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Factsheet

Attention Deficit Hyperactivity Disorder (ADHD)

This factsheet has been developed in consultation with key national agencies with experience and knowledge in the specific areas. The information is provided for **guidance** only, allowing you to be more informed in your approach to being a more **inclusive** coach. No two people are the same, as such, please ensure your first step is to speak directly to the person – understand their abilities and goals and never assume.

What is ADHD?

ADHD is a highly genetic, brain-based syndrome that has to do with the regulation of a particular set of brain functions and related behaviours.

These brain operations are collectively referred to as "executive functioning skills" and include important functions such as attention, concentration, memory, motivation and effort, learning from mistakes, impulsivity, hyperactivity, organisation, and social skills. There are various contributing factors that play a role in these challenges including chemical and structural differences in the brain as well as genetics.

People with ADHD are likely to be creative, flexible thinkers with a lot of energy and spontaneity.

It is important to remember that ADHD exists on a spectrum of severity (mild/moderate/severe). This means that ADHD symptoms (i.e., hyperactivity, impulsivity, and/or inattention) are not exactly the same in every person. So, one person might be very active, talk a lot and interrupt and intrude on other people; another person could daydream and be quiet and withdrawn; another person could be both: all of them could still have ADHD.

As with anything else, no two people with ADHD are exactly the same and everyone experiences ADHD in their own way.

What We May See When Coaching With People Who Have ADHD

Inattention - easily distracted, difficulty following through on instructions (e.g. loses focus, side-tracked), does not seem to listen when spoken to directly, has trouble holding attention on tasks or play activities, fails to give close attention to details or makes careless mistakes with activities.

Impulsivity - difficulty awaiting turns, interrupting conversations or instructions, blurting out answers to questions before they are completed and intruding in others games.

Hyperactivity - difficulty remaining seated, fidgeting with hands and feet, shifting from one uncompleted task to another and difficulty playing quietly.

Other Frequent Features - difficulty coping with peers, engaging in dangerous activities without thinking about the consequences, high pain threshold, can be immature/clumsy.

How To Include People With ADHD In Your Coaching Sessions

- Provide structure with rules and regulations, remain calm and always have a positive approach
- Adapt your coaching style to meet the learning style of your participant; ask the participant/parent/carer how they learn best prior to the coaching session
- Be mindful of heightened levels of frustration or anxiety and know when to step back
- Look directly at the participant when communicating
- Ensure your coaching environment is organised and predictable
- Always praise positive behaviour
- Try to develop a private signal system with the participant to notify them when they are off task or acting inappropriately
- When coaching a group and giving instructions, use the person's first name to attract their attention. (When asking the whole group to 'come over here', some people may need you to tell them specifically by name that you mean them too.)

For further information and support:

Please visit **www.hadd.ie**

or email **info@hadd.ie**

This factsheet resource was funded by:

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Factsheet

Amputee

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What is Amputation?

An amputation can be congenital or the surgical removal of part of the body, such as an arm or a leg, as a result of trauma, medical illness or surgery. Congenital amputation is birth without a limb or limbs, or without a part of a limb or limbs.

It is important to understand the following points:

No two people with amputations are affected in the same way. Some amputees can function as well as any person without a disability, while others may be severely impaired. This depends on a number of factors, such as level of amputation, number of amputations, cause of amputation, pain, other medical conditions, type of prosthetic fit, length of residual limb and scar tissue. As an amputee cannot generate a muscular force to cause the prosthetic joint to rotate, other joints (most frequently the hips) will have to work harder to enable the movement. For instance, a lower-limb amputee will not be able to push the leg from the ankle; rather, they will pull the leg from the hip.

Pain Threshold and Tolerance

As a coach, you need to discuss pain threshold and tolerance with the participant in order to have a better understanding of specific issues and concerns, such as their pain management routine (e.g. use of medication).

This information should be established and monitored regularly to prevent/reduce the risk of any aggravated or potential future injuries. Where needed, make appropriate adjustments.

Phantom Limb Pain/Sensation is very common in amputees. Phantom limb pain (PLP) refers to ongoing painful sensations that seem to be coming from the part of the limb that is no longer there. The limb is gone, but the pain is real. This pain can present itself in different forms where the participant may feel sensations such as burning, twisting, itching or pressure.

