a tool in their toolbox for the most complex service users, or those who require highly specialist individualised approaches to manage high levels need, of distress or in some cases risk. If as a profession we do not continue to provide this evidence based therapeutic approach, other professional groups will take this area of practice and deliver it.

This would be a great loss for the profession of Occupational Therapy where the emphasis on occupation resulted in Ayres’ exemplary work to uncover the sensory foundations of occupation. This therapeutic approach is firmly grounded in occupation, in the hands of other professions, it will lose the very focus and emphasis you seek to protect; promoting meaningful participation in everyday life for all.

Kind regards,

Name

Title

Email