

Different. Just like you

A psychosocial approach promoting
the inclusion of persons with disabilities



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Foreword

Over one billion people in the world live with disability. Despite international conventions providing for equal rights and access to services and opportunities, persons with disabilities face considerable challenges. The greatest barriers to inclusion are caused by society: Inaccessible buildings mean, for example, that children with disabilities may not be able to go to school. Negative attitudes towards differences can take the form of discrimination and stigma. Structural barriers too, such as policies that do not include any provision for young adults with disabilities accessing higher education, can close down opportunities.

‘Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities’ is aimed at professionals and volunteers who work with persons with disabilities. The concept of empowerment is central to the whole approach presented in this handbook. Empowerment is defined as a process of strengthening, whereby individuals, organizations and communities ‘get a grip’ of their own situations and surroundings. They do so by acquiring control, sharpening their critical awareness and seeking to participate. Persons with disabilities are not seen as helpless victims, but are recognized for both their vulnerable and resourceful sides. The focus of empowerment is therefore on health, well-being, power and environmental influences, and not on problems, risk factors and the individualisation of problems.

The handbook provides practical guidance in planning and implementing activities, as well as background material on key concepts and the legal framework in relation to psychosocial support and inclusion. Real-life stories and examples of programmes in the field are included, to share knowledge and learning. The activities range from psychosocial activities that are accessible to all (chapter 3) to physical activities that are adapted to include persons with disabilities (chapter 5). Detailed information is given for all the activities in chapter 5 to enable professionals or volunteers with little or no experience in working with persons with disabilities to consider planning and implementing psychosocial programmes.

Four different organizations, specialists in their fields, have come together to share and learn from each other, and the result is this handbook. They are: The International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, the International Council of Sport Science and Physical Education, LICHT FÜR DIE WELT/ Light for the World and Juul Journalistik & Kommunikation. It is their hope that **‘Different. Just like you:** A psychosocial approach promoting the inclusion of persons with disabilities’ will be a valuable tool in promoting the inclusion and psychosocial well-being of persons with disabilities.

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Key terms

These are key terms used in the handbook relating to disability, psychosocial support and inclusion:

Adapted physical activities are activities responsive to the needs and background of all participants to ensure that everyone with different abilities has the opportunity to be part of the game or activity.

Efficacy is the belief that people can act to improve their own situation. This belief requires building confidence. Problem-solving activities can be particularly useful in developing skills to overcome difficulties and promoting empowerment.

Empowerment is defined as: “A process of strengthening, whereby individuals, organizations and communities ‘get a grip on’ their own situations and surroundings. They do so by acquiring control, sharpening their critical awareness and stimulating participation.¹” A person who feels empowered and in charge of and in control over his and her life, feels much stronger and capable of living life as it is.

Inclusion is seen as a universal human right embracing all people irrespective of race, gender, (dis)ability, health, socio-economic status, etc. Inclusion means making room for all to be part of society, whether at the level of national law or at a local level for example, in terms of how a game is organized or a lesson at school is taught. Inclusion is basically a question of thinking “we” from the beginning; not “us” and “them.”

Inclusion Spectrum is an activity-centred approach to the inclusion of people of all abilities in physical activity. The core principle is that inclusion can be achieved by changing the environment of the activity or the way in which the activity is presented. This makes it possible for everyone to take part in a way that challenges them and celebrates their abilities in a social context.

Persons with disabilities is the term used in the United Nations Convention on the Rights of Persons with Disabilities (CRPD): “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.²”

Psychosocial refers to the dynamic relationship between the psychological and social dimensions of a person, one influencing the other. The psychological dimension includes internal, emotional and thought processes, feelings and reactions. The social dimension includes relationships, family and community networks, social values and cultural practices.

Psychosocial activities are activities that help to improve psychosocial well-being. It is not clinical psychological treatment, but activities tailored specifically to the particular needs and resources of individuals and groups. They may be implemented in many different ways, depending on the resources available and reflecting the cultural context for the intervention.

Psychosocial support is defined as a process that facilitates resilience within individuals, families and communities. By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support helps to restore social cohesion and infrastructure. It includes offering psychosocial support in relation to basic services, family and community supports, and focused non-specialised supports, but not specialised services such as psychological or psychiatric support.³

Psychosocial well-being describes the positive state of being when an individual thrives and is positively influenced by the interplay of psychological and social factors.

Resilience is the ability to react or adapt positively to a difficult and challenging event or experience; the ability to bounce back after something difficult has happened or to get through difficult experiences in a positive way.

¹ Van Regenmortel, T. Empowerment en Maatsoorg. ACCO. 2002.

² UN Convention on the Rights of Persons with Disability, 2008

³ See the intervention pyramid in IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007, pages 11-13.

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Introduction



A number of international conventions have been agreed by the international community to ensure the rights of persons with disabilities to equal access to all services and opportunities in life. The most important is the United Nations Convention on the Rights of Persons with Disabilities (CRPD).⁵ The CRPD addresses rights in relation to all aspects of society, including employment, education, health and family life. The convention applies to persons born with disabilities, as well as to those who acquire impairments later in life, and includes those living with invisible impairments, like autism or learning disabilities.

Working with persons with disabilities

This handbook is aimed at professionals or volunteers who engage with persons with disabilities in their work. This includes school-teachers, social workers, pedagogues,⁴ sheltered workshop instructors, health workers, coaches or volunteers in organizations, sports clubs and recreational facilities.

Society can either disable people with impairments or foster their participation and inclusion. Persons with disabilities unfortunately face challenges in life, despite the ratification of the CRPD by most countries in the world. Physical, social, and attitudinal barriers can lead to institutionalization, discrimination, violence, abuse and exclusion. They may reduce access to education and employment, and this may result in depression, poor health, poverty and a poor quality of life.

Living with disabilities may make coping with difficult circumstances in life more challenging. However it is important to bear in mind that resilience depends on many factors: Support may be needed, but not necessarily because of the impairment itself, as indicated above. Experience from organizations supporting persons with disabilities shows that psychosocial well-being and empowerment improve when programmes provide targeted support.

Empowerment – a central approach

The concept of empowerment is central to the whole approach presented in this handbook. Empowerment as a theory says that a person's well-being is not only dependent on their individual strengths and abilities and their natural support systems. It is also connected with the broader social and political context. This means that the problems that a person may face interact with issues about access to resources of assistance and support. Empowerment is therefore seen as having multiple levels, with a distinction of at least two levels: an individual, psychological level and a more collective, social-political level.

Efficacy is an aspect of empowerment at the individual level. It is the belief that you can act to improve your situation. This belief requires building confidence. Problem-solving activities can be particularly useful in developing skills to deal with difficulties: When persons with disabilities solve problems within the safe setting of a psychosocial programme, for example, they experience and develop efficacy. They can then work on applying this to other parts of their daily lives.

At a collective level, empowerment means, for example, that all stakeholders – professionals, volunteers, persons with disabilities, family members, etc. – work together. All activities and programmes should therefore be framed in terms of “we,” not “us and them.”

Aims of the handbook

‘Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities’, has two key aims:

- to create awareness of the importance of psychosocial support and inclusion in promoting the well-being of persons with disabilities
- to provide guidance about psychosocial support and inclusion, along with practical resources for inclusive psychosocial activities for all kinds of settings.

The handbook describes best practice in psychosocial support and inclusion, and features a wide range of activities – mainly adapted sports and other physical activities – that give persons with disabilities the opportunity to release their full potential and engage actively in society. The handbook is based on a survey of best practice and programming in a number of selected organizations in Europe, Asia, the Americas and Africa. The organizations selected work primarily with children and youth with disabilities. The children and youth often face difficulties in accessing activities, education, employment and human rights in their communities because of the disabling effects of impairment.

However, participating in sports and other activities appears to be a strategy that brings many benefits. They include positive experiences of having fun; of having a chance to be part of local society; and of demonstrating capabilities, regardless of perceived limitations. Many of the programmes also include advocacy for the positive inclusion of persons with disabilities, human rights training, sports therapy and services offering assistive devices.

What is disability?

The United Nations Convention on the Rights of Persons with Disabilities (CPRD) and its Optional Protocol was adopted in December 2006 and came into force in May 2008. It is intended as a human rights instrument with an explicit, social development dimension. It uses a broad categorization of persons with disabilities and states that all persons with all types of impairments must enjoy all human rights and fundamental freedoms.

The CPRD defines how all categories of rights apply to persons with disabilities. It also identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced.

The CRPD defines disability as follows: “Disability is an evolving concept and results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”

It defines persons with disabilities as: “Those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Disabilities or impairment: What is the difference?

According to the World Health Organisation⁶, 'disabilities' is an umbrella term, covering impairments, activity limitations and participation restrictions:

- An impairment is a problem in body function or structure.
- An activity limitation is a difficulty encountered by an individual in executing a task or action.
- A participation restriction is a problem experienced by an individual in involvement in life situations.

In other words, impairment is only about the physical or mental condition of a person, whereas disability describes the experience of having this condition in interaction with the wider social setting, in terms of attitudes to disability and the physical environment, etc.



Steve Kørveil, Egnott Højskolen

Invisible disabilities

It is important to remember that disabilities may not always be visible: Autism and learning disabilities are examples of this. Learning disabilities affect cognitive functioning and behaviour, for example.

Mental health problems also affect thinking, moods, the ability to relate and the capacity to cope with life. Schizophrenia or bipolar disorder, for example, may significantly affect psychosocial well-being. Responses to these conditions should be the same as to any other disability:

- Challenge stigma and discrimination.
- Realize that limitations may depend on factors such as cultural context, support networks, personal preferences and background. Listen and meet the other person with respect and provide psychosocial support if needed.
- Regardless of the impairment, a person can be disabled by society because of stigma and prejudice.

Disability – a social or medical condition?

The WHO 'International Classification of Functioning, Disability and Health'⁷⁷ (ICF) looks beyond the narrow definition of disability as a purely social or medical condition. ICF provides an agreed framework and terminology for the description of health and disability. This includes analysing and recording the impact of the environment and other contextual factors on the functioning of an individual or a population.

ICF recognizes that every human being may experience some degree of disability in life through a change in health or in environment: Disability is a universal human experience – which is sometimes permanent and sometimes transient. It is therefore not restricted to a small part of the population.

ICF measures health and disability in terms of 'impairments, activity limitations and participation restrictions.' (See the box 'Disabilities or impairment: What is the difference?' on page 13 for definitions). This is the framework that allows all conditions to be compared so that the impact of a disability on the functioning of the individual can be defined.



What is psychosocial support?

Psychosocial support is defined as a process that facilitates resilience within individuals, families and communities. By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support helps to restore social cohesion and infrastructure.

Everyone has a degree of resilience and an ability to cope, which can be strengthened and promoted. But many factors influence how people respond to living with a disability. This includes details about the situation when the disability was acquired, or diagnosed, or perhaps when someone's condition started to deteriorate. Resilience also depends on the individual's personality and their history of other similar challenging experiences, plus the severity and magnitude of the impairment.

The following personal attributes can help a person cope in life:

- their ability to make realistic plans and carry them out
- having a positive image of oneself and feeling self-confident
- having the ability to adapt easily to new situations
- being able to deal with strong emotions and communicate one's feelings and thoughts
- believing that change can happen.

All of these personal attributes together with good social support from people and society can promote the empowerment of persons with disabilities.

Empowerment and resilience

Empowerment is about supporting people assert control over factors that influence their life and hence their resilience – the ability to cope with, react and adapt to a difficult event in life. Enhanced resiliency will lead to empowerment.

Case studies

Most of the names used in the case studies in this handbook have been changed in order to protect the identity of the individuals featured. Everyone has given their consent for their stories to be included here. However there are three stories in chapter 1 and 2 where the persons featured have been identified with their consent.

⁴ This role is found in continental Europe and refers to trained professionals who seek to support the whole person in their work.

⁵ United Nations Convention on the Rights of Persons with Disabilities, 2008.

⁶ WHO 'International Classification of Functioning, Disability and Health.' 2001. ICF is the WHO framework for measuring health and disability at both individual and population levels. All 191 UN Member States officially endorsed ICF in 2001.

⁷ www.who.int/classifications/icf/en/

Disability matters



Ulrich Egner

This chapter describes what disabilities are and how persons with disabilities are impacted in everyday life by physical, attitudinal and institutional barriers. It details the provisions of the UN Convention on the Rights of Persons with Disabilities, and introduces the concept of ‘the twin-track approach’ in service provision. It closes with practical examples of how professionals and volunteers can promote the inclusion and psychosocial well-being of those they are supporting.

Persons with disabilities are marginalized

There has been considerable progress in understanding disability in research and applied learning. There have also been advances in technical and economic opportunities for persons with disabilities in many parts of the world. International and state law have set out provisions to improve the rights of persons with disabilities.

However, in spite of all this, persons with disabilities are often among the most marginalised in low resource settings, even though they have the same rights to participate in all spheres of life – in family life, at school, in the workplace or in politics. The UN Convention on the Rights of Persons with Disabilities (CRPD) states that no-one should be limited in their social and economic opportunities.

In practice, however, persons with disabilities are often unable to access basic services and enjoy the full range of human rights. Lack of access to education, health services and employment and limited opportunities to live independent lives are common challenges facing persons with disabilities all over the world today.

Persons with disabilities often feel they have no say or power in their own lives. Professionals and other carers may literally have legal authority to make decisions on behalf of the person with a disability, for instance in relation to the provision of assistive devices. Carers may also take informal charge over people’s lives because of a sense of overprotection or because they do not realize what the person with a disability can and cannot do or what they need. This may be linked with social activities, or access to jobs, education and other services. This can lead to exclusion and marginalization.

Blind girl became a disability activist

From the outside, this situation can appear to be caused entirely by the individual's impairment. However, in reality, the person's exclusion and marginalization has also been negatively affected by social attitudes and expectations about disability. This need not be the case. An example from Ethiopia demonstrates this well:

Yetnebersh Nigussie is a well-known disability activist. She was born in rural Ethiopia and became blind at a young age. When she reached school age, her mother said that if Yetnebersh wanted to be successful in life, she had to focus on education, since not many men would want to marry a blind girl. In the rural area where they lived, girls married at a very early age and so usually girls were not particularly encouraged to go to school. It seemed to the family that education, not marriage and family life, would provide the only future prospects for Yetnebersh.

Today Yetnebersh is a law graduate with a Master's Degree in Social Work. She is director of an organization that works on inclusive development. She owns a private school for children with and without disabilities. She is also married and is a mother. She has provided support for the education of her brothers and sisters and is living a fulfilling life, travelling to many countries with her work. "Disability has been my opportunity. If I were not blind, I would have dropped out of school at early age and would have been married off like my peers," says Yetnebersh.

Her story demonstrates how physical and medical conditions often are connected to environmental factors, including culture and religion. This way of viewing and describing disability plays a role in how persons with disabilities are perceived.



The twin-track approach

The CPRD promotes the full and equal participation and inclusion of persons with disabilities in all spheres of life. Psychosocial programmes have the best possible potential of achieving full participation and inclusion when they are based on ‘the twin-track approach.’⁸

The twin-track approach combines disability-specific interventions with mainstreamed targeted actions. The two aspects of this approach focus on:

- mainstreaming the rights of persons with disabilities in existing policies, programmes, and services
- investing in specific or targeted programmes and services.

According to the World Report on Disability,⁹ “mainstreaming is the process by which governments and other stakeholders ensure that persons with disabilities participate equally with others in any activity and service intended for the general public, such as education, health, employment and social services. Some persons with disabilities, depending on the form and degree of their impairment, may also require specific services such as rehabilitation, support services or training” (p. 264 - 265).

These are the two tracks of the twin-track approach: Disability-specific actions and mainstream actions:

(1) Disability-specific actions	(1a) Addressing specific needs of persons with disabilities through targeted interventions	(1b) Empowerment of persons with disabilities
(2) Mainstream-targeted actions	(2a) Creating access for persons with disabilities to policies, programmes and action	(2b) Breaking all barriers in society excluding persons with disabilities and transform attitudes

Paving the way: The twin-track approach in practice

Seida, a young girl from Palestine, is a wheelchair user. She had difficulty attending school because the roads from her home to school and within the school compound were not accessible by wheelchair. A community-based rehabilitation (CBR) programme supported by the Norwegian Association for the Disabled and Diakonia was being implemented in the area. CBR staff started to work with Seida and her local community. Everybody agreed that she had the right to go to school like all the other children. A group of young people from the community decided to help her attend school. They were able to help Seida access the school compound by lifting or pushing her wheelchair when needed. The local CBR worker spoke to the municipal authorities about repairing the road between Seida’s home and school. This was done and Seida is now able to go to school in her wheelchair. These community-based interventions paved the way for her education.

See Norwegian Association of Handicapped at www.nhf.no/english and www.diakonia.se/en for more information.

Seida’s story illustrates the twin-track approach:

(1) Disability-specific actions	(1a) Seida has a wheelchair. The specific needs of Seida are addressed.	(1b) Seida is keen and confident to go to school and link up with young people from the community. Seida is empowered.
(2) Mainstream-targeted actions	(2a) Seida is welcomed in school: The mainstream education system now is accessible for Seida.	(2b) Young people from the community decided to help and the municipality acted. Attitudinal barriers are overcome (due to the work of the rehabilitation worker). The road was repaired: the physical barrier preventing Seida from accessing school was removed.

Access to cultural life

Article 30.5 of the CPRD refers to cultural life, recreation, leisure and sport as follows: “1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:

- a. enjoy access to cultural materials in accessible formats;
 - b. enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;
 - c. enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.
2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.
3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.
4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.
5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:
- a. to encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
 - b. to ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;
 - c. to ensure that persons with disabilities have access to sporting, recreational and tourism venues;
 - d. to ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;
 - e. to ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.”

The voice of the child

Sheila is a young woman from the Netherlands with a progressive disability which was diagnosed when she was about 10 years old. At the time, she did not feel disabled at all, as her difficulties were fairly minimal. However, her parents were very shocked at the news. Sheila remembers feeling fine, not sad or shocked, but the adults around her interpreted this as denial. She was sent to a child psychiatrist who decided after two sessions that there was nothing wrong with her. In school nothing changed: Sheila still had plenty of friends and she wanted to go on with life as it was. The adults in her life, however, were worried about her and how her life would change.

At one point there was talk by the school, her parents and a medical specialist about sending Sheila to a special school. This was based on the thought that she would feel more comfortable with children of 'her own kind.' Sheila remembers feeling uncomfortable overhearing the discussion, because she wanted to stay with her own friends. However, as the special school could not provide the range of academic subjects she was capable of doing, she was not sent there.

Looking back, Sheila feels that she had very little opportunity to express her opinions in the process. Adults around her decided what was best for her and when she expressed her feelings, they were not recognized or believed. Sheila feels that her parents could have benefitted from some kind of support, since they were the ones struggling at that time. They are now able to see that Sheila has a meaningful future.

Barriers to participation

Defining disability as resulting from an interaction between the person with impairments and her or his environment means that barriers to participation are wider than simply those connected with the person's condition. The environment – in its broadest sense – can be disabling such that physical, attitudinal and institutional factors can impact hugely on the lives on persons with disabilities.

Physical barriers such as the lack of access to transport or poor lighting in public spaces or communicating information in limited formats all create difficulties for persons with disabilities. These difficulties prevent people from enjoying the full range of choices and opportunities in their day-to-day lives.

Attitudinal barriers such as ignorance and prejudice surrounding disability that leads to marginalization and stigma can severely undermine the psychosocial well-being of persons with disabilities. Feelings of sadness, low self-esteem and depression can be a consequence of limited opportunities, pain and isolation. This harms the empowerment and efficacy of persons with disabilities, affecting access to employment, education and social interaction in general. Psychosocial activities and support can help to change and improve this, by strengthening resilience and building social cohesion.