What We May See When Coaching With People Who Have An Amputation

Prosthetic limbs mimic real limbs in a more simplistic way. The coaching techniques you normally use are a good place to start, but you might have to make adaptations.

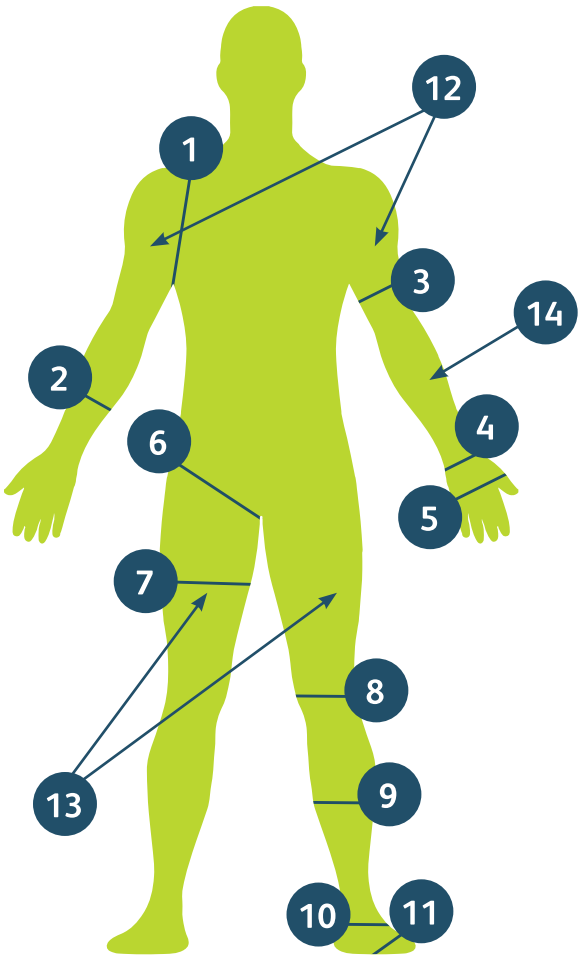
Let the participant guide you on what works best for them, as more often than not, they will be very familiar with what works for them, what causes discomfort, necessary adaptations etc.

- Consider their balance, coordination and strength as a starting point before introducing any sport-specific technical modelling
- A user should be aware that they can exercise on practically any type of prosthesis and do not necessarily need a blade. Some of the less active feet may restrict performance, feeling heavy and slow, but will allow them to do a degree of exercise. Encourage the individual to speak to their prosthetist
- If the participant is limited by their prosthesis, work with them on alternative exercises (sitting, lying etc.)
- Participants may use stump socks or liners to help with the fit of the residual limb into the socket (like wearing socks in shoes). Participants will sweat in the socket, which can become swollen and uncomfortable and may cause skin irritation or breakdown, so give them time out to change them or remove their prosthesis during the session if necessary
- Find out what the participant can do, or what may be preventing them from taking part (e.g. self-confidence, socket fit, pain, and technology)
- Consider the individual's physique, mobility and application. Speak to the participant to understand their personal abilities and desires
- Check the participant's range of movement as this can vary greatly.
- Constant and continual repetition and reinforcement can improve coordination and mastery, but it can cause skin breakdown. Talk to the participant about finding a good balance between repetitions and changing the nature of the loading
- Participants may have a slower response time when initiating movement on command, due to their prosthesis
- The participant may have limb movement restrictions. Therefore, they need to improve their basic movement skills, through drills
- Be aware of any balance and coordination problems, and take these into consideration with any relevant drills or game play
- Safety and comfort are paramount

Levels of Amputation

Mobility, range of movement, coordination, balance and comfort vary greatly depending on the level of amputation. As a general rule, the more residual limb (stump length) an amputee has, the more mobile they will be.