Institutional barriers such as the lack of provision of services or problems with funding or not applying standards and policies can also affect the opportunities and choices persons with disabilities have to fully participate in society. For example, the ratification of the CRPD by a nation state does not automatically mean that that state's policies and laws conform to the convention. The CPRD is therefore only meaningful if domestic laws

and policies support it. The obligation on states to conform to the CRPD once ratified is provided for within the convention:

- The state has obligations to review or repeal laws that are not in line with CRPD. This means that the state should not approve discriminatory legislation, nor should they
- approve non-retrogression (i.e. the state should not back protections already granted).

A state's compliance with the convention (and other international human rights legislation) is assessed in the light of resources. Many national constitutions allow for the 'progressive realization' of rights, meaning that the economic, social and cultural rights provided for in the CPRD are addressed over a set period of time.¹⁰

How the law prevents love

This story describes the impact of local authority policies on the independent decision-making capacities of two adults in Denmark:

A young couple in their early thirties met and fell in love. They both have cerebral palsy and live in supported housing. They both use electric wheelchairs and rely on support 24 hours a day. They live about 150 km (90 miles) from one another. They have both been granted assisted outings from their institutions for 8-15 hours a month. In effect, this means that they are able to see each other once or twice a month.

They decided they wanted to move in together. The young man wanted to move to the same supported housing as his girlfriend so they could be together every day. But it seems the decision is not his to make.

The big issue is his financial support and who is responsible for paying for it. He was born in city A, now lives in city B and wants to move to city C where his girlfriend lives. This requires a meeting between social workers from cities A, B and C, together with the young man and his supporters.

The question is whether city A will pay for him to move to city C, where the support may be more expensive than the support he now gets from city B. In effect, city A holds the future of the young couple in their hands, subject to the decision about funding. His eventual move to city C is still unresolved. These are challenges that a couple without disabilities would never have to face.

See www.sumh.dk for more information

Access to employment

The World Report on Disability¹¹ indicates that persons with disabilities are limited significantly in accessing the labour market in comparison with persons without disabilities. Data is scarce, but the information available shows that this is caused by a variety of factors:

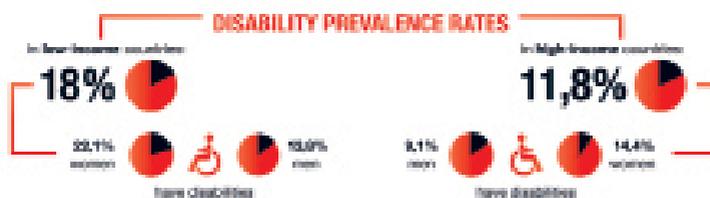
- Persons with disabilities have higher costs associated with working, because transportation, for example, often is more expensive. In some countries, entering the labour market may mean a loss of social disability benefits with the consequence for some that they cannot afford to work. For instance, earning money can mean that the person with disability has to pay for assistive devices or home support that was formerly a social welfare benefit.
- Employers believe that a person with disability will perform more poorly than other people – even when the disability has no bearing on the skills for the job.

- The workplace may need adaptations to enable a person with a disability to work.
- People with disabilities earn less than non-disabled persons and women with disabilities earn less than men with disabilities.
- A person with a disability wanting to start a private business may face barriers in obtaining funds, being met with expectations of not being able to pay back a loan.
- Lack of access to education and general skill development may also reduce the likelihood for persons with disabilities to succeed in getting employment.

This illustration shows how poverty can arise as a consequence of missed job opportunities for persons with disabilities:

POVERTY

SITUATION



REASONS



CONSEQUENCES



SOLUTIONS

- create job opportunities and adapt workplaces
- reform policy and legislation towards equality
- raise awareness in society and companies via training
- accessibility: remove barriers
- access to technical and vocational training
- equal access to social protection

GOAL

Inclusion of persons with disabilities into the job market contributes to sustainable growth and development.



END EXCLUSION

ambasciata italiana



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Bartimeus

Life skills in the garden for young and old

Bartimeus, a Dutch organization which provides care, support, education and training for people with visual impairments, realized that having a visual impairment affects the way people acquire everyday skills and knowledge. They devised an innovative way of promoting the self-empowerment of the young people they work with.

One of the outcomes is a beautiful garden of 2500 square meters where the young people learn to use all their senses. In the garden they do gardening work together and have fun. In the process they gain knowledge and skills that will help them in their transition into adulthood and society. The programme has proved to make a difference in the lives of many young people

with visual impairments. It enables them to enjoy plants and wildlife, to improve their motor skills, to extend their orientation and mobility skills, and to discover and develop their practical strengths. Every young person chooses ‘a garden friend’ and each pair is allocated a garden of three square meters. They learn the basics of gardening together such as tilling, sowing, planting, watering, harvesting, and how to distinguish weeds from vegetables and flowering plants. They also learn to work with and cooperate with one another, to handle a wide range of tools, and to cope with disappointments. The young people learn that all kinds of skills are important for success in the garden.

See www.bartimeus.nl for more information



Bartimeus

How can professionals and volunteers make a difference?

Professionals and volunteers can make a difference in how they interact with persons with disabilities to initiate change. Thinking and acting inclusively, supportively and equally is central to the approach advocated in this handbook. It is very important not to push people, but to encourage them and to a certain extent challenge them to try new things. Development comes from mastering a task that may have seemed unconquerable. Looking at the resources and abilities of the individuals being supported is vital: Keep the focus on what the person can do rather than what he/she cannot do and work on ideas for activities that promote participation, inclusion and equality. Keep the following in mind:

- Ask honest and direct questions: “What would you like to do?” or “How do you feel about ...?” etc.
- Do not think that you know what is best and therefore make decisions on behalf of the person with a disability.
- Listen and try to understand the reality of the other. If the person is experiencing problems, don’t belittle them, but act in a supportive way. See beyond the impairment. All beginners face difficulties in new tasks.

- Do not be afraid to ask for help. There are organizations and experts with knowledge, experience and ideas about improving accessibility and in relation to psychosocial support and inclusion. (See also ‘Resources’ on page 86).

Included in education and family life

Tigist was discovered in her home at the age of 13 by the team of Rehabilitation Services for the Deaf (RSDA) in Ethiopia. She was born deaf and her family communicated with her using gestures. However they were very limited in what they were able to communicate. The RSDA fieldworker introduced Tigist to a sign language class. She was a bit too old for the first grade, but having had no previous schooling, she started there. In the beginning, Tigist felt awkward with children who were much younger than herself. She attended class but did not mix much with the other pupils. After a while she started enjoying the school environment and her classmates, and she is now fully involved in school life. Tigist is now in the fourth grade and is in the top four of her class. Her family has also learned sign language. Now Tigist is able to play a much bigger part in her family and neighbourhood life.

‘Getting up and getting on with it’

‘Getting up and getting on with it’ is a toolkit developed by the British Red Cross for those working with young people who are going through the transition from supported to independent living. Many young people with physical disabilities miss out on routine experiences such as taking part in community activities and using public transport. Understandably, this can affect their self-esteem and self-confidence. When young people make the transition to living independently, there can also be changes in family ties and friendships because needs and perspectives change. Such occasions may leave parents and carers worrying about increased vulnerability.

‘Getting up and getting on with it’ is split into seven sections, with activities addressing the issues associated with transition to independent living:

1. Being me: developing self-awareness
2. Knowing you: building sustainable relationships
3. A home of my own: getting and maintaining a tenancy
4. Healthy living: ways to live a healthy lifestyle
5. Out and about: accessing the local community
6. Taking my place in the world: actively participating in society.
7. Buddy up – guidance on managing a buddy mentoring scheme.

Read more about the toolkit at www.redcross.org.uk/What-we-do/Health-and-social-care/Independent-living/Services-for-people-with-disabilities/Options-for-Independence-Scotland/Toolkit-for-young-people-with-disabilities

⁸ See UNDP Guidance Note. Inclusion of the rights of persons with disabilities in UNDP programming, 2011.

⁹ WHO. World Report on Disability. 2011.

¹⁰ Convention on the Rights of Persons with Disabilities (art. 4 (2)): With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.

¹¹ WHO. World Report on Disability. 2011.

Psychosocial well-being for persons with disabilities



Light of the World



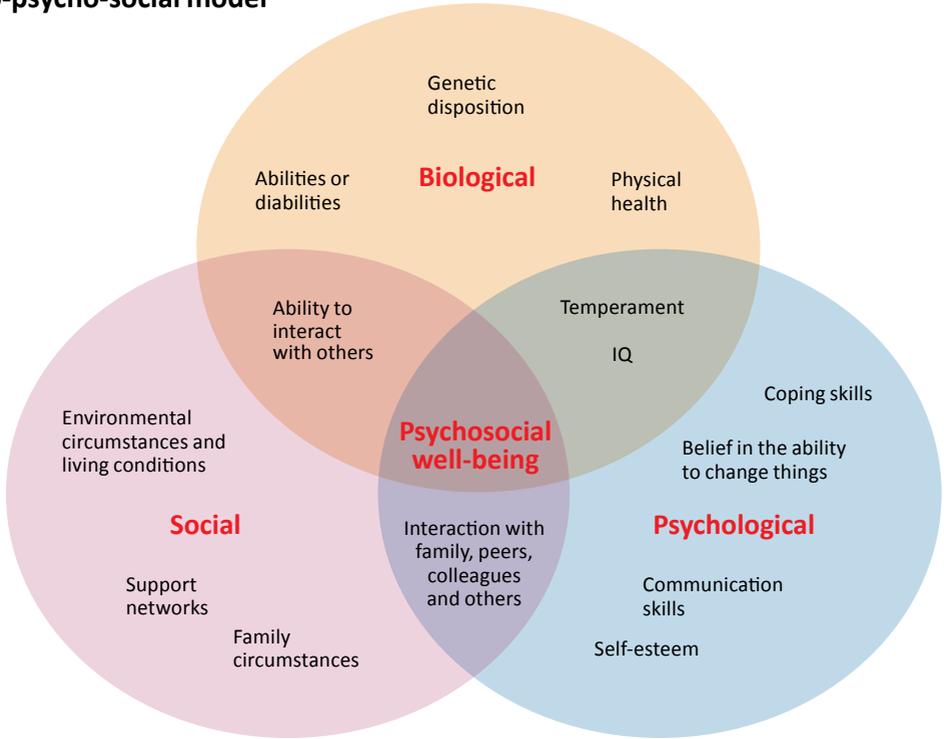
This chapter focuses on the psychosocial well-being of persons with disabilities. It describes psychosocial well-being in detail and then looks at factors affecting the personal development of persons with disabilities (with a focus on puberty and ageing). It then sets out principles and best practice in relation to psychosocial support.

Psychosocial well-being

Psychosocial well-being describes the positive state of being when an individual thrives and is positively influenced by the interplay of psychological and social factors. Professionals and volunteers promote the psychosocial well-being of persons with disabilities, when they take full account of the social, biological and psychological factors influencing the lives of those they are supporting.

The bio-psycho-social model puts all these factors together and shows they interact and impact health and well-being:

Bio-psycho-social model



Adapted from G. L. Engel. The need for a new medical model. A challenge for biomedicine. Family Systems Medicine. 1992. Vol 10 (3), 317-331

This model reflects the understanding that there is a close relationship between the mind and body. What affects the body often also affects the mind and vice versa. They are not independent and separate, but are connected and interdependent: Whether someone is well or ill is not simply a matter of the physical state, but is also influenced by the individual's psychological and social status. The stress, anxiety and depression that is often felt during crisis situations, for example, can be seen in physical symptoms like muscle tension, headaches, stomach aches, lack of energy and sleeping problems.

The theory behind psychosocial well-being draws on studies about individuals' position and relationship with family, community and wider society. Community-based professionals use this framework to understand how the quality of life of those they are supporting is impacted within the interconnected levels of society.

The term 'psychosocial' itself refers to the dynamic relationship between the psychological and social dimensions of a person, one influencing the other. The psychological dimension includes internal, emotional and thought processes, feelings and reactions. The social dimension includes relationships, family and community networks, social values and cultural practices.

Resilience

Resilience is an important factor in protecting and promoting good psychosocial well-being. It is commonly defined as, "the ability to react or adapt positively to a difficult and challenging event or experience, the ability to bounce back after something difficult has happened or to get through difficult experiences in a positive way."

Studies indicate that there are protective and adverse factors which affect the relative resilience or vulnerability of individuals. These factors can be identified in terms of the individual themselves, but can also be seen within relationships, and in terms of community and culture.

For example, caring relationships and a network of social support from people inside and outside the family are central to building resilience. Resilience is also influenced by previous life experiences and critical events. Someone who has recovered from a difficult experience, for example, may be seen to have strengthened their resilience to face similar events in the future. However, the opposite can also be the case: If a person has not resolved or recovered fully from previous critical events, he or she may be more vulnerable to distress, if new significant or critical life events happen.

Persons with disabilities may integrate their disability as part of their identity in various ways. One is to defeat the disability – to perceive oneself as someone fighting against the negative stigmas related to having a disability such as being seen as weak or incompetent, needing help. Or a person can distance him or herself from the disability and perceive it as something external, not part of one's identity. A third possibility is to recognize the disability as a personal attribute in line with other attributes and integrate it into one's personality; this may help strengthen the person's resilience.

Life events

For all of us, life offers different experiences: We face luck and misfortune, adjust to changed circumstances, learn and develop.

As indicated in the previous section, a person's previous experiences, personality, level of social support and the person's subjective experience of the event can all affect the way life events are negotiated. The key to psychosocial well-being is in maintaining a balance in one's life so that protective factors outweigh risk factors.

There are a range of life events which may threaten psychosocial well-being to a lesser or greater extent:

A significant life event

This is an event that interrupts the normal course of our daily lives and causes an imbalance between our social and physical worlds and us. The event forces us to face change and to cope by learning new modes of action, feeling and thought. The event itself may be perceived as pleasant or unpleasant, but still brings about a change in our life.

Some life events can be particularly stressful: The birth of a child, a change in jobs, sudden serious illness, marriage or divorce, moving to a new environment, the loss of a loved one, loss of health or change of health perspective because of a disability or a decline in a chronic disease.

Stressful events

Stress can be understood as a normal response to a physical or emotional challenge. Stress occurs when the demands are out of balance with resources for coping. At one end of the scale, stress represents challenges that excite us and keep us alert – if we can meet the demands and perceive them as positive challenges. At the other end of the scale, situations can ultimately cause physical suffering or psychological breakdown where we are unable to meet demands.

A personal crisis

A personal crisis is the felt experience of a person; an inner process of questioning or stress arising from the transition into a new phase of life, such as puberty, growing older, slowly losing abilities. It may also be the consequence of experiencing a significant life event or a traumatic event. People in a personal crisis experience an imbalance between their resources to cope and the stressors they are facing, and in relation to the deeper questions about their life. Two people with the same disability may react and cope very differently depending on their levels of resources versus stressors.

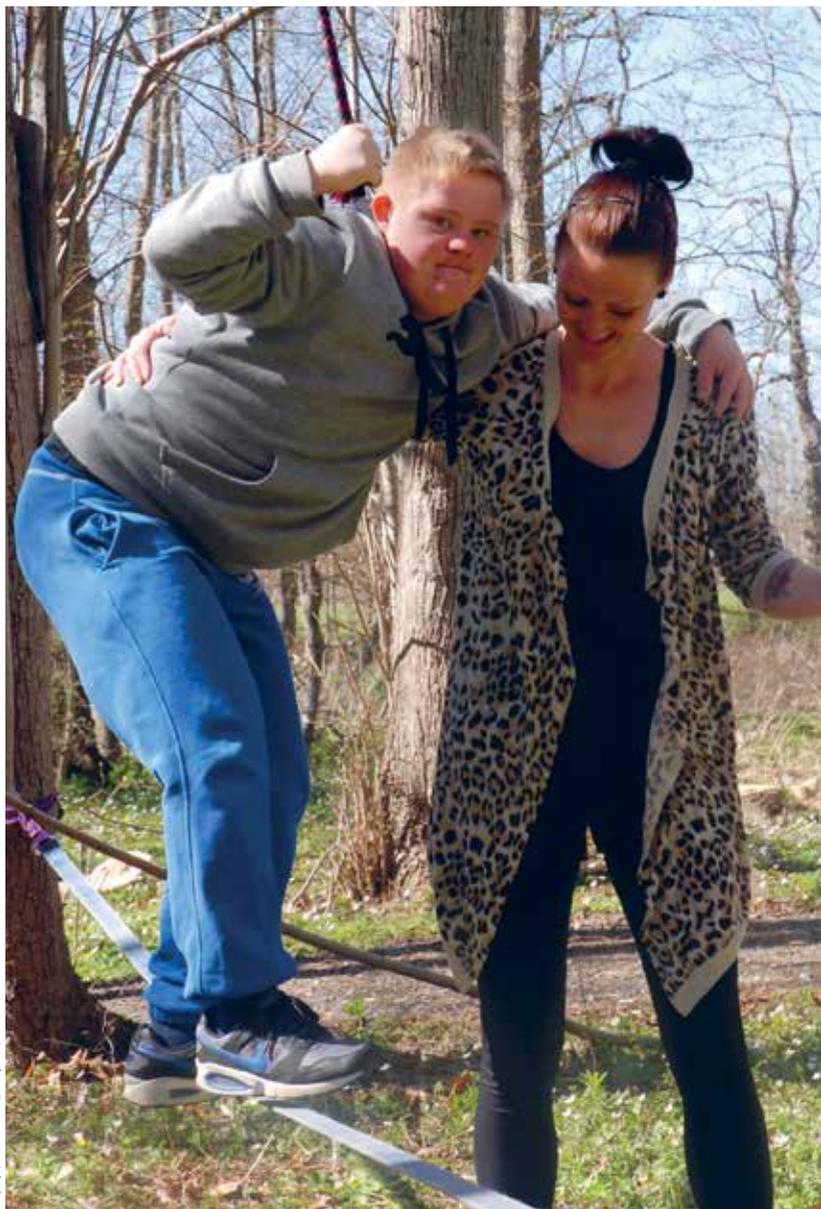
Traumatic events

These are extreme events that are far beyond usual everyday experience. They are events that threaten life or personal integrity and cause feelings of intense fear, horror or helplessness. A traumatic event can, for instance, be when someone experiences a serious road accident, or sees or hears that a family member or colleague has been killed, or someone is diagnosed with a serious, chronic condition.

The grieving process

Individuals who acquire an impairment or find their condition is getting worse, face substantial challenges which impact the way they perceive their life. Some people may experience these challenges and changes as a significant life event, and some as a personal crisis. For others it may be a traumatic event. The experience of disability, as explained in chapter 1, depends on the nature of the impairment, the physical, social and attitudinal barriers in the context in which the person is living and the person's own response to this in terms of their resilience.

When we experience a life event that leads to a serious loss, a strong emotional reaction is normal and to be expected. This may indicate the beginning of a grieving process, for instance, in relation to the loss of sight, or hearing, or the ability to move freely or to be independent.



Kasper Rander, Egmont Højskolen

The grieving process can be seen as a period of adjustment that a person needs to go through to move on in life after a serious loss. However it is important to note, that grief is not worked through in phases, one after the other: Many people find that they move back and forth in grief. One day they feel much better, the next they may feel that everything is lost and life seems meaningless. Here are four aspects of the grieving process:

1. Recognition and understanding: Coming to terms with the fact that what is lost will not come back.

It may be very difficult to grasp that what is lost will not return. But recognizing this is necessary and can be a great challenge. This goes for many aspects of life, for example, in losing people we care about when they die or through divorce or when we lose certain capacities. Many people feel that doors close when they grow older, for example, because of health problems or when they realize that conception is more difficult. These are challenges that people deal with in different ways.

2. Managing negative emotions: Living through feelings of anger, sadness and frustration. The experience and recognition of loss releases deep emotions of anger, pain and helplessness. However, these feelings need to be experienced and managed in order to work one's way through grief and move on in life. This is not easy, as emotions do reoccur – sometimes prompted by special occasions like birthdays, but sometimes appearing on days where one just feels down, tired or sad in general.

3. Skills: Gaining new skills in the changed life situation.

Loss often means having to gain new skills, for example, in making new friends, learning to be alone or finding joy in new experiences. The changed life situation may come with financial issues or practical problems, etc. that have to be dealt with. If the person who is grieving says: "This has never been me", or "I have never been able to do this and have no intention of learning," moving on will be difficult.

4. Hope and finding meaning in the future: Learning to live with the future.

Loss and grief can leave a person with the feeling that the future is meaningless and there is nothing to look forward to any longer. But creating new dreams and a vision for the future is an important and necessary part of overcoming loss. This does not happen overnight. It is a process of trying to gradually (re)build a sense of having something to look forward to, of finding some kind of sense in one's own life and of being able to manage the challenges in life.

All of these processes may take place more or less at the same time. People can be sad and be working on new skills for the future at the same time. It may feel like 'one step forward and two steps back.' Most people find, however, that they move on if they focus on certain tasks, working their way through the challenges the new life presents to them.

Refer if necessary

As we have explained, people's reactions to living with or acquiring an impairment vary. Most people in fact adapt to the situation and cope over time. However, sometimes, an individual may need to be referred to professional help, if they are not doing well. Generally, the most important signs to look for are:

- significant behavioural changes, for instance, if a person shows signs of continuous sadness or talks about ending his or her life
- physical signs of not thriving, like losing or gaining weight, having headaches or nausea
- abuse of drugs or alcohol
- hyperactivity or passiveness, anxiety and difficulties in learning or in concentrating
- occurrence of nightmares.

Factors that influence personal development

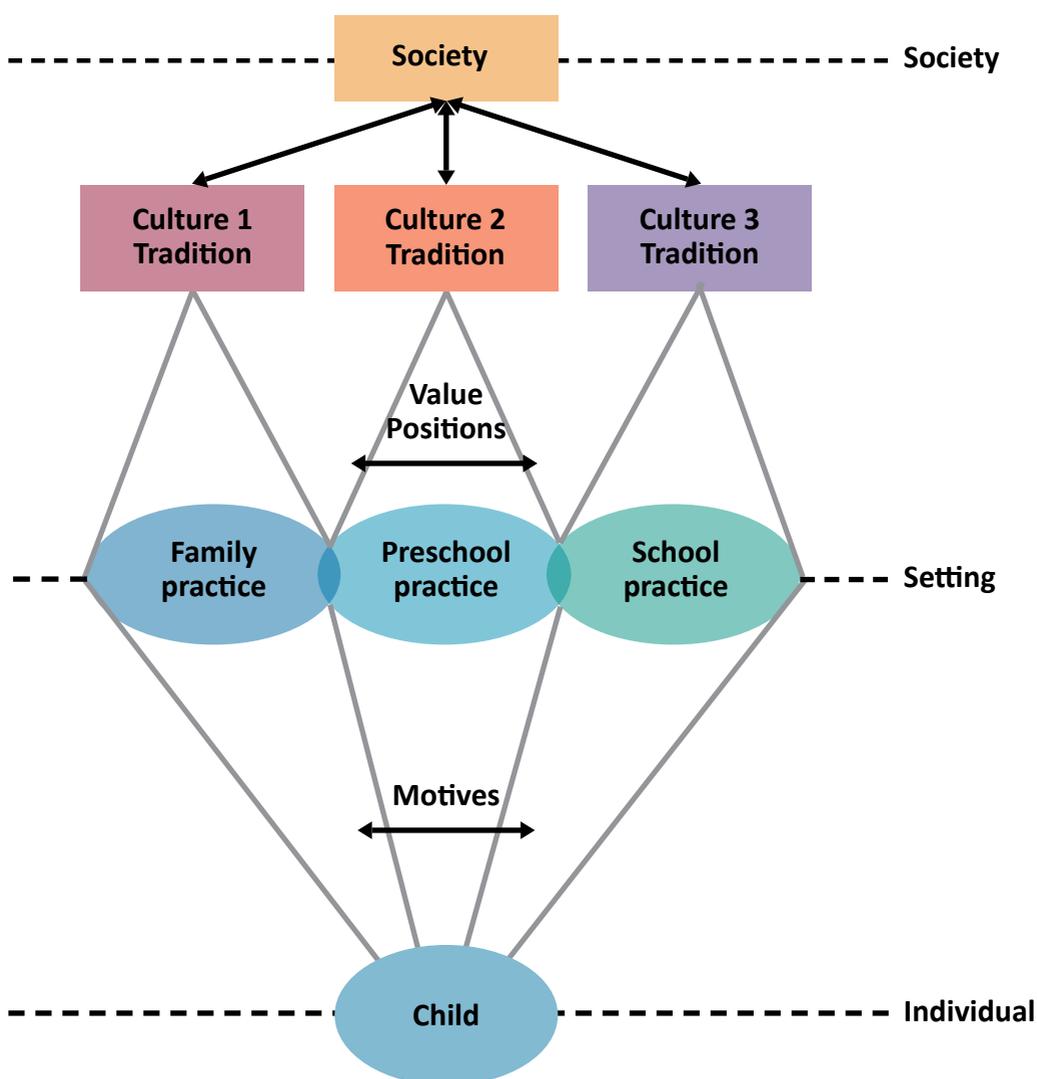
The psychosocial approach presented in this handbook emphasises looking at the whole person. Professionals and volunteers can only understand the needs and resources of an individual if they take account of the person's context and background, and not just focus on the person's impairment. In this section we look at the factors that influence the personal development of persons with disabilities, including the environment, puberty and ageing.

The environment

We focus first on the influence of the environment on psychosocial well-being. For example, if a child with a hearing impairment grows up in an environment where people around him or her find ways of communicating, for example through sign language, the person will find it less difficult to express thoughts and feelings.

Children are influenced by the different settings¹² they live and grow up in, for example, home, kindergarten or school. Each setting has its own traditions and includes different people that set the norms and values for what is seen as good behaviour. Children adapt to these different norms and values and so these different settings form part of the range of influences that contribute to a child's behaviour and development.

Children's learning and development through participation in different settings



Adapted from M. Hedegaard (2009)



IFRC

However, children are also active participants in their own lives. They have opinions and intentions of their own, and so the ways in which a child engages and participates in these different settings also influences the individual development.

Children's motives and competences are often related to how home or school view the children's capacities and how they support them in growing up. The responses a child receives and his or her interaction in daily life with other people – parents, schoolmates, neighbours, friends, teachers and other professionals – therefore have a strong influence on the development of confidence and self-esteem in childhood and in later life.

Challenges in puberty

Children with disabilities just like other children develop into puberty³ and face hormonal and bodily changes. If the child's intellectual development has been slower than other non-disabled children, parents may be surprised by this physical development. They may therefore not prepare the young person for what is to come, possibly because they are not prepared themselves. This can leave young people with disabilities themselves shocked and confused.

In the course of adolescence, young people gradually detach themselves from their parents or carers. However young people who have disabilities may face challenges between dependence and independence during puberty. Trying to be independent while at the same time having to rely on others for personal care may be difficult. For example, personal care may include help in getting dressed or in handling personal hygiene, menstruation, etc. Sexual development is a dimension both for the teenager and his or her caregivers.

During puberty, non-disabled friends may be less inclined to be inclusive as a result of their own psychosocial development. Young people with disabilities need to identify with their peers, but this can be difficult if they develop differently. They may find their own

difference difficult to accept because they “just want to be normal like all the others.” This impacts the young person’s psychosocial well-being. It is crucial therefore that all the people supporting the young person – their family, teachers, carers, volunteer mentors, etc. – make every effort to ensure the young person’s full inclusion in everyday life.

Feelings of sexual desire are a basic part of human development and persons with disabilities are no different in this respect. But the lack of possibilities of exploring and experimenting can be a factor, if personal carers are with the young person all the time. Persons with disabilities might not even be recognized as sexual beings. This makes it difficult to express feelings, thoughts and needs, especially where sexuality and disability is taboo. The media too make it hard for young people to feel good about their bodies. Images of physical perfection are widely used to portray sexuality on TV and in magazines, etc. This type of portrayal is challenging for many persons with disabilities in general.

Policy on sexual behaviour at special school

Persons with disabilities may face challenges in their sexual development and this can be a difficult issue to tackle. However, assisting and supporting healthy sexual development does not need to be difficult or awkward, as this example demonstrates. Enghaveskolen – a special school in Odense, Denmark for children with autism – has found a way of dealing with these issues. Their approach is transferable to other settings:

A 15-year-old boy with autism is physically big and strong, but is mentally around the age of five and has little language. He has difficulty whenever he is not able to immediately meet his own needs in any way. He can react aggressively if he is told to wait, for instance when he wants to masturbate.

To help him communicate his needs, his teacher and classmates have laminated a drawing of a hand on a piece of paper. When the boy needs to masturbate, he takes the drawing and puts it on the teacher’s desk. The teacher then unlocks the toilet door, helps him to unbutton his trousers and leaves. He helps the boy when he is finished.

The headmaster, employees, school board and parents have agreed on a policy on sexual behaviour. The policy contains guidelines for teaching the children about sexuality, dealing with situations like the one described above and handling possible sexual abuse incidents (i.e. incidents between pupils and between adults and pupils). The policy fulfils the requirements laid down in Danish law for teaching children about sexuality. It also provides information and guidance about supporting pupils in this area.

“As employees we should be able to recognize signs of sexual abuse and know how to handle it, if it happens. But we also have to teach the kids about sexuality, to explain what is acceptable and unacceptable behaviour. Some of my pupils would masturbate openly in class, if nobody stopped them,” says Pia Winther, sexual counsellor at Enghaveskolen and the lead person in the process of agreeing and writing the school’s policy on sexual behaviour.

“To me, our policy on sexual behaviour is about respecting and acknowledging that the children are sexual beings as well. Therefore we teach them about body awareness, boundaries, emotions and falling in love. For instance, a lot of them may never have a boyfriend or girlfriend and will have to express their sexuality in other ways. So how do we teach them rules and boundaries for what is acceptable, and when and where certain behaviour is appropriate, like masturbation for instance?”

Supported by Sammenslutningen af Unge med Handicap (SUMH), a political umbrella organization run for and by young people with disabilities, Enghaveskolen has also produced an information pamphlet for parents about the policy on sexual behaviour. SUMH implemented the project ‘Policy on sexual behaviour at special schools.’

See www.projektseksualpolitik.dk for more information.

Ageing

People grow old gradually. They do not suddenly become old when they reach 60 or 70 years of age. Though physical health does decline with age, it does not necessarily mean that older adults are incapacitated or disabled, though they may be restricted in terms of mobility, etc.

WHO estimates that 15 per cent of the world's population has some form of a disability. 20 per cent of those over 70 years is considered to have a disability, and 50 per cent of those over 85 years is estimated to have a disability. The most common causes of disability among older adults are chronic diseases, injuries, mental impairment, malnutrition, HIV/AIDS and other communicable diseases.¹⁴

Maria Marcus, 88 years old, tells her own story about acquiring an impairment late in life and learning to cope and live with it over time. It is a story that encourages reflection and highlights challenges for those working as carers and professionals.

"I can sit down and dance"

Five years ago, Maria Marcus was about to have gastro-intestinal surgery. But the anaesthetologist made a mistake and injected her spinal cord. As a result Maria was paralysed from the waist down. She can no longer walk and is in a wheelchair. She is now 88 years old and still works as a psychotherapist, sexologist and writer in Denmark. Her latest book is about living with a disability: "Lady with chair."

Much in Maria Marcus' life has changed. She is less mobile, does not manage to do all the things she would like to and is dependent on help in her everyday life. Her home is well equipped, with an elevating bed, commode, etc., but going away for a week or a month like she used to, once in a while, is not possible without having to make a lot of arrangements. Even leaving a social event when she feels like it is not an option, as she depends on disability transport which has to be pre-booked.

"Just a weekend in a cottage is unimaginable without a special bed and personal carers to help me get up. And in general, being alone and concentrating on my work is difficult. Working on the computer is now more difficult because sitting in the right position is hard. And everything just takes more time – so the days are shorter. I am often upset about tiny, everyday issues



– the computer acting up, dropping something on the floor and spending a long time picking it up when you cannot reach the floor. Then I swear and curse a lot. So I am more frustrated, but at the same time more content than before. I am content if I do something I enjoy; if I get good ideas, do therapy, write something or look at something beautiful. Before I used to express myself with my body and movement made me happy. That is difficult now but it is still possible; I have discovered that you can sit down and dance. If I put on some nice rhythmic music, I can move my arms, upper body and hips – I can dance!

So when you lose one thing, other senses take over. Proportions change. I have moments when I feel I have never felt better in my life – especially when I spend time with my boyfriend, Carsten. Imagine being so lucky to have a loved one to care for you.”

Did not want to go on living

For weeks after the operation Maria Marcus was in shock. “I was completely devastated and did not know what was left or right. Mentally, I had lost all orientation in life and almost felt dead inside. I don’t remember much of the first few weeks. But I do remember thinking that if my physical condition did not change, I did not want to go on living. I did not feel I had anything to offer as a partner or workwise. So I gave up everything that had any meaning to me – sex, writing, having clients. I simply did not recognize myself – I had lost my identity.”

The turning point came spending time with her boyfriend Carsten over the following months. And wanting to work also re-emerged. Today Maria Marcus lives with “constant discomfort” – not pain. But she forgets about it when something interesting is going on. Every morning she is worried that her carers will not arrive in time to help her get to the bathroom, as she cannot just pop into the bathroom herself. She also worries about technical problems with her wheelchair and stair lift. “But I do not feel stigmatized or shut out. There are things I cannot do compared to other people – and not everybody knows how to hug somebody in a wheelchair. But in general, people are extremely nice and friendly, offering help on the street and in the supermarket. I have also received all the support from the municipality I could dream of – best of all my electric wheelchair. It has been extremely important to me because I can raise and lower it, so I am not stuck at the level of other people’s navels. That is so degrading and you get the feeling of being wrong and uninteresting and shut out.”

Acceptance and dignity are important values

Maria identifies two core values in getting professional help – acceptance and dignity. “Accept the fact that you are seen and respected as another human being and not just a person with a disability. You are supported to gradually accept your new life. I now realize there are some things I need help to do – and a lot of things I can still do and maybe just have to learn to do better. I certainly don’t need a superficial response like “Everything will be OK,” if I am miles from that feeling. It is crucial that other people find the balance between too much and too little, between sympathy and pity, helpfulness and crossing personal borders, seriousness and humour, too small or too big challenges. I do not need pity or to be overly comforted. You get very sensitive deciding whether a smile or small talk is genuine or not.”

“I also believe it is important that professionals know about shock, grief and crisis and that they understand that feelings come in different phases. They should have empathy and be sensitive to whether I need to talk about my situation or not. And most importantly you need a chance to change focus and discover that: Yes, I have lost something important, but I also have something left – and this is maybe even better than before!”

What to do in an emergency?

In emergency situations, persons with disabilities can be particularly vulnerable. For example, how would an older person with a visual impairment escape from a fire in their house?

How would a child with autism escape from a fire in a classroom or from a building collapse?

In most public institutions and work places, there are emergency plans, fire exits, etc. It is important as professionals and volunteers to know exactly who is responsible and what roles each person has in case of an emergency. It is also vital to know what special needs a person with a disability has in emergency situations.

Persons in charge need to establish whether warning systems are adequate for the needs of persons with disabilities. Does everyone in the team have the right information and do they know how to respond to situations? Do they know what information to provide to emergency responders in relation to the needs of persons with disabilities?

What provision has been made in emergency plans specifically for persons with disabilities? Will they be ignored or helped first? Will they be asked how they can be assisted and will they receive accessible information about what is going on? Are shelters, hygiene facilities and distribution points accessible for persons with disabilities? Does the distribution of food and non-food items include everyone – women, men, children, people from different ethnic groups and persons with disabilities?

There are substantial challenges for persons with disabilities who are caught up in an emergency situation. For example, some people may have severe anxiety and this may not be evident to emergency responders. People with hearing impairments may not run to safety if they are not able to hear alarms going off to warn people to evacuate a building. Older people may not be easily found and brought to safety, being unaware of what is going on. People with cognitive impairments may have difficulties in coping with the emergency situation itself.

Please reflect on what role and responsibilities you have in an emergency as professionals or volunteers in relation to persons with disabilities.

Principles for psychosocial interventions

Five principles for psychosocial interventions¹⁵ have been identified as essential when implementing activities after crises, disasters etc. They are good guidelines for planning psychosocial activities and programmes for persons with disabilities, as well as those who are not disabled: The five principles are:

1. A sense of safety

- Conduct activities in safe and secure places (e.g. environments should be as free as possible from physical, psychological and social harm in the given context).
- Ensure that the activities are safe for all participants, taking injuries and health issues into account (e.g. ask the group beforehand so you know what precautions to take).
- Activities should help to restore a sense of normalcy (e.g. try creating a regular routine like the same time of day or day of the week and introduce activities familiar to the community like traditional games, local sports, etc. Ensure that a support system is developed).
- Provide information and allow questions to be asked. Allow time for participants to discuss and share reactions and feelings during the sessions. Develop a trust-based relationship with participants and a referral system for those that may need additional support.

- Provide quality activities and have enough facilitators for the number of participants.
- Make sure all participants are comfortable with the type of activities being planned and the way they are carried out.
- Consider offering more than one activity in a session.
- Deal with transportation problems the participants might have in accessing the activity.
- Use sign language or have interpreters for participants with hearing impairments.

2. Calming

- Have time for sharing and learning during the sessions. Have a sharing circle at the beginning or end of each session, for example, where the facilitator leads a discussion about building trust, or strengthening cooperation.
- Plan time for relaxation exercises such as visualization, stretching, yoga in each session.
- Take time to make the group feel safe and calm.
- Provide ample space for participants to move around and opportunity in sessions to express positive emotions. Be careful with confrontation.

3. A sense of self and collective efficacy

- Build success by setting goals: Achievable goals and breaking big tasks into smaller parts will make participants feel more successful. Make sure to acknowledge accomplishments and ensure that no one gets left behind.
- Design activities to suit all abilities. Every participant should be challenged but should leave the session feeling successful.



Special Olympics Deutschland

- Allow time to reflect on activities and include teaching opportunities regularly. Ask questions that promote reflection such as: What did you learn from the activities? How can what you learned be applied outside of sport?
- Create an environment where facilitators and participants encourage and support efficacy and learning.
- Use a variety of activities that promote both individual and team problem solving.

Psychosocial interventions in practice

The five principles for psychosocial interventions are all inter-related in practice and so it is important that they are all taken into account when planning activities. It will not be possible to promote calm, for instance, if participants do not also feel some sense of emotional and physical safety. It is also the case that building collective efficacy will not be achievable without a basis of connectedness across the group. Promoting hope arises in many different aspects of psychosocial activities too in relation to the direct content of an activity and in the way the activity is facilitated and the relationships that are built.