1. Shoulder disarticulation or forequarter
2. Below elbow
3. Above elbow
4. Wrist disarticulation
5. Partial hand or finger(s)
6. Hip disarticulation or hemipelvectomy
7. Transfemoral amputation (above the knee)
8. Knee disarticulation (through the knee)
9. Transitibial amputation (below the knee)
10. Syme's (through the ankle)
11. Partial foot or toe(s)
12. Bilateral upper-limb loss
13. Bilateral lower-limb loss
14. Elbow disarticulation



For further information and support:

Please visit **www.amputee.ie**

or **www.nrh.ie**

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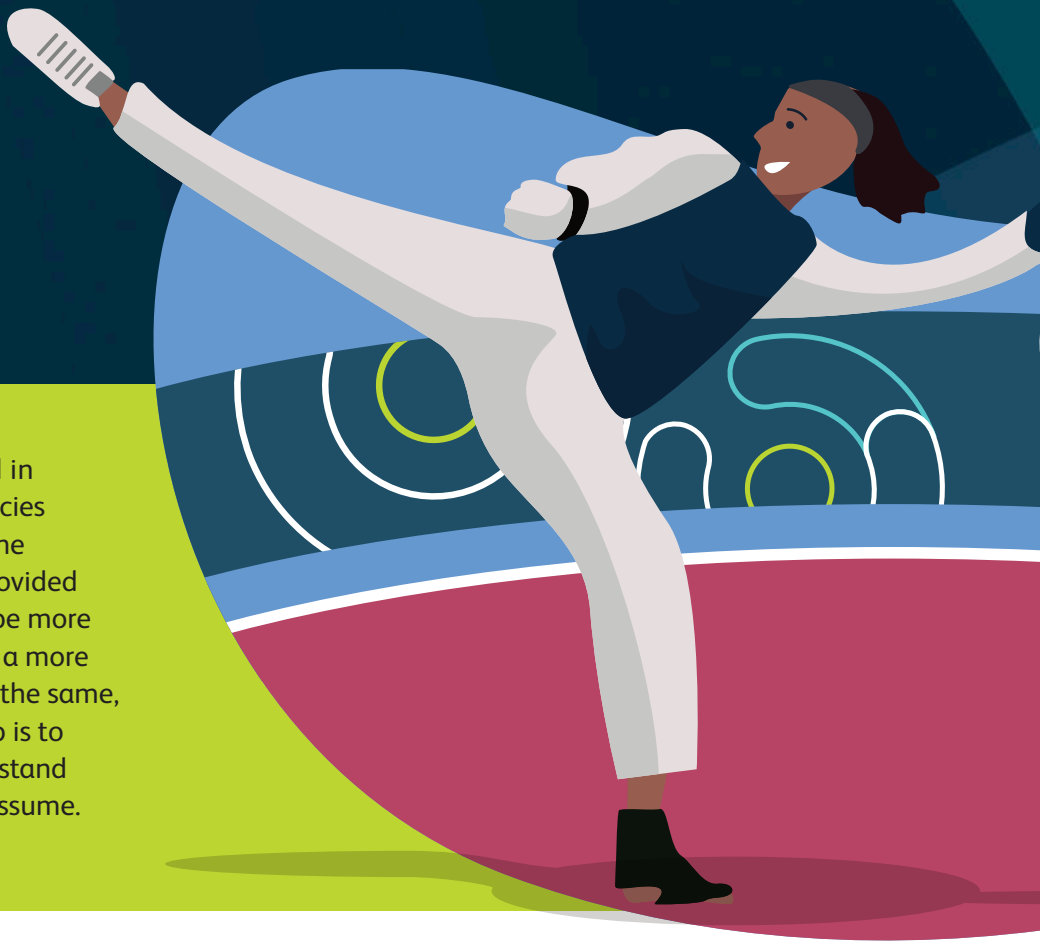
Factsheet

Autism



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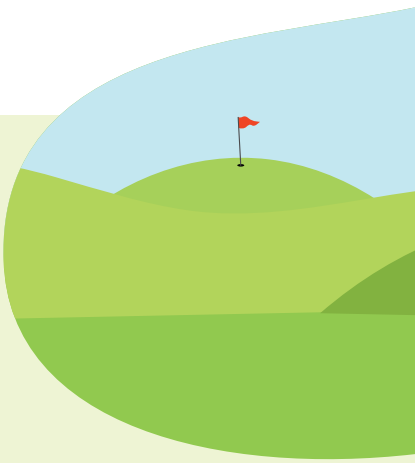
What is Autism?

Autism is a lifelong condition that affects how a person communicates and interacts with others. It also affects how a person makes sense of the world around them. Autism is much more common than many people think, '1 in 65 people in Ireland' and autism can be a hidden disability – you can't always tell if someone has autism.