4. Connectedness

- Work in pairs, three or four or the whole group. Specific activities such as mirroring movements, helping each other to try out new patterns of movement, dancing in a group, taking turns, inspiring the others to make funny or difficult movements, for example, all foster feelings of connectedness and group cohesion.
- Plan activities where participants have to rely on their team partners in order to develop trust and sharing.
- Organize discussions and sharing in plenary, e.g. focussing on positive experiences during the session, or on things that participants appreciate about working together with others. Being part of the group strengthens feelings of connectedness.
- Create mixed teams (gender, religion, culture, abilities) to break down barriers and stigma through interacting.

5. Hope

- Hope empowers people. Encourage meaningful relationships amongst participants and with facilitators in an appropriate way.
- Include playful activities. Every joyful moment contributes to feelings of hope.
- Highlight positive outcomes even if they are only small gains: “One good thing that I managed today is ...” “Over time I feel that I’m getting better at ...”
- Encourage meaningful relationships amongst participants and with facilitators.
- Use positive role models to demonstrate how to overcome difficulties.

Psychosocial activities

Psychosocial activities are activities that help to improve psychosocial well-being. They are tailored specifically to the particular needs and resources of individuals and groups and vary greatly, since context, culture and available resources influence the choice of activities. They do not include clinical interventions, which are linked with specialised services responding to mental health issues, etc.

Psychosocial activities range from psychological first aid in the immediate phase after critical events; to psycho-education, sport and physical activities, family and community support after crisis; and more focused, non-specialised services, for instance, a special programme for children and adolescents recovering from the death of a parent.

Positive emotions such as hope, joy and playfulness play a vital role in coping with crises, including grief and trauma. When psychosocial support includes bringing out positive emotions, it is shown to benefit affected people. It is therefore crucial that psychosocial activities facilitate and strengthen positive individual characteristics and skills, as well as collective support mechanisms.

Psychosocial support can impact a person's well-being in three areas:

1. **Skills and knowledge:** For example, a person can learn skills in sign language, using easy format reading or Braille, walking on crutches or using a wheelchair. Other life skills could include resolving conflicts, make good choices and improve communication with peers.
2. **Emotional well-being:** For example, this is about having a sense of hope for the future, having a sense of control and improving self-worth.
3. **Social well-being:** For example, this is about improving one's ability to interact and solve problems with others, and establishing a sense of belonging to the community or group.

How does psychosocial support promote inclusion?

Feeling included means feeling part of a whole – being seen, heard and recognized on an equal basis with others in the community. Inclusion means having a legitimate say and having a place in society. Persons with disabilities who participate in their communities stand up for themselves and demonstrate self-efficacy.

Experience from psychosocial programmes shows that psychosocial support creates social cohesion and connectedness, as well as more individual attributes such as having a sense of safety, calmness and hope. Accessible and adapted psychosocial activities promote psychosocial well-being and in doing so also enable persons with disabilities to participate on an equal basis with others.

Do no harm

Psychosocial support must be implemented in a way that ensures no harm is done, whether intended or not. It is extremely important to make sure that all participants are safe, and that the activities and their intended outcomes go hand in hand. This means that professionals and volunteers should:

- be adequately prepared
- be sensitive to the context, target group and local systems or structures
- focus on the individual's resources
- provide holistic support and build capacity
- avoid victimization and dependency
- make sure that the activities are contextual, appropriate and sustainable. (For example, they should not affect the local environment in a negative way.)
- coordinate with other sectors, caregivers and institutions
- not raise expectations that cannot be fulfilled
- not blame it on participants, if an activity does not work.

Planning and implementing psychosocial activities to promote inclusion

Planning and implementing psychosocial activities promote inclusion when facilitators:¹⁶

- include persons with disabilities in the design of the activity. Encourage their involvement and motivate them to contribute ideas about relevant activities. This may mean in some settings, for example, having separate boys and girls groups.
- learn the sign language that is used by participants to improve interactions between facilitator and participants, where this is possible.
- provide information to family members and carers about the planned activities.
- trust in the abilities and capabilities of participants.
- listen carefully to participants and don't judge what the person is saying.
- do not interrupt and allow participants to speak.
- are sensitive to unexpressed feelings.
- demonstrate good communication skills with participants by using appropriate language, posture, gestures and expressions, etc.
- keep discussions moving and allow everyone to voice their opinions.
- are prepared to take part and also to change or adapt activities when needed.

When facilitators are calm and believe in the participants they are supporting, this encourages participants to open up and fully participate in the group or wider community. They may be willing too to talk about difficult things in life. Facilitators are most effective when they see participants as resourceful human beings who have a contribution to make.

Buddies help with personal hygiene

The University of Gondar in Ethiopia runs a community-based rehabilitation project in the areas surrounding the town of Gondar. The project promotes the inclusion of persons with disabilities and one of the programme supervisors had an idea. She was in touch with a group of young women with intellectual disabilities who had not learned the basics of personal hygiene during menstruation. In fact their parents did not think that their daughters would start menstruating. They did not expect them to go through puberty and develop sexually.

The CBR supervisor suggested a buddy system in which every girl with an intellectual disability would be linked with a non-disabled buddy. All the buddies got a short training about menstrual hygiene, with the opportunity to ask questions. After that the group could ask the team for help at any time. Everyone was keen to join the group – not just the girls with a disability. This was because the programme gave all the girls a platform to ask questions which are usually taboo in this context. Everyone enjoyed themselves and learned a lot.

Read more about the rehabilitation project at the University of Gondar at www.uog.edu.et/services/

Supportive communication

Learning how to listen, pay attention and communicate in a supportive way are core skills for professionals and volunteers implementing psychosocial activities. This section focuses on two important aspects of supportive communication – active listening and supported decision-making.

Active listening

Active listening means giving full attention to the person communicating with you. This means not only listening to what is being said, but also listening to the 'music' behind the words, registering movements, body language, tone of voice and facial expressions. The art of listening is to be able to distil the meaning, both from what is said and how it is said. Active listening in support situations requires an ability to focus on the speaker and allowing them space to communicate, without voicing one's own thoughts, feelings and questions while they are speaking, gesturing or expressing themselves in any other way.

Basic elements of active listening are:

- Maintaining eye contact – if culturally appropriate – without staring, and giving the person room to talk and communicate, allowing time for silence and thoughts.
- Using clarifying questions and summarizing statements, e.g. “What do you mean by saying ...?”; “I am not sure I understand what you mean when you mention ...?”; “Are you saying that you ...?”; “Did I understand you correctly ...?”
- Not giving opinions, arguing or sympathizing, and focusing on what the person is saying, rather than guessing, or preparing what you yourself will say next.
- Using your own body language to convey your attention, such as facial expressions and words like ‘yes,’ and ‘hmm,’ and ‘go on.’

Communicating with persons with a hearing impairment:

- Make sure the light is good and that you face the person.
- Make eye contact before and during communication.
- Use sign language if you are able to or use a sign language interpreter. Speak clearly and not too fast, but do not shout.
- Position yourself at the person's better ear, if they prefer this.
- Meet in a quiet room with no background music.
- Make sure your face is visible to the person and do not cover your mouth or rest your chin in your hand.

Communicating with persons with a visual impairment:

- Be concrete and descriptive in your communication. Do not use words like “over there” or point to things. Don't be embarrassed to use phrases like “I see.”
- Make sure the lighting is good for persons with low vision. Seat yourself facing the window, avoid rooms with a lot of glare and use clear lines to mark physical spaces to help with orientation.
- Guide the person to the room and tell them where you are positioning yourself. Give them an idea of the length of the session.
- Remember that persons with visual impairments often do not see your facial expressions so make sure you express what you want to communicate. Check regularly that the person has understood what you are saying.

Communicating with persons with cerebral palsy:

- It is sometimes difficult to understand what a person with cerebral palsy is saying. Make time to understand them and do not be afraid to ask for clarification.
- Let people finish their sentences. Do not shout or treat them like they do not understand you (it is probably you who do not understand them).
- Some people with cerebral palsy use a communication system, using picture or a voice output device.

Supported decision-making

Persons with disabilities say they are not always heard or involved in making decisions about their own lives. Key points in empowering persons with disabilities in decision-making include:

- Asking questions which clarify the problem, and provide relevant practical information to support the individual.
- Supporting the individual in identifying possible solutions.
- Dealing with the 'here and now' and trying to guide the individual away from making any life-changing decisions, when he or she is feeling upset.
- Using a statement to encourage someone to say more: "The more you tell me, the better I understand you." "I would like to know more about that."
- Asking a direct question. This offers a person the opportunity to fill out his or her story.
- Using a closed question which gives the person the opportunity of saying yes or no: "Are you feeling better than last time we met?"
- Using an open question which allows the person to answer the way he or she wants: "How do you feel today?"
- Avoiding leading questions, because they include assumptions and undermine empowerment. It puts the questioner's presumptions into the forefront, so that in
- replying the person feels forced to agree with you: For example, "Are you feeling very unhappy about your disability?"

How to communicate and listen actively

In this conversation, V, a volunteer, talks to A, an old woman with poor eyesight. The woman had to be evacuated from her home due to flooding.

A: – Why did they have to move me? It was so terrible.

V: – From what you say it sounds like you did not feel like moving. Is that right?

A: – Yes, it was awful ... (tears start running down the woman's cheeks).

V: – I see ... (V moves a little closer). Would you like to tell me why you did not want to be relocated?

A: – On the radio they were talking about the flooding and the need to relocate everyone who lived in the affected area. Oh, it was really horrible ... (A cries more quietly now). I received a phone call, and someone told me that I had to be relocated.

V: – I would like to hear more about what you did.

A: – When my doorbell rang, I opened the door and some men told me that I had to come with them to this other facility for people who had been relocated. But I did not want to go with them and I had not packed my bags.

V: – So you did not want to go?

A: – No, I was afraid that I would not be able to manoeuvre myself around in the new place. My eyesight is not that good anymore. But I have lived in my house for many years and know my way around inside so it's easy for me to take care of myself. I was afraid that I would not be able to do that in the new place.

V: – I can understand how it must have been difficult for you to leave. So what did you do?

A: – (Sighing ...) Yes, that is true, it was scary but then I told the men about my bad eyesight and I told them I was frightened. It was the first time I had told anyone that I was almost blind.

V: – How did it feel to tell them?

A: – It felt ok. They promised that they would make sure that I would get the right help in the new place.

V: – How are you feeling now?

A: – It's much better now. I find I am no longer scared to tell people that I have bad eyesight and that I need extra help.

Victims or resourceful?

The approach presented in this handbook is not about perceiving persons with disabilities as helpless victims. A psychosocial approach recognizes that people have both vulnerable and resourceful sides. Whenever an individual feels they are a victim of life, biology or fate, the best support to give is in accepting those feelings and understandings, whilst helping the individual to move towards feeling, “I am, I can, I will.” A person who feels in control over his or her life feels much stronger and capable of living life as it is. Saying “persons with disabilities are not victims” is not the point. Professionals and volunteers need to know how to support and encourage the person to gain control and self-respect, whilst listening to how they feel.

Daniel Kulonka, a young Danish man living with an amputation, tells his story of a life lived to the full, with family, friends, job, etc. His reflections provide a picture of the challenges he has faced and the opportunities he has taken in the course of his life.

“Often my head is my limit”

“There were never things I could not do. Well, of course I could not walk as far or run as fast as the others, but I always played along and set my own limits.” Daniel Kulonka from Denmark is 28 years old and is a trained orthopaedic technician, making artificial arms and legs. At the age of six he was diagnosed with cancer in his right leg. Over the following 11 years he had surgery four times – the last time when he was 17 and in high school. “I remember a doctor and a nurse standing at the end of my bed, telling me that my leg had to be amputated. I just thought it was fine, since it would take away the pain. In a way, I think it was good that I wasn’t older. Children think more straightforwardly than adults. But of course it has not been easy. The process of amputation took a long time and having a prosthesis as a teenager was difficult because I felt different and wondered if there would ever be a girl for me.”

Allowed to be wild

These were not thoughts Daniel shared with anyone – mainly because he was a teenager and teenagers do not do that, he reflects. “It’s not so cool to talk about feelings, sexuality and stuff with your parents.” But in many other ways, Daniel’s parents have been supportive.” They have never failed me for a single second. Whenever I needed them, they have been there to support me and never overprotected me. Thanks to them I’m not sitting in a corner, feeling sorry for myself. They have always allowed me to be wild, playing war games and climbing trees.”

And yes, there are bad days, too – but not many, he says. “When my leg hurts or the prosthesis has eaten a hole in my skin, life sucks. I wear down my body in a way others don’t. I think my pain threshold is actually quite high, and now I just accept that on certain days, I cannot go cycling or play football. But fortunately, it doesn’t happen often. I don’t know if my disability has made me more resilient. It has made me who I am today with experiences others don’t have. But I’m not necessarily stronger or tougher than others.”



Say things straightforwardly

During the course of his illness, Daniel was in contact with lots of doctors, nurses, physiotherapists and orthopaedic technicians and basically only has good things to say about the way they dealt with him. “Most of them only have the best intentions and saw the challenge in working with me and the product – the prosthesis – that I needed. But as a child I wrecked lots of prostheses, because I was so active. Sometimes the prosthetist would not admit that they could not give me what I needed and so I wore bad prosthetics affecting my body, and the way I walk.”

Going about his business today, Daniel rarely experiences prejudice or verbal assaults. Occasionally a child is curious about his artificial leg when he wears shorts in the summer. “Often parents don’t know how to deal with it and try to drag the child away. That can be very unpleasant. I think it is much nicer, if children are allowed to ask the questions they want and I can explain that I was sick as a child, and they run happily along. But even so, there are still psychological barriers towards people who are different. It even happens to me if I meet someone different. But really, it’s much easier if you just say things out loud, just straightforwardly. It gets so awkward for everyone otherwise. I think it’s all about seeing me as any other human being, treating me as you would anyone else. My friends tell me that people often stare at me in the summer when I wear shorts. But I don’t notice – my artificial leg is so much part of me that I don’t notice. And if someone thinks it’s disgusting, there is nothing I can do about it anyway.”

Actually, Daniel is proud of his legs and what it has done for him. “I’m really proud that I can ride a bike to Paris with ‘Team Rynkeby’ and that I can play football. I often think my head is the limit for what I think I can or cannot do. If I decided to run a marathon in three years, I would probably succeed. I do not feel limited in any way.”

Want to help others

In the summer of 2014, Daniel did a marathon by bicycle. He rode exactly 1224 kilometres from Copenhagen to Paris as part of ‘Team Rynkeby,’ a team of people cycling to raise money for the Children’s Cancer Foundation in Denmark.

“Maybe I said yes a little too quickly when a friend’s mother asked if I would join the team. It takes an amazing amount of training ... But I did it, I went all the way. And it was so cool to ride along the Champs Elysées in Paris! In those moments, all the long, cold, painful hours on the bike just disappeared. I have already signed up for the team again next year.”

Besides the personal satisfaction in succeeding, Daniel also managed to raise 55,000 Danish Kroner in sponsorship money for the Children’s Cancer Foundation. “I’m so proud and happy about that, having had cancer myself as a child. But it is also a cause that matters to many people – almost everybody knows someone with cancer in one way or another.”

In terms of education and training, Daniel’s illness and his subsequent disability has been very significant. “I have chosen to be an orthopaedic technician myself and make prostheses for a living. That would probably not have been my choice, had I not had a prosthesis myself. But it’s really a thrilling job and a profession with many very talented people who inspire me. It is also an area of rapid technological development. So I really feel I can make a difference to others. My dream is to have my own business and work with talented colleagues. I might even go abroad and help people there.”

So all in all, Daniel is quite satisfied. “No, I don’t go around wishing my life had been different. I am deeply grateful that I can do the things I can and that I have been given the opportunities and positive experiences that I have. It’s not something I consciously strive at – they just happen. And I’m very grateful.”

¹² M. Hedegaard. Children’s development from a cultural-historical approach: Children’s activity in everyday local settings as foundation for their development. *Mind, Culture, and Activity*, 2009: 16, 64–81.

¹³ Puberty is the process of physical changes through which a child’s body matures into an adult body capable of sexual reproduction to enable fertilization. It is initiated by hormonal signals from the brain to the gonads: the ovaries in a girl, the testes in a boy.

¹⁴ CIRRIE, International Encyclopaedia of Rehabilitation, University of Buffalo, 2011.

¹⁵ S. Hobfoll et al. Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry*. 2007 Winter: 70 (4), 283-315.

¹⁶ Facilitators may be professionals or volunteers who have been trained to provide psychosocial activities.

Accessible psychosocial activities



Kasper Rander, Egnort Højskolen

3

There is a vast range of accessible activities that promote psychosocial well-being and build inclusion in society. This chapter focuses on mainstream activities found in many communities around the world. It describes what accessibility means and details some of the activities that can be accessed in order to promote participation and inclusion.

Accessibility

Accessible psychosocial activities are activities that are open to everyone – irrespective of their abilities. Life skills programmes, arts projects, dancing or drama sessions, counselling, self-help groups and support groups are all examples of psychosocial activities that can be implemented in such a way to enable everyone to participate. Accessible activities like these provide lots of opportunities – for example, for making friends, for communal participation, for personal achievement, for fun and enjoyment, and for building networks of support.

Making psychosocial activities accessible means identifying the physical or social barriers that prevent persons with disabilities from joining a programme and then working on solutions to promote their participation. For example, arranging transport to and from a venue might greatly help individuals to attend an arts project. Reaching out to parents of children with disabilities to encourage them to consider involving their children in a community drama programme, for example, also opens up opportunities for participation.

Participation and inclusion are closely linked. Persons with disabilities benefit psychologically and socially, by participating in a wide range of activities that involve members of their community. Being more actively involved in community life lifts the spirits, enhancing mood and a sense of hope. It can contribute to an acceptance of disability and to a more independent approach to life.

Persons with disabilities who do psychosocial activities often say their well-being improves significantly: Their self-image and levels of self-satisfaction increase and their self-esteem and feelings about their health and body image all improve. They feel empowered. They find they need less medical care, as secondary conditions tend to reduce. They are energised, and are functionally more independent and physically more capable.

Promoting programmes to increase participation

Contact local disability organizations regularly with information about local accessible activities.

The twin-track approach

The twin-track approach – mainstreaming psychosocial activities on the one hand and investing in targeted activities on the other – is central to the approach for psychosocial support and activities for persons with disabilities in this handbook (see chapter 1 for full details). The STEP model (explained in chapter 5) also helps professionals and volunteers to understand how inclusion works.

This means that psychosocial programmes should usually feature activities that are open for everyone (this is the ‘mainstreaming’ track). Sometimes, however, a psychosocial programme that targets a specific group of persons with disabilities to address a particular need may be appropriate (this is the disability-specific track). A programme like this would feature activities that are designed to enable participants to achieve specific goals or skills.

From summer camp to school

Husen, a young boy from Palestine, has a mobility disability and is small in stature. His parents are farmers and they sent him to kindergarten from the age of four because they needed someone to take care of him and the kindergarten was close by. When he was eight years old, Husen could not stay in kindergarten any longer because of his age, but he refused to go to school. A community-based rehabilitation worker visited him when he was 13 years old and she suggested he participate in a summer camp with a mixture of children with and without disabilities. His parents were very worried. They wondered how he would feel as a small person for his age and with a disability. However, Husen loved the activities at summer camp – drawing, singing, music and games, and he loved being with children his own age. After the summer camp was over, he decided he wanted to go to school. Husen is now 16 years old and is in the fourth grade. This story demonstrates how significant it was for Husen that the CBR worker persuaded his parents to let their son go to the summer camp and based on that positive experience, convincing them that school would be good.

Read more about The Norwegian Association of Disabled (NAD) at www.nhf.no/english and about Diakonia at www.diakonia.se/en/

Participation and inclusion is a process

Participation and inclusion may happen gradually – it is a process. It is very important for facilitators of psychosocial activities to develop trust in participants and to respect their capacities and abilities. A key focus of this handbook is creating a conscious awareness amongst professionals and volunteers about how to provide psychosocial support to promote inclusion and psychosocial well-being. The five principles of psychosocial interventions (see chapter 2, page 37) establish a setting which is safe and positive for participants, including:

- a sense of safety
- calming
- a sense of self and collective efficacy
- connectedness
- hope.

Choosing to participate

A girl at a Danish Red Cross Youth summer camp did not feel like participating and for the first three to four days she just watched the other kids do activities. The very last day of the camp she finally took part in a couple of activities. The camp volunteers thought that the girl must have been completely bored the whole week. However, a couple of days after the girl got home, her mother phoned to say that it had been the best week ever for her daughter. The girl felt she had been seen and respected as she was, not forced to do anything she did not want to do and had chosen when to participate on her own terms.

As the story above shows, not everyone will automatically want to participate in activities. If they do not feel safe, they should not be forced. However it is important not to overprotect persons with disabilities and keep them from any kind of new challenge or risk. Parents or other carers in the family play a special role in this sensitive area. They instinctively want to make sure that the person they are caring for is not confronted with difficulties or hurt by being in contact with others. Professional carers also may not know how to support the person they are assisting in taking part in sports, games and other activities. Out of fear of doing the wrong thing, they may overprotect the person from what they see as inappropriate or dangerous activities, rather than enabling the person to develop, learn and have fun. Overprotection will almost always lead to reduced empowerment. An approach to this can be psychosocial support for parents and carers, e.g. to assist them in facilitating the independence of those they care for.



Kasper Rander, Egmont Højskolen

A broad range of accessible activities

All over the world, professionals and volunteers provide a broad range of activities enabling persons with disabilities to participate in their communities. There is a lot of experience especially in the field of sport and physical activity (see more about this in chapters 4 and 5.). Other types of activities include, for example, music, drama, dance, art, political involvement and life skills:

Music

Music therapists say there are many benefits of working with music. Music can make people happy. It is motivating and enjoyable and can promote connection, relaxation, learning and self-expression. Music as a skill can stimulate creativity. It can benefit all groups of people, for instance, children with autism.

Music in a school or after-school setting could include:

“Stomp” – find pots and pans and other objects that can make a noise and get a rhythm going.

Singing – pick well-known songs and ask the group to make up their own words to them.

Drama and storytelling

Drama and storytelling enable participants to think about important issues and respond, for example, in adapting fairy tales, or performing in inclusive theatre or circus shows. The books featured below show how stories can help children to address difficult issues. The first is about attention deficit hyperactivity disorder (ADHD) and the second about HIV/Aids:

‘Wilbur – a brat’¹⁷ is a Danish story of a boy with ADHD who finds it difficult to adapt to rules and structures in everyday school life. The story is about how Wilbur is supported in experiencing success in his life.

‘Brenda has a dragon in her blood’¹⁸ is a book developed by UNICEF about a girl called Brenda who is living with HIV/Aids. The story explains that to stay well, the dragon in her blood needs to be asleep.

Dance

Experiencing movement together can challenge misconceptions and prejudices that non-disabled or persons with disabilities might have about themselves and each other. This is the experience of the organization, DanceAbility International, based in the U.S. Their workshops provide a supportive atmosphere in which people learn about the beauty and joy of communicating through movement and as a result attitudes can change. Dance-Ability uses improvisational dance to promote artistic expression and exploration between persons with and without disabilities.

Art

The story of Jeroen Bouwmeester, a Dutch artist, demonstrates how painting and drawing can break isolation and enhance inclusion. When he first joined the Dutch disability art organization, De Witte Olifant, at the age of 20, Jeroen was very shy and always worked behind a screen.

Some time later, Jeroen was invited to exhibit his work at an exhibition. He was expected to say something about it in front of an audience. One of the team members suggested he video his presentation, showing his art behind a screen. They were able to repeat the recording several times until he felt he had got the message right. In the process he became heavily involved in producing the video. Finally after about a month he went on stage and spoke freely to the audience. Later he became a member of a theatre group. Jeroen is now 30 years old and interacts confidently with other artists and is a long-standing member of the theatre group. The video can be seen on YouTube: www.youtube.com/watch?v=1xjjMQ33A5s

Life skills

Life skills are empowering skills that enable people to cope with life and its challenges and changes. Life skills support psychosocial well-being by promoting good communication, positive thinking, analytical skills and goal setting, cooperation and coping. They are learned through experience and with guidance from parents and carers, teachers, friends, mentors, etc. For instance, young people have to learn to manage their finances at some point in their lives, so that they can live independently of their parents.

Life skills activities therefore may include such things as practice in reading bus timetables and taking bus rides to promote independence; sessions on practising how to talk to strangers; learning how to ask for help in a positive way, etc. Danish Red Cross Youth has summer camps for children and youth with and without disabilities to promote inclusion and practise life skills. At the camp, the children and youth learn how to play cooperatively, listen and accept one another, and identify good role models amongst themselves.

The organization CHANGE based in the U.K., has a co-working model of employment: People with learning disabilities are employed to co-lead on all of the projects alongside non-learning disabled colleagues. Both are paid an equal salary. This is a peer-to-peer way of working. There are many psychosocial benefits of this approach. By being employed, the persons with disabilities have a high level of self-esteem and are motivated to improve their skills. They also act as role models for other people with disabilities.

Counselling, support groups and self-help groups

Sometimes, persons with disabilities need counselling or other types of psychosocial support. Counselling, support groups and self-helps groups can be offered by professionals or volunteers alongside the other types of activities within a psychosocial programme.

Counselling

Counselling of the type offered within psychosocial programmes does not require formal mental health training. It is however mandatory for professionals and volunteers to have had a training in counselling techniques. The most common form of counselling in the Red Cross Red Crescent Movement is lay counselling. Most organizations use the terms 'peer-to-peer counselling' and 'lay counselling' interchangeably. This type of counselling does not include psychotherapy or psychological or psychiatric treatment.

Please note that the training needed to provide counselling for persons with disabilities is beyond the scope of this handbook. The guidance below describes **the basic approaches that apply to all counsellors**, though the specific skills needed depend on the setting and the issues and challenges being raised:

- **Empathy, respect and being genuine** are all important in showing the affected person that he or she is valued and cared for.
- **Supportive communication** (which is non-judgmental and neutral) encourages the affected person to be strong and active in making decisions and coping with challenges. (See chapter 2, page 41).
- **Active listening** ensures that the counsellor understands the point of view, experiences and needs of the affected person. Active listening not only helps the peer counsellor understand the situation and challenges of the affected person, but also makes the help-seeker feel heard and understood. (See chapter 2, page 42).
- **Sharing helpful information** is one of the most important aspects of lay counselling, as many people affected by crisis or emergency situations feel lost and confused, may not know where to access help, and may not have information about how to contact their families and loved ones.
- **Supporting people make informed decisions** is especially important when people feel overwhelmed or lack information to make decisions. It is important that information is as unbiased as possible to avoid influencing their decision, but instead empowers them through knowledge to make the best decision in their particular situation. (See chapter 2, page 43).
- **Making referrals** involves knowing why, when, and where to refer someone for professional mental health services such as psychologists or psychiatrists. This is very important knowledge for lay counsellors, as they are not trained to treat people with mental health disorders. (See chapter 2, page 31).

Peer-to-peer counsellors do's and don'ts

Peer-to-peer counsellors **do**:

- Give comforting and practical support;
- Listen and provide comfort;
- Provide helpful information;
- Facilitate self-help;
- Act alongside the help-seeker;
- Help people make decisions and solve problems;
- Help people access basic needs;
- Refer to specialised care if needed.
- Use proper, correct and supportive language
- Work alongside the person you are working with on how to solve problems.

Peer-to-peer counsellors **do not**:

- Break the confidentiality of those they are supporting;
- Show disrespect;
- Make promises they cannot keep;
- Act as a psychotherapist, for example, by asking the person to discuss painful memories about their childhood or past events or about inappropriate aspects of the person's impairment.

Support groups

Support groups are commonly used in community-based psychosocial support responses, particularly when many people have been affected by an emergency or crisis situation. In these circumstances people often share similar concerns and challenges. They are very useful activities, as they help people realize that they are not alone, and the peer support offered within the group gives participants strength and courage.

Support groups are usually arranged for natural groupings such as relatives, caretakers, adults, spouses, children of similar ages, or for older people. The key factor in the grouping is that everyone is valued and feels comfortable and safe about sharing and asking questions.

Support groups are used:

- to provide psycho-education (a method that focuses on strengthening people's capacity to understand their own or family members' reactions to distressing situations)
- to orient and update people with important information relevant to their situation
- to give participants an opportunity to share their concerns and worries, and to encourage them to support and help each other.

Staff or volunteers who have been trained in facilitating support groups can either facilitate the support groups themselves, or arrange the time and venue, and invite another skilled facilitator from either inside or outside the group.

Self-help groups

Self-help groups are a combination of support groups and peer support, where people facing similar challenges meet to support each other, with the intention and commitment to change something in their lives for the better. The focus of self-help groups are many and varied: They can be provided for people with a particular health issue such as cancer or diabetes, for example, or for persons who have acquired a disability after a stroke or heart attack, or who have had an amputation, or hearing loss, etc. They can be set up for people who are isolated and lonely. They can assist people who have lost relatives or have experienced violence or sexual abuse. They can be implemented with people with alcohol abuse or other substance abuse difficulties.

¹⁷ Renée Toft Simonsen. Wilbur, en møgunge. ADHD-foreningen. 2007.

¹⁸ Hijltje Vink. Brenda has a dragon in her blood. Garamond Publishers. 2005.

Inclusion through adapted physical activities



Bo Jørgensen, Difiaktivitet

4

This chapter focuses on the physical and psychosocial benefits of adapted sport and physical activity for inclusive psychosocial programmes. It introduces the inclusion spectrum and shows how adapted physical activities have enabled young people and adults to flourish and grow.

Introduction

It is well known that inclusive physical activities have a strong and positive impact on cognitive and psychosocial well-being. Sport and physical activity offer a motivating setting for engagement with multiple levels of participation, opportunities for personal achievement, high levels of fun and enjoyment, networks of support and opportunities for friendship.

The psychosocial benefits of adapted physical and social activity are at least as important as the more conventional physical health outcomes. “The best possible outcome will be a greater sense of psychosocial well-being,” says ‘Designed to Move.’¹⁹ This worldwide initiative demonstrates the potential of physical activity in bringing joy, friendship, and happiness to people’s lives. There is great value in its potential to include everyone, irrespective of abilities.

Their path-breaking research also indicates that, “Positive physical activity experiences permeate the quality of all aspects of life – improving education, health, psychological and social well-being and lifelong success.” However, professionals and volunteers can only promote these goals and empower the individuals they are working with, if they facilitate the activities carefully. It is vitally important to understand that psychosocial outcomes are not automatically generated from a sports game, for example. Facilitators need to do more than find a playing field and a ball. They need to enable participants to reflect and learn from the interactions and relationships formed in such activities.



Making health and safety a priority

The guiding principle in planning and implementing activities should always be “Safety first!” Health and safety issues are of the utmost priority in sport and physical activities, as well as in other kinds of psychosocial support activities. Key features include the safety of the space that is being used and an awareness of the health and safety of participants, before, during and after activities.

Here is a list of health and safety considerations:

- Wherever possible, select locations that are screened off from the general public.
- Before activities begin, all facilitators, helpers and participants should do a safety check on the playing field. Dangers might include glass, garbage, plastic bags and wrappings, animal excrement, sharp rocks, wood or any other debris that could cause injury to participants.
- Use locations that are safe for all users (e.g. stay away from rivers, embankments, cliffs, roads, etc).
- Make sure there is enough space for all of the participants to do the activity.
- Make sure there is enough equipment for everyone and that it is the correct equipment for the activity wherever possible.
- Make sure it is safe to get to and from the playing field, if a sports activity is held outside (e.g. no travelling in the dark).
- Changing rooms and bathrooms should be available, wherever possible.
- First aid kits should be available and all facilitators trained in using them.
- Be aware of participant’s pre-existing health conditions (e.g. asthma, diabetes), psychological/emotional problems or current illnesses or risk conditions.
- Always plan each session and ensure that the activities are suitable for the participants.
- Rival groups should not be involved in competitive games. If competitive games are played, rival group members could play in mixed teams. Choose activities carefully to promote cooperation.
- Make sure that participants choose team members in a fair way and in a manner that does not demean anyone. For example, if two team captains choose team members in turn, someone will be left at the end, feeling they are not wanted in any team.
- Be sure that there are enough facilitators and helpers for each session so that the participants are supervised well and are not at risk of harm. Facilitators should be trained in risk management.

Note: Further advice and help on planning and implementing safe, friendly activities and on being a good facilitator is available from ‘Moving Together. Promoting psychosocial well-being through sport and physical activity’ at www.pscentre.org

Well-being and physical activity

Sport and physical activity have an impact on all aspects of health and well-being, including:

Physical well-being

Physical activity improves physical health by enhancing the efficiency of the heart, the lungs, the blood and the nervous system. Physical activity also improves health by reducing overweight and obesity. According to WHO, cardiovascular diseases are the single

largest causes of ill health and death around the world. These diseases of the heart, lungs, and blood system are to a large extent caused by inactivity.

Physical activity improves movement skills – the ability to coordinate the body, balance and manipulate or handle things. Through physical activity people can practise and improve these skills, which they use and need every day, throughout their lives. Physical activity leads to general physical fitness – the body’s ability to make its way in the world. Physical activity builds muscles and strength, stamina and endurance. It releases chemicals called endorphins in the brain. Endorphins make people feel happier, less anxious and generally good about life during the activity and for some hours afterwards.

These benefits are important for all of us, but especially so for children and young people. When they are growing and developing, physical activity has an added impact; it not only brings immediate benefits during childhood, but also carries longer term positive effects and has longer-term impact throughout the lifespan. As the root causes of ill health can often be found in childhood physical inactivity, children and young people are generally able to lead healthier lives, both in the present and when they grow up.

Cognitive well-being

Cognitive well-being is also improved through physical activity. Cognitive functions are the mental processes such as memory, attention, concentration, understanding language, learning, solving problems and making decisions.

Research has shown that the brainpower of school children benefits especially from physical activity. Physically active children are more likely to stay in school, and physical activity also has a positive impact on children’s ability to concentrate.

Psychosocial well-being

Sport and physical activity develops the psychosocial well-being of individuals and communities in many different ways including:

- Increasing levels of self-esteem, or the ability to feel positive about oneself, one’s body and physical abilities
- Increasing confidence in the individual’s own abilities to relate to peers
- Reducing feelings of depression
- Clearing people’s minds as they concentrate on the activities
- Improving the ability to sleep better
- Reducing headaches and other bodily pain
- Reducing social isolation by spending time with others at play
- Making new friends or strengthening existing friendships by spending time together while doing activities
- Strengthening social skills as people engage with one another
- Learning about positive and negative emotions, such as winning and losing, and how to deal with them
- Providing a positive and safe space for releasing tension and stress and for dealing with emotions such as fears and frustrations.

The table shows examples of adapted activities that promote physical and psychosocial benefits and indicate the aims for each activity:

Activity	Description	Aim of activity
Team touch football	Divide the group into teams of 4-5 players. In short 5 minute-games, each player in a team must touch the ball once, before the team can try to score a goal. A mini playing area and small goals will be most effective.	To promote cohesion amongst participants.
Sharing circle	At the end of each session, find a comfortable place, for example under a shady tree or in the corner of the gym. The facilitator opens a discussion with the group on a topic that is relevant, e.g. health issues, how to deal with conflict with friends, etc. The discussion could also directly connect with the aims of the game, e.g. the group could talk about how they cooperated in the game they played.	To provide an opportunity for participants to share their feelings and reflect on what they are experiencing in their lives.
Guided relaxation	Have each participant find a place to sit or lie down. Ask participants to close their eyes. The facilitator then guides the group through a visualization exercise.	To enable participants to be relaxed.
Blanket volleyball	Each team needs a blanket or sheet. Set up teams of four people. Each person holds a corner of the blanket. Have one team serve the ball by placing it in the middle of the blanket. They 'throw' the ball, by lowering and raising the blanket together. The opposing team must catch the ball in their blanket and toss it back again. (This game can be played with a volleyball net between the teams, but this is not essential.)	To promote cooperation and to build confidence.
Emotional mirror	Participants in pairs face each other. One of the pair thinks of an emotion or feeling (e.g. anger, happiness, being in love) and starts talking in gibberish (words that don't make any sense) to describe how they feel. Their partner should try to copy the emotion and speak in gibberish too. After 10 seconds, they change sides and the second person takes the lead.	To give participants a safe place to laugh and play.

Key points about sport and physical activity

1. Sport plays a huge role in the lives and communities of many people around the world both disabled and non-disabled. Sport offers a context for learning to play together; for dealing with losing, winning and with competitiveness; and for building fitness and strength. It gives people the experience of facing challenges and overcoming barriers and as such is a great boost to self-esteem, empowerment and physical well-being.
2. Sport and physical activities are not always programmed for persons with disabilities. In general, unfortunately the focus is primarily on treating medical conditions and providing care and rehabilitation services. The abilities of most disabled persons are undervalued in both developed and underdeveloped countries.
3. Sport and physical activities need careful planning if they are to achieve their aims in promoting psychosocial well-being and inclusion. It is not enough simply to arrange a volleyball game, for example, and turn up on the day expecting everything to go well. Skills, experience and sustainable programmes are needed to achieve longer-term benefits.

Best practice in the field

A survey was undertaken in preparation for this handbook with selected disability organizations from Europe, Asia, the Americas and Africa. The survey identified examples of best practice within the organizations and documented their experiences of providing psychosocial support programmes. The beneficiaries of those organizations include:

- children with severe traumas from abuse and neglect
- children who lack opportunity due to poverty
- children who are not included because of the disabling effects of impairment.

The survey showed sport is a strengthening and empowering modality for all the children. Sports programmes provide moments of fun, but also offer benefits associated with participating in the wider community. Young people are also able to demonstrate what they are capable of doing, regardless of perceived limitations. This reinforces their self-worth and self-efficacy. Many of the sport programmes include other activities, such as working on inclusion with young people with disabilities, teaching them about their rights, providing therapy and advising on assistive devices (e.g. to increase mobility).

A healthy social climate

The quality of relationships established during an activity is at least as important as the choice of the activities themselves. These relationships make up what is sometimes called the 'social climate' of the session, and it is a vital element in effective support and intervention. If the social climate is inappropriate, for example, by being too competitive, culturally inappropriate or exclusive, the benefits of the activity can be lost. It is the combination of well-selected activities and a positive social climate that make up high quality sport and physical activity sessions.



Footballer with one leg

A girl with one leg lived on the streets with her mother in Uganda. Her father had left the family when he realized his child had been born with a disability. The girl was then brought to an orphanage. Initially she was very shy. However she gradually got involved in playing football. The more she realized that she was really talented, her self-confidence grew.

Now, when she plays in a match, her focus and attention is 100 per cent and she forgets everything else around her. From time to time, she even kicks the ball so hard that her leg prosthesis flies off, along with the ball across the field. Being such a skilled and enthusiastic footballer, she was selected as captain of her team for an international championship.