Some of the strong qualities a person with autism can bring to the team are loyalty, dedication, new way of thinking or seeing things from a different perspective.

What We May See When Coaching People Who Have Autism

- A person with autism may use or take other people's things or enter their personal space
- Some people with autism may stay on their own and not join games or activities. They may watch others or remove themselves completely from the area
- Some people with autism might want to follow the rules rigidly and may get distressed if there are any changes in the routine
- A person with autism may have differences in communication and social skills to approach another person and initiate a conversation with them. A person with autism may behave in a way that is perceived to be inappropriate, such as snatching objects away from others to start a chasing game, standing beside other people but not saying anything or saying inappropriate things to get their attention
- A person with autism may become upset easily over seemingly small issues
- A person with autism may talk out of turn, longwinded, off topic, one sided conversations etc.
- A person with autism may misunderstand commonplace phrases or teasing. For example, "pull up our socks", "think on our feet", and "let's get the show on the road"
- A person with autism may misunderstand general instructions such as "let's go in"
- A person with autism may find it hard to focus on the activity and may be easily distracted
- The movements of a person with autism may be uncoordinated and appear clumsy



Social Communication

People with autism may have difficulties with the following areas

- Not understanding or misinterpreting unwritten social rules, e.g. around friendship
- Appearing to be insensitive because they have not recognised how someone is feeling
- Preferring to spend time alone
- Being aloof, distant or uninterested in others
- Not seeking comfort from other people
- Appearing to behave strangely or inappropriately, as they are not always able to express feelings, emotions or needs
- Not speaking, unusual use of language, echolalia, making up words, pronoun reversal – e.g. James looks across the pitch and says to his coach 'you scored a goal'. The ideal coach response would be: Yes James, you did score a goal, well done! James uses 'you' when he should have said 'I'
- Not understanding or misinterpreting 'jokes or sarcasm
- Not understanding or misinterpreting 'common phrases or sayings

Restricted Interest and Repetitive Behaviours:

People with autism may have difficulties with the following areas:

- Being able to understand and interpret other people's thoughts, feelings and actions
- Predicting what will happen next, or what could happen
- Understanding the concept of danger
- Engaging in imaginative play and activities
- Preparing for change and planning for the future
- Coping in new or unfamiliar situations

How To Include People With Autism In Your Coaching Sessions

1. Give the person plenty of information about the activity before they come to the coaching session

Try the following:

- Provide photos of the facilities/playing area and the coaches/volunteers
- Provide information about what usually happens in the session/activity and a general timetable of what happens
- Provide the rules of the game and information about equipment needed/used
- He/she could visit the room/facility when nobody is there/taking part
- He/she could attend/observe a session without having to participate

2. Use more visuals when coaching

Try the following:

- Use picture cards and/or video clips and/or demonstrations when coaching skills
- If coaching a new drill, let them go last so that they can watch others do the drill first
- Use visual tricks, e.g. put a mark on where they are to hold a hurley
- Use cones/mats/spots to show where they are to stand/sit and where to run to
- Give clear and precise explanations when outlining activities, particularly the rules

3. Have a clear agenda and if there is a need to change, prepare them for it in advance.

Try the following:

- Have a general agenda to a session – e.g. warm up, drills, practice game, cool down
- Write up the agenda for the session – e.g. list of drills, exercises etc. so they know what to expect and are less anxious. You can use a notepad or notebook to do so if you are training outside
- Let them know and prepare for changes - e.g. coach is away next week but Mary will take the session and will write down what will happen

4. Clearly communicate the rules of the session, write them down and have them available if needed.

Try the following:

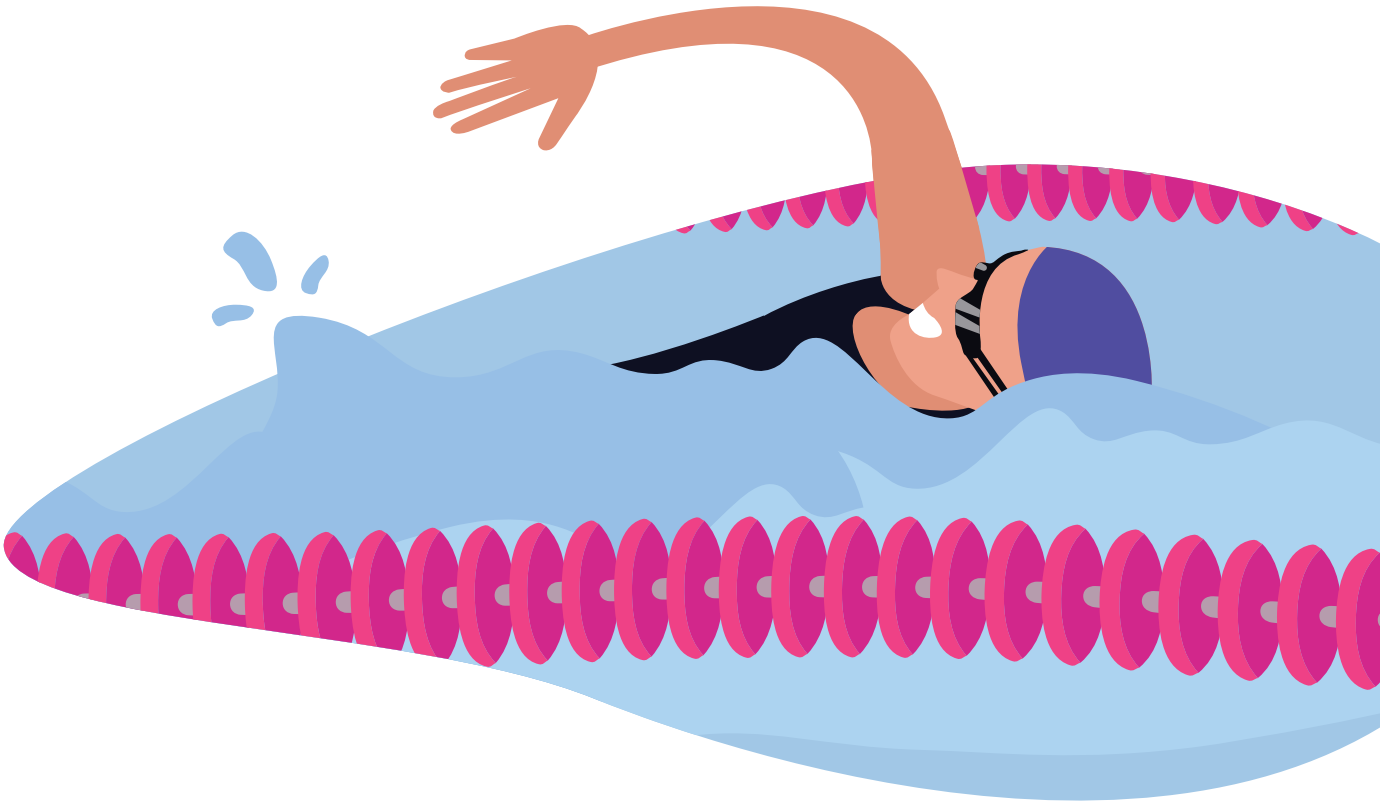
- Be clear about the rules of the sport
- Be clear about safety rules and why these are important
- If incidents do occur, take time with the person to explain why it was unsafe

5. Provide a safe place that he/she can go to have a time out if stressed or overwhelmed.

It is important that they have somewhere they can go if they do feel overwhelmed to regulate themselves so that they can continue with the group if possible.

This might be a bench at the side of the pitch, the hallway, a corner in a room etc.

You may want to have "calming equipment" that they can use to regulate themselves - e.g. fidgets, something I can hold/squeeze in my hand such as a stress ball, water bottle, bean bag, or an exercise ball for them to sit on.



For further information and support:

Please visit **www.asiam.ie**

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Factsheet

Cerebral Palsy

This factsheet has been developed in consultation with key national agencies with experience and knowledge in the specific areas. The information is provided for **guidance** only, allowing you to be more informed in your approach to being a more **inclusive** coach. No two people are the same, as such, please ensure your first step is to speak directly to the person – understand their abilities and goals and never assume.

What is Cerebral Palsy?

Cerebral palsy (CP) is a lifelong condition that affects body movement and muscle coordination.