See PlayAble at www.play-able.org for more information

“I play sports”

Left to die as an infant in America and abandoned by her mother who had drug addiction problems, Jenny had an uphill battle from the start. After being rescued from near death, her early life was marred by sexual abuse and severe neglect by those charged with her care. Jenny was cared for by several foster families, hospitals, and treatment centres. Jenny now has lesions on her brain, chronic post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), and muscular issues making it difficult to open and close her hands. From her early years, it was often difficult for Jenny to feel good about herself and her life.

Jenny finally began to do well, when she reached a treatment centre offering Doc Wayne programmes. The centre provided a stable and caring environment coupled with an opportunity to take positive risks and be active. In spite of health concerns and the need for intensive therapy, Jenny began to feel competent and proud. She learned to run and use her hands; she acquired social skills, confidence and improved her self-esteem. When people ask Jenny what she likes to do or ask her to describe herself, she always replies: “I play sports.” Doc Wayne gave Jenny hope, provided a supportive group of understanding peers and transformed her life through the power of sport.

See Doc Wayne Youth Services at www.docwayne.org for more information.

Win-win for both children and parents

BlazeSports America believes in an approach where people with a disability can learn and practise their skills in a safe environment before going out to public events and tournaments, since children with disabilities grow up more isolated than their non-disabled peers. The BlazeSports programme helps them to get to know other children, both with and without disabilities. The children learn new skills and get more confident with the possibilities of their bodies, which in many cases improves their capacity to move around by themselves. The tournaments and events create networks between parents who have a child with a disability. Sport is a way for the children and adults to enjoy themselves and improves general health.

BlazeSports America has found that the sports programme for children with disabilities increases their confidence in general and that more children at the age of 18 also feel confident to continue education and go to college.

See BlazeSports America at www.blazesports.org for more information.

Working inclusively through adapted physical activities

The overall goals of any session are both to promote inclusion and to strengthen psychosocial well-being. The focus of facilitators should be to work inclusively so that everyone can participate and have fun, learn and grow. But they also need to keep in mind how activities are psychosocially supportive. (See chapter 2 for principles of psychosocial interventions).

Facilitators are most effective when they are responsive to the needs of all the participants in the group that may include people with different abilities. This ensures that everyone has the opportunity to be part of the game or activity.

For instance, using a balloon instead of a ball slows down the game and enables everyone to be included. This simple change in the choice of equipment may help people who have coordination difficulties or certain learning disabilities to play with everyone else. Simplifying the rules can also be helpful. For example, in volleyball a rule could be to allow players to catch and throw, instead of playing one touch, or in basketball or handball to allow players to do more than three steps with the ball.

Facilitators promote inclusion by building on individuals' strengths and interests, rather than focusing on their impairments. They need to listen to participants and their parent or caregivers where appropriate to find out what their strengths and interests are. The approach that facilitators use in promoting inclusion is in fact the approach that should be used when working with any person, regardless of their ability or background. The key elements in this approach are:

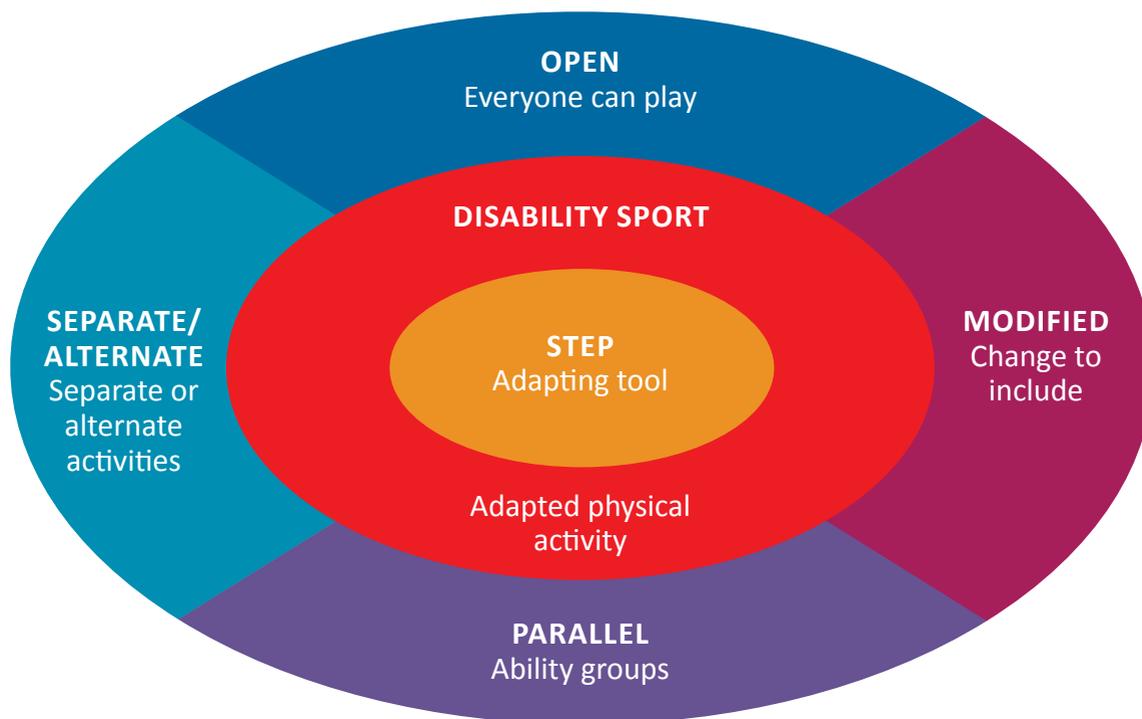
Changing the rules for a soccer game

Sometimes a few soccer players in a team are much better or much more physically fit than the rest. This can lead to them dominating the game, making it less enjoyable for the rest. But if the group decides to change the rules of the game by saying that each member of a team must kick the ball before the team can try to score a goal, then even the ones that are not so skilled get to touch the ball. This rule means the team needs to work very closely together and include all their players in order to win the game.

- **Do not underestimate** the person's abilities.
- **Have a plan** for positive experiences by setting challenging but achievable goals.
- **Have a flexible approach** to coaching and communication that recognizes individual differences.
- **Be creative** and explore new and unconventional methods to ensure that every session is fun and rewarding for all.
- **Be aware** that there are different impairment groups (blind, deaf, learning disabled and physically disabled) that need different adaptations and that safety, (both physical and mental), is very important.

The inclusion spectrum

The Inclusion Spectrum model, incorporating STEP



Source: The Inclusion Spectrum²⁰

‘The Inclusion Spectrum’ is an activity-centred approach to promote the inclusion of people of all abilities in physical activity. It provides programme managers and facilitators with different methods of supporting inclusion. By delivering activities differently, it is possible to balance different needs within a group and help to maximise the potential of all participants.

The core principle of the inclusion spectrum is that inclusion can be achieved by changing the environment of the activity or the way in which the activity is presented. This means that everyone is able to take part in a way that challenges them and celebrates their abilities in a social context.

The inclusion spectrum has five settings:

1. Everyone can play (OPEN activities)

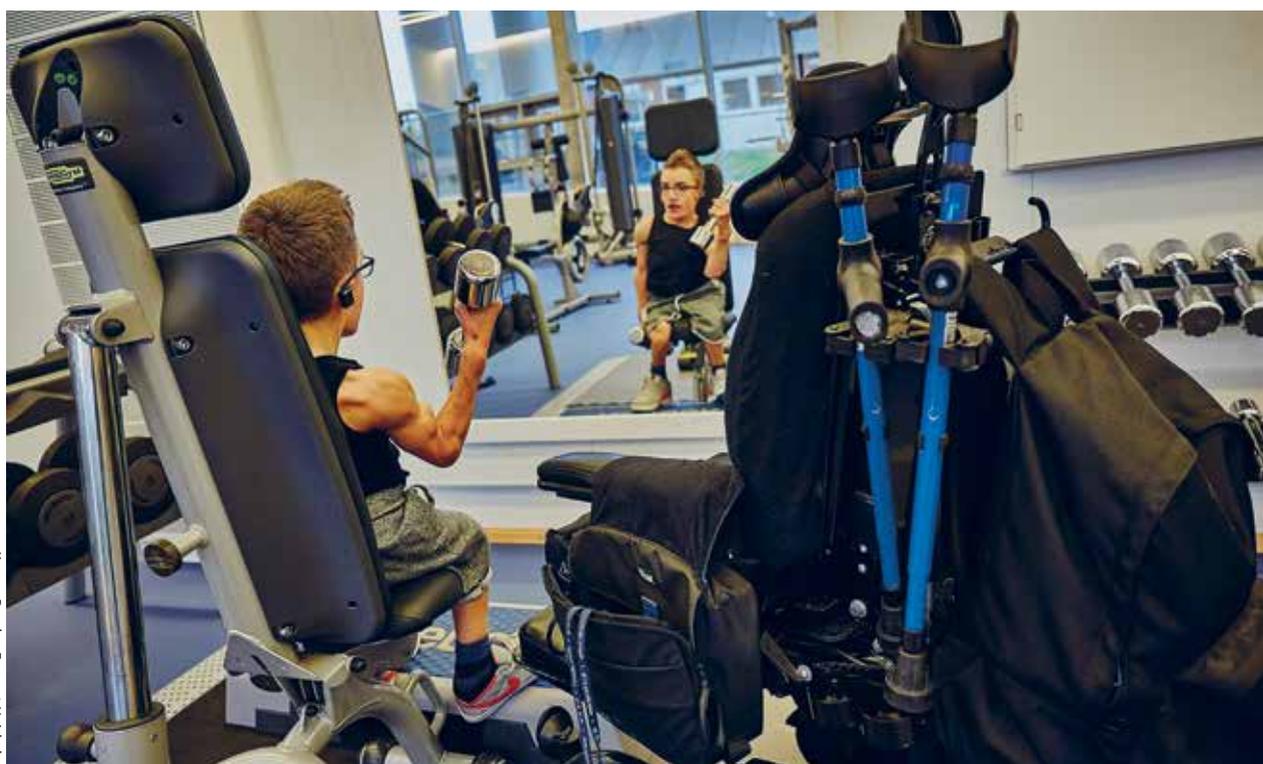
In this context, participants engage with naturally inclusive activities based on what everyone can do with little or no modifications. For example:

- Warm-ups and cool-downs, where players can find the level of participation that suits them; and/or
- Collecting or gathering games, in which players gather up objects scattered around the playing area and arrange them in some way.

2. Change to include (MODIFIED activities)

Here, everyone does the same activity using adaptations to provide both support and challenge across a range of different abilities. The STEP adaptation tool (Space, Task, Equipment and People) provides a structure for adapting and modifying the activities. Changes in the way the activity is delivered can be made in one or more of the STEP areas, as the table below shows. This simple system helps facilitators to adapt the sport, game or activity for different abilities and ages.

STEP	Examples
Space	Increase or decrease the size of the playing area; vary the distance to be covered in activities to suit different abilities or mobility levels; use zoning, e.g. where players are matched by ability and therefore have more opportunity to participate.
Task	Ensure that everyone has equal opportunity to participate, e.g. in a ball game, all the players have the chance to carry, dribble, pass, shoot etc.; break down complex skills into smaller component parts if this helps players to more easily develop skills; ensure there is adequate opportunity for players to practise skills or components individually or with a partner before including in a small-sided team game.
Equipment	In ball games, increase or decrease the size of the ball to suit the ability or age range of the players, or depending on the kind of skill being practised; provide options that enable people to send or receive a ball in different ways, e.g. using a chute or gutter to send and a catching mitt/glove to receive; the use of bells or rattle balls can assist the inclusion of some players.
People	Match players of similar ability in small teams or close marking activities; balance team numbers according to the overall ability of the group, i.e. it may be preferable to play with teams of unequal numbers to facilitate inclusion of some players and maximise participation of others.



Kasper Rander, Egnort Højskolen



3. Ability groups (PARALLEL activities)

In this setting, participants are grouped according to ability, and each group does a version of the same activity, but at a level that suits the individuals in each group, for example:

- Creating two or more versions of the same activity, for example, a standing version and a seated version of volleyball.
- It may also be appropriate to group participants together based on their age, depending on the type of activity. For example, have an adult team and a children's team playing soccer.
- Almost any physical activity can be organized in different versions: some that are more challenging (for players with higher skill levels) or some that are more supportive (for those whose skills are still developing).

Please note that this approach might need more facilitators to assist in the activities.

4. Separate groups (ALTERNATE OR SEPARATE activities)

In this approach, individuals work separately for a time on specific skills before joining the whole group. Sometimes, in order to include someone more effectively, they need to practise separately first, although this should not be most of the time. For example:

- Setting up specific, more simplified drills and skill-based activities for beginners, such as allowing participants to practise lay-ups before moving into a full-sized basketball game.
- In cricket or baseball, for example, participants may have more success in striking the ball if they start by hitting a static ball (for example, from a tee or post). Once they have mastered this skill, they can move on practising hitting a moving ball.

5. Adapted physical activity (DISABILITY sport)

This is when activities based on adapted physical activity or disability sport programmes are included in all approaches. This setting provides specific opportunities for persons with disabilities and new challenges for non-disabled players, for example:

- Persons with disabilities teach their non-disabled peers a paralympic sport activity, like boccia (a game like bowls or petanque), wheelchair basketball or crutch soccer.
- Participants organize and run competitions featuring disability sports.

Do's and Don'ts in adapting activities

Do	Don't
Change the activity to include everyone	Don't try to change the person to fit the activity
Explore all aspects of the inclusion spectrum	Don't apply the same approach to all participants. This might mean using different approaches within the same activity to meet the needs of different participants.
Adapt activities using the STEP adaptation tool	Don't assume that activities cannot be changed
Address gender issues related to sport and physical activities	Don't be gender or culture-blind

It is important to remember that participants should always be the ones to decide whether they want to participate or not. Facilitators need to be sensitive about the extent to which they can encourage participation. Pushing participants further than they feel comfortable to go is not advised. It is much better to consult with the participants as to what they feel able to do and set achievable goals together with them. There may also be some individuals who require an individualised approach in how activities are set up and implemented.

Gender matters

In some countries or cultural settings participation in activities relates to gender. For example physical activity can be considered primarily a boys' domain, seen as a "vehicle for shaping boys into men who will lead society," and the qualities it develops are seen as 'masculine'. By encouraging girls with disabilities, for example, to participate in physical activities, gender perceptions and exclusion issues are challenged.

¹⁹ Designed to Move: A Physical Activity Action Agenda, 2012, Nike Inc.

²⁰ K. Black and P. Stevenson. The Inclusion Spectrum Australia: Theinclusionclub.com, 2011

Activities for all



AUSAID

5

This chapter features a set of activity cards that have been developed to promote the inclusion and psychosocial well-being of persons with disabilities. The chapter also gives facilitators useful tips for facilitating sessions that takes account of the different needs that participants may have.

Introduction

The activity cards are grouped into six different types of sport and physical activity and provide clear instructions to facilitators for planning and implementing the activities. There are 13 activity cards in this handbook, with more available in ‘Moving Together – Promoting psychosocial well-being through sport and physical activity.’²¹

The six types of activity include:

1	Warming-up and cooling-down games
2	Simple movement activities or simple exercises
3	Group movement games or cooperative games
4	Local sports and traditional games
5	Adapted international sport games
6	Relaxation

It is important to select activities based on the intended objectives for the programme. It is good practice to discuss the objectives with the participants at the start of each session.

Objectives may include:

- This activity provides a safe, comfortable setting for participants to laugh and play.
- This activity promotes cooperation between participants.
- This activity provides an opportunity for participants to share their feelings and emotions about personal experiences.
- This activity aims to create an atmosphere where participants feel relaxed.
- This activity promotes self-confidence and independence.

The activity cards

Each activity card has the following information:

	A short explanation of the activity
	The number of participants required/suitable for the activity
	A description of the preferred environment and any necessary equipment
	The basic rules
	Other important issues regarding the activity
	Possibilities for adaption of rules, equipment and space to suit specific contexts
	Reflection points, i.e themes that can be discussed after the game, for psychosocial awareness to be carried out after the activity.

The reflection points can be done individually, in pairs, in small groups or in plenary. There are usually three or four different reflection points to choose from. The facilitator chooses one of the themes and asks questions about it.

Using ‘trust’ as an example, the facilitator might ask, “When you think about today’s activities, trust played an important role. What are your thoughts about it?” “Do you think that it is easy or difficult for you to trust other people? Why do you think this is the case?” “How could developing trust-building skills help you?” “How does trust in the game we played today relate to other parts of your life?” “How can you apply what you have learned or worked on in this game?” Participants discuss these questions together in pairs, for example, and then share in plenary.

Some cards have an extra box (‘Take care’) which highlights risk factors or other important issues you might need to consider in planning the activity.

Useful tips for facilitating activities²²

Choosing teams

Too often facilitators let participants choose teams by selecting two captains and allowing them to take turns selecting students. The problem with this is that the participants that are not naturally athletic will typically be picked last. This can be a very frustrating and humiliating experience. An easy way to solve this problem and to help everyone feel equal is for the facilitator to select the teams. There are a variety of creative ways to make teams, e.g. the facilitator numbers the children off, has them draw straws, or picks team members at random.

Modifications

1. General tips:

- Demonstrate exercises or techniques, as well as explaining them
- Use peers as partners
- Give verbal prompts during the session to help participants understand what they are doing
- If needed for some participants, provide more space to move
- Don't have games that cause participants to be 'out' during the session
- Allow the ball to stop during an activity to give the teams a break or time to get re-organized
- Place persons with disabilities near facilitators if they need extra assistance.

2. Tips about the play area:

- Make the play area smaller
- Use clearly marked boundaries
- Change the play area, e.g. remove obstacles.

3. Tips about movement:

- Change the movement in an activity, e.g. from running to walking
- Change body positions, e.g. allow the person batting to sit on a chair
- Change the grasps, e.g. increase the size of a grip on a bat
- Reduce the number of actions
- Provide frequent rest periods.

4. Tips about equipment:

- Have larger or lighter bats available, if possible
- Provide scoops for catching
- Use velcro for attachments
- Lower the height of a goal or target
- Make the goal or target larger
- Mark positions on the playing field
- Vary balls or other equipment (e.g. in terms of size, weight, colour, texture).

5. Tips about timing:

- Vary the tempo of the game
- Lengthen or shorten the time
- Provide frequent rest periods.

Modified ball games

Basketball

- Use different kinds of ball (size, weight, texture, colour)
- Allow 'travelling' with the ball (i.e. the player can run while bouncing the ball)
- Allow two-hand dribble
- Do not include the three second lane violation
- Use a larger and/or lower goal
- Slow the pace, especially when participants are first learning to play
- If some participants use wheelchairs, allow them to hold the ball on their lap.

Bowling

- Simplify or reduce the number of steps
- Use two hands instead of one
- Bowl from a stationary position
- Use a ramp to launch the bowl along the ground
- Use a partner to help with bowling
- Give verbal prompts to help participants learn how to bowl.

Softball

- Use velcro balls and mitts
- Use larger or smaller bats
- Use a batting tee
- Reduce the base distances
- Use a training ball that is soft
- Shorten the pitching distance
- If participants are wheelchair users, provide a ramp or tee, or let them launch the ball off their lap
- Use beeper balls
- Provide a peer to assist
- Participants without disabilities count to ten before tagging out a person with a disability.

Communicating well

Communication can often be a significant barrier to full inclusion in a group for persons with disabilities. Here are some basic strategies for communication (but please note this is not comprehensive guidance):

Persons with cognitive impairments

- Allow enough time for the individual to learn and master a new task; repetition is important
- Give one direction at a time
- Be patient and allow extra time for the person to put their thoughts together
- Give exact instructions (i.e., "Please be back at 12:30" as opposed to, "Please be back in 30 minutes.")