It is caused by damage to one of the parts of the developing brain which controls and organises a person's movement and posture. The damage to the developing brain can happen before, during or after birth and is usually diagnosed before the age of three.

Cerebral palsy will affect a person's coordination, tone and strength of muscle action.

Cerebral palsy is not progressive.

Each individual with CP will be affected differently, and it can vary from mild to severe.

For some people, cerebral palsy will affect them physically, making muscle movements more difficult due to muscle tightness or spasticity and involuntary movements. People with CP may present with balance difficulties, and a disturbance in gait or mobility and have perception issues (difficulties making sense of and interpreting the messages received from the senses, moving around objects, judging size and shapes of objects etc.).

Others may also be affected by epilepsy, breathing difficulties, hearing and vision impairment, a poor swallow or difficulties with speech and language.

It is often assumed that people with CP who are unable to talk, or have difficulty controlling their movements, have an intellectual disability. This is not always the case and should never be assumed. CP does not necessarily affect intelligence, though some people might have an intellectual disability.

Forms of Cerebral Palsy (CP)

Spastic Cerebral Palsy:

- Affects 70 to 80 percent of people with Cerebral Palsy
- Muscles are stiff and permanently contracted
- More involvement of the lower limbs than the upper limbs

Athetoid Cerebral Palsy:

- Affects about 10 to 20 percent of people with Cerebral Palsy
- Uncontrolled, slow writhing movements which can affect the hands, feet, arms, or legs, and, in some cases, the muscles of the face and tongue, causing grimacing or drooling. These movements often increase during periods of emotional stress and disappear during sleep
- Some people may also have problems coordinating the muscle movements needed for speech, a condition known as dysarthria

Ataxic Cerebral Palsy:

- Affects an estimated 5 to 10 percent of People with Cerebral Palsy
- Affects a person's sense of balance and depth perception
- Often have poor coordination or walk unsteadily with a wide-based gait, placing their feet unusually far apart
- Can experience difficulty when attempting quick or precise movements

Mixed forms:

It is not unusual for people with Cerebral Palsy to have symptoms of more than one of the previous three forms. The most common mixed form includes spastic and athetoid movements, but other combinations are also possible.

How To Include People With Cerebral Palsy Into Your Coaching Sessions

- The important factor is that no two people are the same, so the coach will have to consider the persons physique, mobility and application
- Speak to the participant to understand their abilities
- For some people with cerebral palsy, outdoor temperature could be a limiting factor to an effective training session during winter months
- Constant and continual repetition and reinforcement can reduce coordination difficulties
- Participants may have a slower reaction time when initiating movement on command
- The participant may have limb movement restrictions. Therefore, they must work at their maximum capacity to enable optimum performance. The participant must be supported to move any affected limb to the best of their ability
- The participant may have short-term memory loss, requiring constant and continual reinforcement of instructions
- Circulatory problems may mean additional stretching and flexibility exercises, and/or shorter drill times are required
- Be aware of any balance difficulties and take these into consideration with any relevant drills or game play

For further information and support:

Please visit: **www.enableireland.ie**

or email **communications@enableireland.ie**

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Factsheet

Deaf or Hard of Hearing

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What is Deafness?

Deafness means that a person has a limited ability to hear sounds. It is a communication difficulty rather than merely a loss of sound perception.

Congenital deafness affects all aspects of a child's development: cognitive, emotional, social and educational.

Hearing Loss affects volume (loudness) and frequency (pitch).

Adults who become Deaf (deafened) do not rely on hearing alone to communicate. Vision is also important.

The terms **mild**, **moderate**, **severe** and **profound** describe the extent of deafness.

People who have **mild hearing loss** have some difficulties keeping up with conversations, especially in noisy surroundings.

People who have **moderate hearing loss** have difficulty keeping up with conversations when not using a hearing aid.

People who have **severe hearing loss** will benefit from powerful hearing aids, but often they rely heavily on lip-reading even when they are using hearing aids. Some also use sign language.

People who have **profound hearing loss** are very hard of hearing and rely mostly on lip-reading, and/or sign language. They may hear loud sounds.