Persons with hearing impairments

- Look at the person and speak clearly, slowly, and expressively, using a normal tone
- Get their full attention with gestures
- Depending on the level of hearing loss, keep in mind people may not hear a whistle

- Use written notes to communicate with one another – but when you are writing, do not talk at the same time
- Place yourself near a light source
- Do not cover your mouth
- Talk directly to the person who has a hearing impairment, not to the interpreter (if there is one present)
- Be sensitive about levels of literacy – use pictures or demonstrate an activity, if that seems appropriate.

Persons with mobility impairments

- Don't move a person's assistive device without permission
- Speak at their eye level
- When giving directions, think about the distance, terrain, or other obstacles.

Persons with speech impairments

- Give your whole attention to the person
- Allow time for the person to finish speaking
- Ask short questions that require short answers and speak normally
- Speak expressively, and use written notes if needed
- Don't pretend to understand when you do not.

Persons with visual impairments

- Orient persons to the room, using specifics like “clock clues”
- Don't shout
- Give verbal cues when talking with the person, e.g. tell the person who is in the room beside yourself
- Don't leave without saying you are doing so
- Don't leave equipment lying around the playing area that may be trip hazards.

Materials

It is important to ensure that all materials that are used in psychosocial programmes are accessible to persons with disabilities. Here are some tips for formatting printed materials, visual aids and presentations, and for improving web accessibility:

1. Printed materials

- Use double spaced lines, and 1 inch margins on all sides
- Use a bold serif 16 font for text and non-bold serif font for headings
- Underline, instead of italics
- Print single-sided pages
- Use non-glare paper (pale yellow or buff matt).

2. Visual aids and presentations

- Visual aids should be large with bold fonts, using bright, high-contrast colour
- Provide copies or outline of presentations ahead of time
- Have computer disks available for assignments
- Save information as a text file
- Have audio tapes on hand with a tape recorder
- Always orally describe visual images.

3. Web accessibility (and other media access)

- Have site features such as alt tags (descriptions that pop up when a mouse rolls over an image), large sans-serif fonts (non-decorative fonts like Arial, Veranda, and Tahoma), clear colour contrast, and web software testers such as 'Bobby Approved' displayed icons to assure better accessibility (see www.bobby-approved.com)
- Have written or visual descriptions of audio information
- Use captions on videos.

Guidance about warming-up and cooling-down games

Warm-up and cool-down activities should always be used in every activity session. They should be fun and motivating.

The warm-up aims at:

- preparing the body and mind for the activity
- increasing body core temperature
- activating the cardio-vascular system
- increasing the breathing rate.

Cool-down can help to calm down emotions and excitement and gives the participants time to get physically and psychologically back to their 'normal' state. This includes:

- a transition from an exertion state to a resting state
- return of heart rate to its resting rate
- decreasing body temperature
- cooling down of emotions
- warm up their bodies before stretching
- stretch all the muscle groups involved in the activity
- stretch gently and slowly, never bounce or stretch rapidly
- stretch gently to the point of mild discomfort, never pain!
- do not hold your breath, when stretching; breathing should be slow and easy.

If you would like to use stretching in your session and are not experienced, please remember that stretching wrongly may have painful consequences. Try to get more information and speak to experienced facilitators.

²¹ PS Centre. Moving Together – Promoting psychosocial well-being through sport and physical activity. 2014.

²² Some parts of this section on activities are from PE Central, at www.pecentral.org/adapted/adaptedactivities.html; 05 December 2014.

1. WARMING-UP GAMES

1

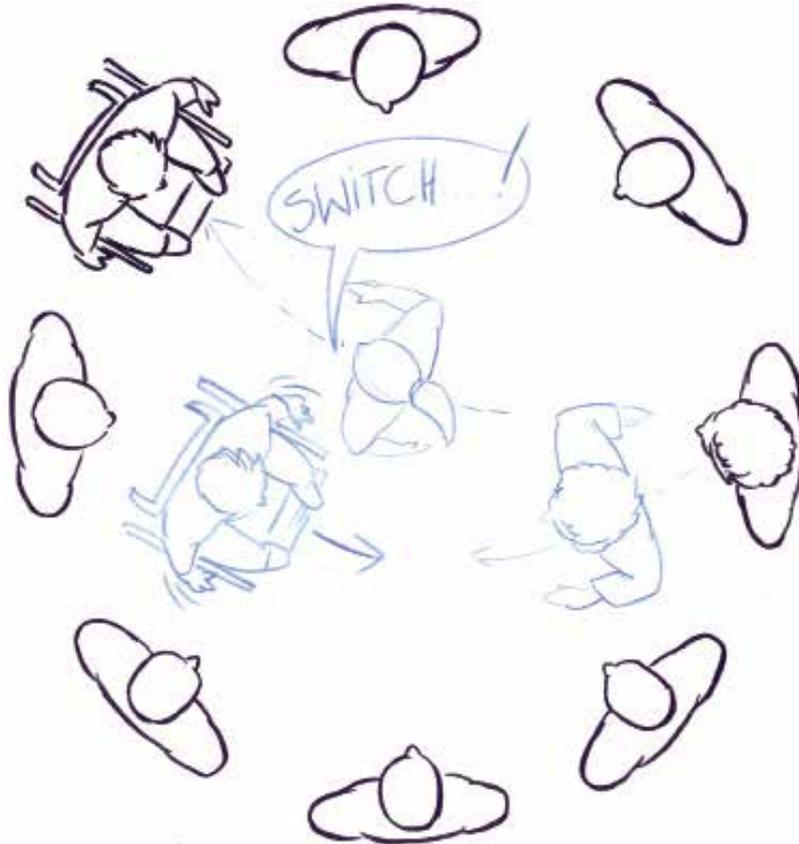
Switching Places



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Any safe area of ground or space (as flat and clean as possible).



- Everyone stands in a circle with one person in the middle.
- The person in the middle calls "Switch places if...," for example "Switch places if you have a little sister" or "Switch places if blue is your favourite colour."
- Players who fit this statement then go and stand in the middle of the circle. The player/s previously in the middle then try to find a gap in the outer circle again. When everyone has found a place, the player/s in the middle call out the next statement.



- Make sure everyone has a turn to stand in the middle.



- This game can also be played sitting down, by placing chairs in a circle with one chair in the middle. If there are people using wheelchairs in the group, this arrangement may give them a slight head start.
- If there are players with visual impairments in the group, the game can be played in pairs to make moving around easier. Pairs then have to decide how to take turns in playing the game.



Suggested themes for discussion:

- Respecting and learning about similarities and differences
- Fairness
- Communication

1. WARMING-UP GAMES

2

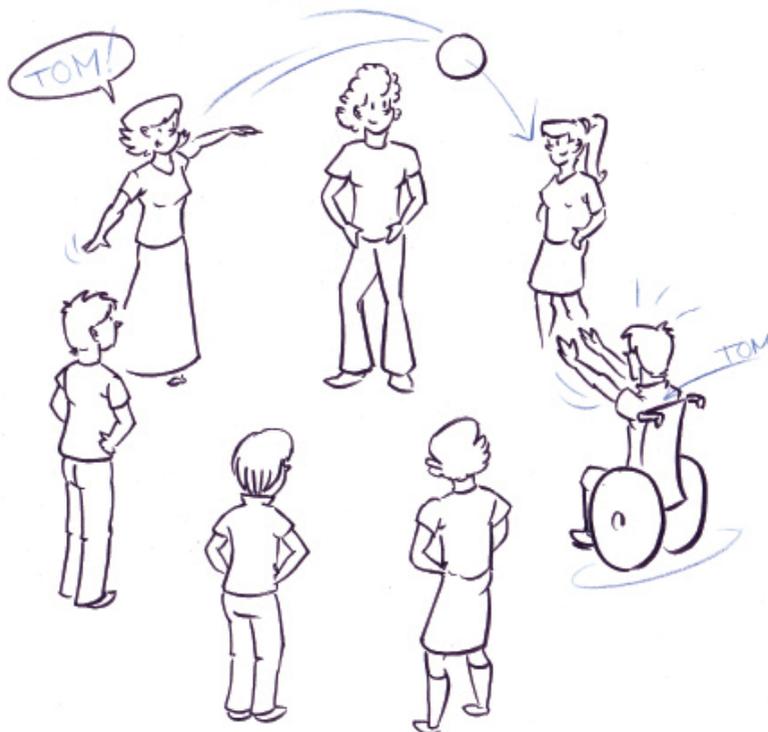
Name Circle



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Any safe area of ground or space (as flat and clean as possible).
 A ball or other item that can be thrown.



- Players stand in a circle. At the beginning of the game, every player says his or her name.
- One player then begins by calling out another player's name and throws the ball to this person, who catches it and calls the next name. The game ends when everybody has had the ball at least once.



- Getting to know one another by name is an important aspect of creating a safe environment and should be part of any programme.



- Players can sit or stand for this game.
- Players can use a balloon, which is slower and may be easier to catch.
- It may be easier to sit on the floor and roll the ball, rather than throw it. A goal ball or other type of "bell ball" could be used if any of the participants are visually impaired. (Wrapping a ball into a plastic bag is also effective.)
- Use two or more balls.



- Team building
- Communication
- Concentration
- Coordination

Take care!

- This game may need modified equipment, if there are persons with mobility and/or coordination difficulties.
- Make sure participants throw the ball gently, so that the person catching it is actually able to do so. Children sometimes throw a ball with the intention to make it difficult for their partner to catch it. Facilitators should give clear instructions before the game begins to prevent this from happening.

1. COOLING-DOWN GAME

3

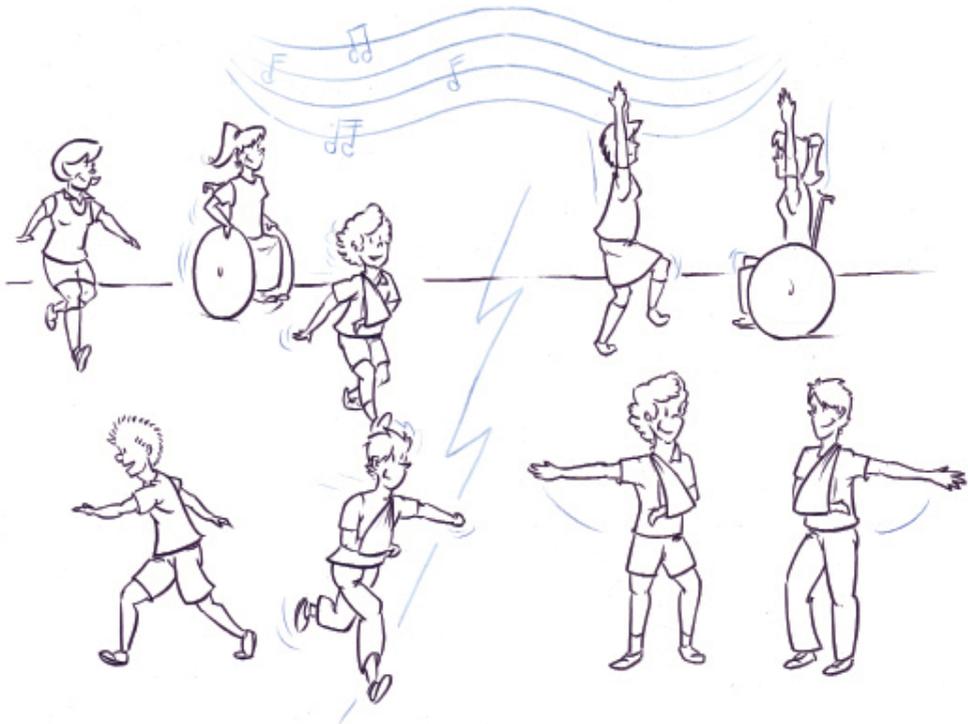
Mirroring



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Any safe area of ground or space (as flat and clean as possible).



- The group walks slowly around the space. When the music stops or a whistle is blown, players have to get into pairs and stand facing one another.
- One player makes a movement, and the other player has to try to copy it as if they were a mirror.



- If you do not have music or a whistle, you can call out “freeze” or “statue.”



- If players are visually impaired, one partner can make a ‘statue’ out of the other partner who then remains in that position for a short while.
- If players have hearing impairments, use a visual sign that has been agreed by the group.



- Feelings and sensations (about cooling-down/settling down)
- Trust
- Concentration
- Body awareness

Take care!

A game that involves body contact of any kind can be very difficult for some people. Be very careful if participants are expected to touch one another in the activity you are planning. Before the session starts, explain the game to the participants and check that everyone is happy with it. Depending on the context, it may be advisable to have single gender groups.

2. SIMPLE MOVEMENT ACTIVITIES OR SIMPLE EXERCISES

4

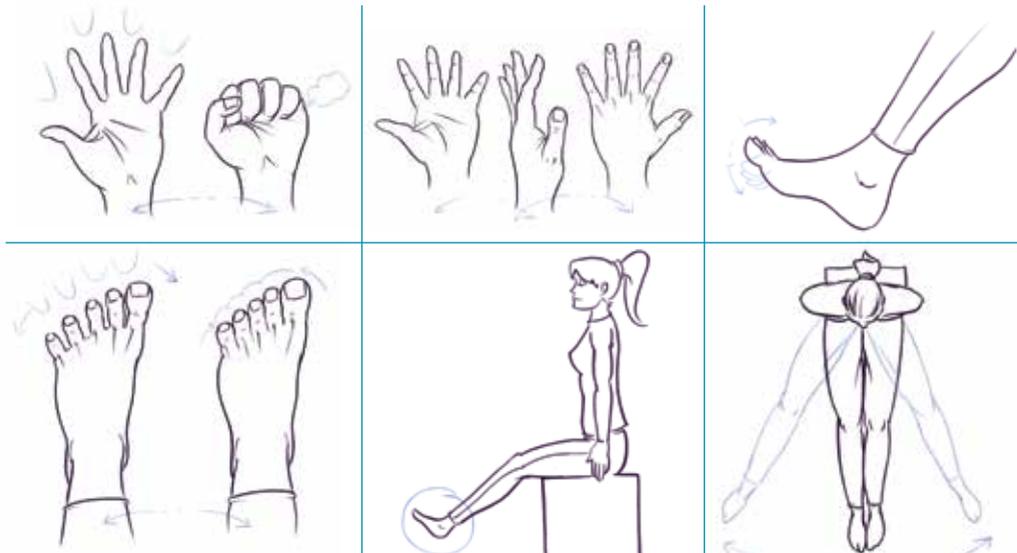
Gentle Exercises



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Any safe area of ground or space (as flat and clean as possible).
 Towels or small mats, if needed and available
 Chairs or pillows (arranged in a circle)



These exercises involve simple, light movements of the hands, legs, fingers, toes, etc. The facilitator gives the following instructions:

Hand exercises:

- Simply open and close your hands as quickly as possible.
- While opening the hands, try to stretch your fingers as much as you can, and when you close them, try to make your fists tight.
- Continue to open and close your hands 10 times.
- Now that your hands have done some exercises, your muscles will be slightly taut. Now relax them by shaking both hands together. Imagine that their hands are wet and they need to dry.

Feet and leg exercises:

- Start in a sitting position and raise both feet together a few inches above the ground.
- Now move the toes in any direction.
- Place feet back onto the ground as soon as it feels uncomfortable to keep them in the lifted position.

Another exercise for the legs:

- Sitting down, lift both legs as much as possible in a V-shape.
- Slowly bring the legs together and lower them.
- Repeat the movement 5-6 times.



- Always breathe deeply when moving.
- Repeat the exercises, but not too many times.
- Use light stretching and shaking to relax afterwards.
- Please note that fast movement increases spasticity and is therefore not so suitable persons with spasticity.



- Do all the exercises while sitting or standing, or with eyes closed.



- Concentration
- Calming
- Body-awareness

2. SIMPLE MOVEMENT ACTIVITIES OR SIMPLE EXERCISES

5

Keep It Up!



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Any safe area of ground or space (as flat and clean as possible).
 Balloons or light-weight balls



- Players sit in a circle, either on the floor or on chairs.
- Throw a balloon or ball into the circle – try to throw it high above the players.
- The aim of the game is to pass the balloon/ball to other players without letting it touch the ground.
- Players are not allowed to hold onto the balloon/ball.



- Ask players to call out their own name when they touch the balloon and if possible, to call out the name of the person they are passing it to. This helps the group get to know one another.



- Use more than one balloon at a time. This is fun for the group and calls for more teamwork and coordination.
- Use a heavier ball – this means it will move faster.



- Concentration
- Coordination
- Teamwork

3. GROUP MOVEMENT GAMES OR COOPERATIVE GAMES

6

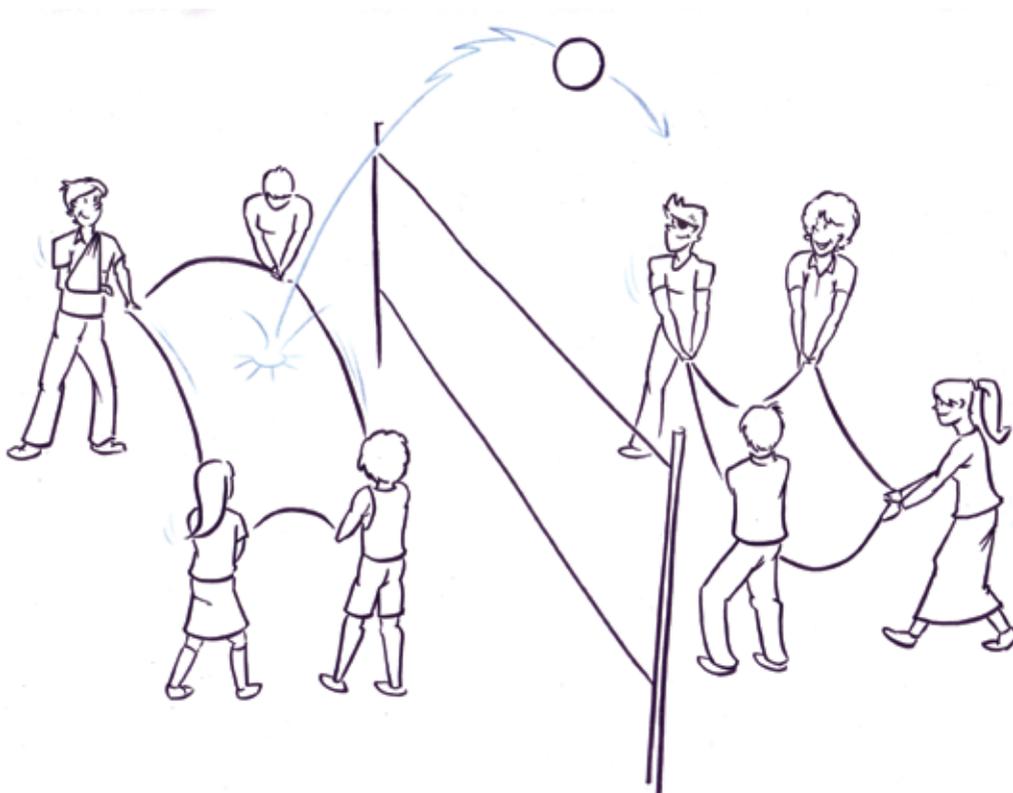
Blanket Ball



Medium group (7-14 participants)
Large group (over 15 participants)



Any safe area of ground or space, as flat and clean as possible
Light-weight ball
Net or other barrier
Sheets or blankets



- Divide players into groups of 3 to 6 players.
- Each team has a sheet or blanket. Two teams play against each other.
- The aim is to use the sheet to throw the ball across the net and catch it. If a ball is dropped, the other team scores a point.



- Use more balls in the game.
- Play with or without a net.
- Have more players around each blanket.
- Use a beach ball which may make the game easier.
- If using a net makes the game too difficult, draw lines on the ground instead.



- Team work
- Cooperation
- Communication
- Timing

Take care!

Planning cooperative activities must always be done with sensitivity and care, as this will affect how activities are set up and facilitated. The cultural context which influences how boys and girls and women and men interact with one another appropriately, for example, needs to be taken into account. Ethnic and religious considerations are important, too. Being aware of local sources of conflict too, (for example, amongst young men because there are different gangs operating in a town) will help facilitators avoid harm in how a programme is implemented.

3. GROUP MOVEMENT GAMES OR COOPERATIVE GAMES

7

Tunnel Ball/Over-Under



Medium group (7-14 participants)
Large group (over 15 participants)



Playing area
Area markers
Goal ball/a ball that makes a noise when in motion
Blindfold



- Players are divided into two teams with a team captain.
- Both teams put on blindfolds.
- Teams line up behind their team captain and stand with their legs apart.
- At the signal, the captain passes the ball through his/her legs to the person behind, and so on.
- The person at the back of the line picks up the ball and moves to the front of the line.
- The player then passes the ball back again. This is repeated until the captain has received the ball at the end of the line and is back at the front. The team then calls "Finish."
- As a variation, players can alternate with passing the ball through their legs or over their heads ("over-under").



- Team members may help the person moving to the front of the line, by guiding him/her with their hands.
- Limit the size of each team to 10 players.



- Allow players to move to the front without the blindfold on until they have gained the confidence to leave them on.
- Use regular balls (such as footballs or basketballs) to increase difficulty.
- Use other objects instead of a ball.



- Trust and confidence
- Responsibility
- Team work
- Cooperation
- Communication

3. GROUP MOVEMENT GAMES OR COOPERATIVE GAMES

8

Target Boccia



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Flat, clean playing area
 Boccia balls (or paper balls)
 Targets, e.g. different-sized hoops, bowling pins, a circle drawn in chalk, etc.



- Divide players into pairs or small teams.
- Each team makes their own type of target, decides on the distance between the target and the throwing line and makes up their scoring system.
- The aim of the game is get the ball on target. This could be by throwing the ball through a hoop, or by knocking over one or more bowling pins.



- Working together to make the target and agree on scoring is as much a part of this game as throwing the balls at the targets.



- For some players, it may be easier to roll the ball rather than throwing it. The target should then be set up on the ground accordingly.
- Players may stand or sit closer to the targets or farther away according to ability.



- Cooperation
- Creating your own rules/agreeing on rules and targets
- Group cohesion
- Empowerment (influencing the situation by controlling/affecting aspects of the game).

4. LOCAL SPORT AND TRADITIONAL GAME

9

Pukamitjal

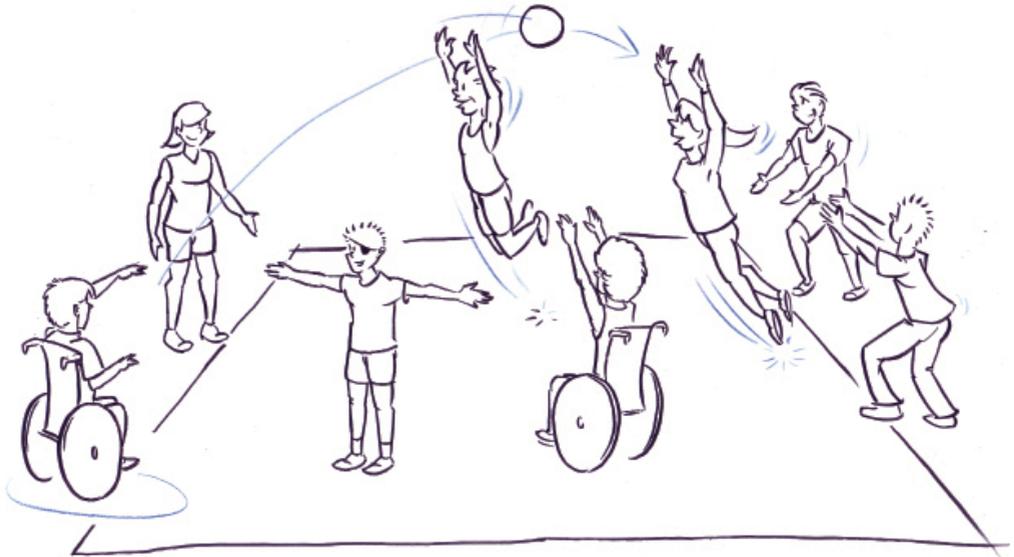
A ball game popular on Mornington Island, northern Australia.



Medium group (7-14 participants)
Large group (over 15 participants)



A flat safe open space
Markers to outline the playing area
Ball



- Divide the group into two teams.
- Mark out throwing lines 10 to 15 meters (10 – 15 yds) apart.
- Team A stands on both sides of the throwing lines, passing the ball to each other. Team B stands between them and tries to get possession of the ball.
- When Team B manages to get the ball, the teams change over (i.e. Team B stands on the throwing lines and Team A stands in the middle)



- The game is continuous but runs for an agreed time period.



- Use different types of ball to suit varying abilities and age groups.
- Introduce the rule that Team B only has to touch the ball (instead of catching it) before the teams swap.
- Try making the playing area bigger or smaller. (Increasing the playing area makes it easier for Team A. Decreasing the playing area makes it easier for Team B.)



- Team work
- Cooperation

5. ADAPTED INTERNATIONAL SPORT GAMES

10

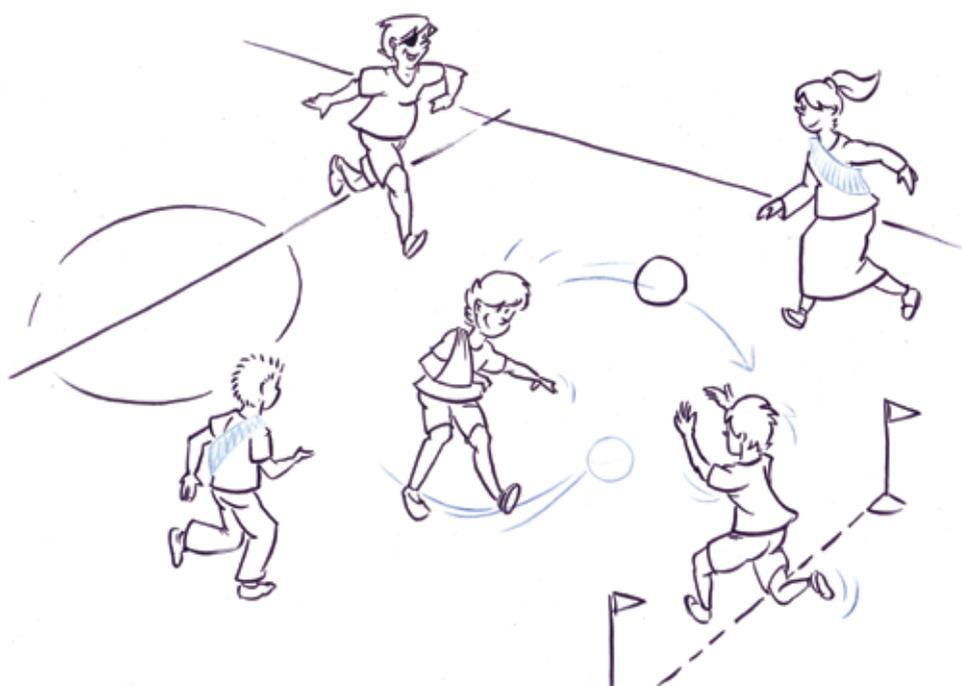
Football/Soccer



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



3-11 participants per team
 Football pitch (or any flat, safe open space)
 Goal posts or cones or other objects to mark the goal area
 Ball
 Choose a way of identifying the members of each team, e.g. provide coloured bands to wear on top of T shirts, etc.



- There are two teams with the same number of players (if possible), depending on the number of participants.
- The main aim is for one team to score more goals than the other team.
- Scoring is only permitted, by kicking the ball or heading the ball into the goal.
- No touching the ball with the hands is allowed except for the goalkeepers of each team. They are allowed to pick up the ball and handle it during the game.



- Plan this activity carefully because there may be players with a lot of experience in the team alongside others without any. This can create lots of difficulties. See below for ideas to make the activity fun for everyone.



- For mixed ability groups, have the rule that everyone has to touch the ball once before a goal can be scored.
- Or have the rule that very good players have to kick with their weaker foot.
- Play crutch or sitting football/soccer.
- Use a goal ball or other type of ball that makes a noise for games with persons with visual impairments.
- Change the size of the goals or the pitch.
- Change the number and/or size of the ball.



- Team-building
- Mixed groups
- Trust
- Fair play (i.e. this is about fair behaviour on the sports field and in life in general)

5. ADAPTED INTERNATIONAL SPORT GAMES

11

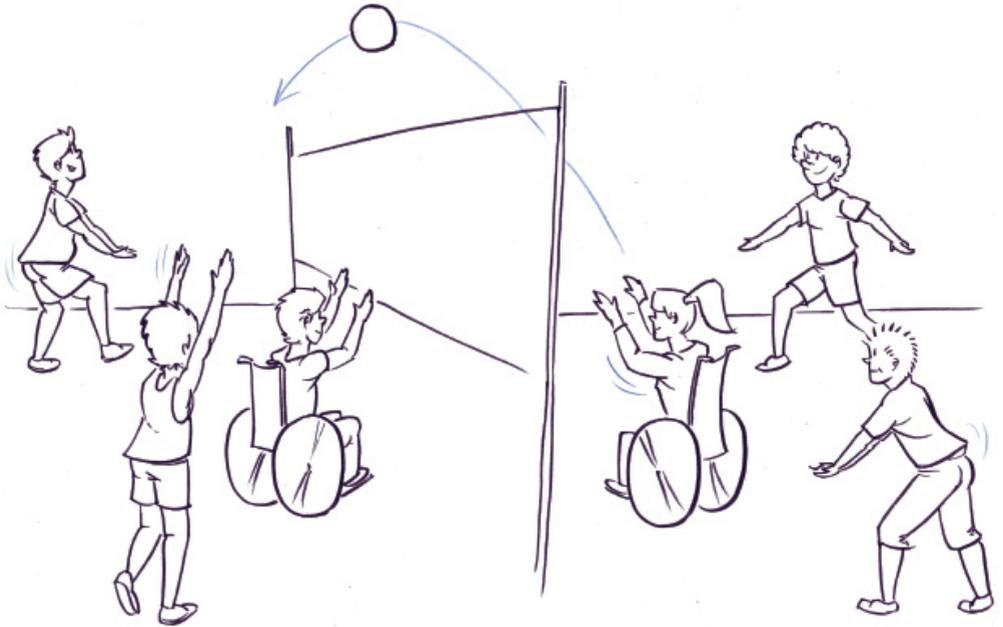
Volley-All



Medium group (7-14 participants)
Large group (over 15 participants)



Playing area (safe and flat, indoor or outdoor area), at least 6 x 10 metres/yds
Area markers, such as cones, discs, stones, sticks, bottles, etc.
Net or rope
Volleyball or similar ball



- The playing area on each side of the net is divided into two zones. The front zone is used for seated players and the one at the back for standing players.
- Divide the group into two teams.
- Each team selects the players for the front zone (sitting in wheelchairs or on chairs or on the floor and the players for the back zone who play standing up.)
- Players take turns in serving the ball.
- The ball can be touched by three players on the same team, before it has to be hit to the other side.
- Follow basic volleyball rules for scoring, etc.



- Everyone in the group can decide whether players stand or sit.



- Teams can make up their own rules for scoring.
- A lighter ball, such as a beach ball or a balloon may be easier to play with.
- Rules can be changed such as a team can touch the ball four times before hitting it over the net, or players may be allowed to catch and throw the ball, if volleyball techniques are too difficult.
- The height of the net can be lowered to make it easier for the players who are seated.



- Team work
- Coordination
- Communication

6. RELAXATION

12

Body Stress Buster (progressive muscle relaxation)

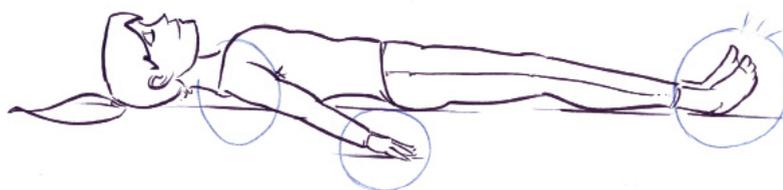
This is a relaxation technique which shifts between tensing muscles and relaxing muscles to improve body awareness and control and helps to relieve for stress. Participants should stand comfortably or find a space on the floor and breathe deeply before they start the exercise. Participants should tense and release muscle groups in their different body parts individually, starting with the facial muscles, then the shoulder, arm, hand, stomach, back, leg and foot muscles.



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Clean, safe space with enough room for everyone to spread out..
 Chairs if needed.



Use a calm, soothing voice to take participants through this exercise:

- Ask participants to stand comfortably or find a space on the floor and breathe deeply.
- Explain that the exercise will focus on a group of muscles in turn, starting with the head and going through to the feet. Explain that you will ask everyone to first tense their muscles and then release them after a few seconds.
- Begin with the facial muscles, and ask everyone to first tense the muscles in their cheeks and around their eyes for a few seconds, and then release them.
- Now move onto the neck muscles, and then the shoulder muscles, arms, hands, stomach, back, legs and feet and give the same instructions.



This exercise may relieve tensions or emotions that people have built up in their bodies over time. This is normal, and so it is important that facilitators explain that participants may react.



- This exercise can also be done in a sitting or lying position.
- Facilitators can demonstrate the exercise first for persons with hearing impairments.



- Balance between body and mind
- Relaxation/calmness
- Concentration/focus
- Safety
- Stress relief

Take care!

Be aware that not all relaxation exercises are always suitable for people who are traumatised. No one should be pressured to do the exercises if they don't feel comfortable. Signs of distress include:

- having difficulties gaining control
- crying all the time
- shaking or having difficulties managing stress, especially in the immediate aftermath of a disaster.

If you notice any of these signs, the activity should be stopped or changed. It often helps people if they sit up to regain control. A person feeling distressed may wish to leave the room. If there is more than one facilitator, have one person stay close until he/she calms down, listen if he/she wants to talk, provide water and tissues, reassure the person that these are normal reactions, and that this kind of exercise can relieve tension built up over time in the body.

6. RELAXATION

13

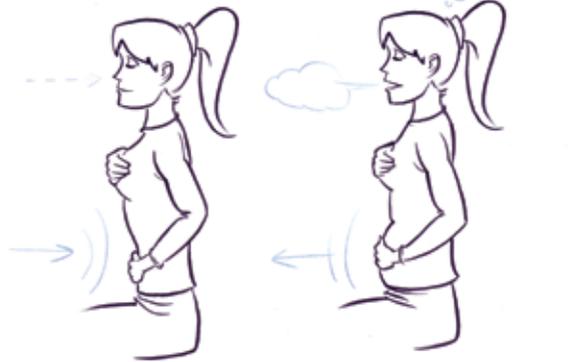
Breathing Exercise



Small group (2-6 participants)
 Medium group (7-14 participants)
 Large group (over 15 participants)



Clean, safe space
 Chairs



Use a calm voice and guide participants through the exercise:

- Ask participants to sit comfortably with straight backs, one hand on their chests and one on their stomachs.
- Explain the breathing technique first before asking the group to do it:
- Say that when they breathe in, they should breathe in through their nose. When this is happening, the hand on the stomach should rise, but the hand on the chest should not move very much.
- Now explain breathing out. When they breathe out they should breathe through the mouth. They should try to push out as much air as possible while pulling in their stomach muscles. So now the hand on the stomach should move in, while the hand on the chest again moves very little.
- Now do the breathing exercise with participants, asking participants to slowly count on every exhale.



- It helps if this exercise is done in silence and in a space where there is some privacy.
- The key to deep breathing is to breathe deeply from the abdomen, so as to get as much fresh air as possible into the lungs. More oxygen is inhaled when taking deep breaths from the abdomen, rather than shallow breaths from the upper chest. The more oxygen one gets, the less tense, short of breath, and anxious one feels.



- This exercise can also be done in a sitting or lying position.



- Balance between body and mind
- Relaxation/calmness
- Concentration/focus
- Self-confidence

Take care!

Be aware that not all relaxation exercises are always suitable for people who are traumatised. No one should be pressured to do the exercises if they don't feel comfortable.

Signs of distress include:

- having difficulties gaining control,
- crying all the time,
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Resources



Publications

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Factsheet: **‘Make education inclusive.’** Light for the World available at www.light-for-the-world.org/fileadmin/content/files/End_Exclusion/Factsheet_Make_education_inclusive.pdf

Factsheet: **‘Social Protection And Disability.’** Light for the World. Available at www.light-for-the-world.org/fileadmin/content/files/End_Exclusion/social_protection_factsheet_screen.pdf

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'**TOP Sportsability. Introducing the Inclusion Spectrum.**' Youth Sport Trust. Available at www.topsportsability.co.uk

'**The World Game.**' Light for the World. Available at www.light-for-the-world.org/fileadmin/content/files/World_Game_End_Exclusion.pdf

'**The World Report on Disability.**' WHO, 2011. Available at www.who.int/disabilities/world_report/2011/en/

'**Travelling together. How to include disabled people on the main road of development.**' World Vision, 2010. Available at www.worldvision.org.uk/our-work/reports-papers-and-briefings/travelling-together/#section0

'**Understanding Children's Well-being. Psychosocial support in and out of schools.**' Reference Centre for Psychosocial Support and International Federation of Red Cross and Red Crescent Societies and Save the Children, 2012. Available at www.pscentre.org

Useful websites

www.changepeople.org/free-resources/

CHANGE is a human rights organization, based in the U.K., co-led by disabled people. This website has various resources co-developed by persons with learning disabilities.

www.designedtomove.org

This is a call-to-action supported by a community of public, private and civil sector organizations dedicated to ending the epidemic of physical inactivity, initiated by Nike.

www.disabilitycentre.lshtm.ac.uk

The International Centre for Evidence in Disability. It focuses on disability research and teaching in public health and development and has an extensive resources section.

www.egmont-hs.dk/en

Egmont Højskolen is a Danish boarding school where around a third of the students are persons with disabilities. The school accepts applications from international students.

www.theinclusionclub.com/

The Inclusion Club provides information about inclusive sport and active recreation for people with disability

Different. Just like you

A psychosocial approach promoting the inclusion of persons with disabilities

Over one billion people in the world live with disability. Despite international conventions providing for equal rights and access to services and opportunities, persons with disabilities face considerable challenges. The greatest barriers to inclusion are caused by society: Inaccessible buildings mean, for example, that children with disabilities may not be able to go to school. Negative attitudes towards differences can take the form of discrimination and stigma. Structural barriers too, such as policies that do not include any provision for young adults accessing higher education, can close down opportunities.

Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities is aimed at professionals and volunteers who work with persons with disabilities. The concept of empowerment is central to the whole approach presented in this handbook which has two key aims:

- to create awareness of the importance of psychosocial support and inclusion in promoting the well-being of persons with disabilities
- to provide guidance about psychosocial support and inclusion, along with practical resources for inclusive psychosocial activities for all kinds of settings.

The handbook describes best practice in psychosocial support and inclusion, and features a wide range of activities – mainly adapted sports and other physical activities – that give persons with disabilities the opportunity to release their full potential and engage actively in society.