How To Include People Who Are Deaf Or Hard Of Hearing In Your Coaching Sessions

- Suggest that the person be at the front of the group when communicating plans or instructions, or, as the coach in the activity, move to a position where he/she is in front of you. Convey this message at the beginning of the session rather than bringing the person to the front at the beginning of each demonstration. Make sure you are in front of, or fairly close to (approx. 3-6 ft), and on the same level as the person who is deaf or hard of hearing
- Check that background noise is kept to a minimum. Hearing aids are not selective in the sounds they amplify and, therefore, any background noises will be amplified as much as your voice. An exception to this is during sports competition. In Deaf Sports you will have to remove hearing aids/cochlear implant in competition – it is part of the rules under the International Committee of Sports for the Deaf (ICSD). In a training session they are allowed to wear their aids
- Speak clearly and do not exaggerate lip movements. If you are a fast speaker, you might find that maintaining a normal rhythm of speech could help
- Position yourself with your face to the light and avoid placing yourself in front of a bright window. Light sources make lip-reading difficult
- Try to face the person when speaking and do not cover your mouth with your hand, paper or a pen; do not chew gum or eat. Be aware that a beard or moustache may make lip-reading difficult
- Ensure the person is paying attention before you begin to communicate instructions or coaching points. Attract their attention before speaking to them or else they may not realise you are talking to them. A tap on the shoulder or a wave is acceptable

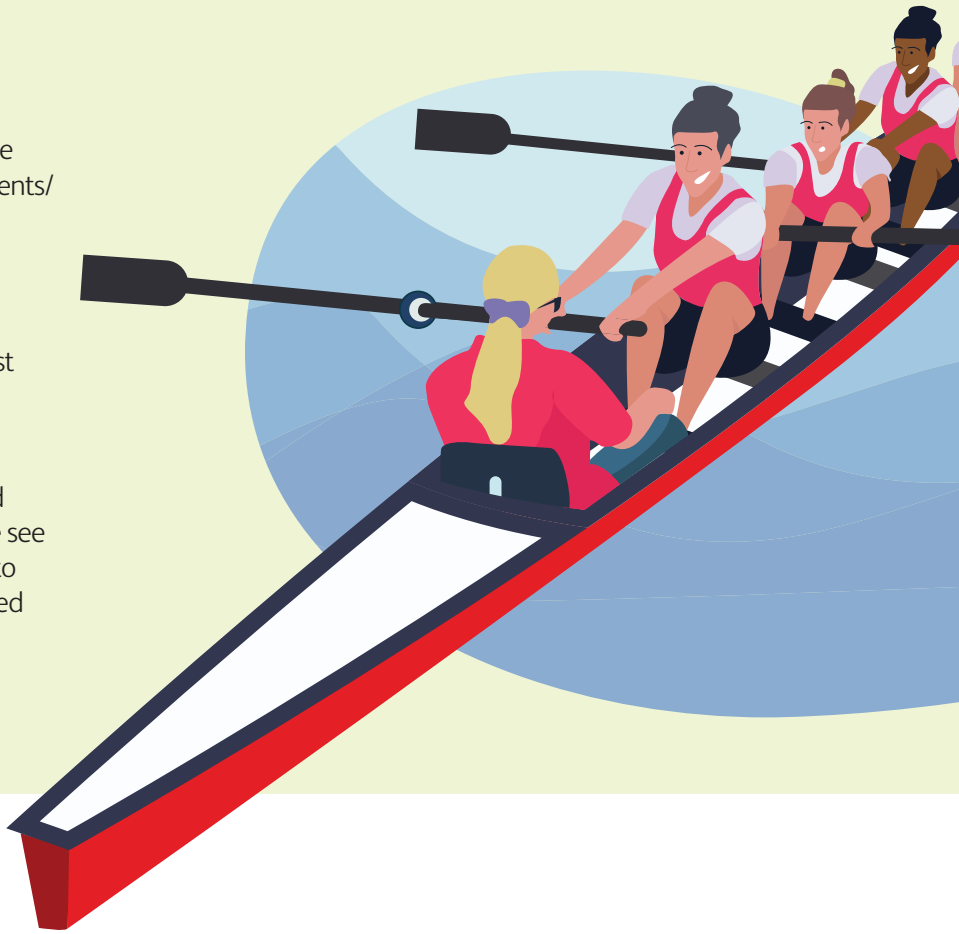
- Present one format of visual information at a time. The person cannot 'read' two things at the same time; for example, the white board and your lips. Therefore, try to avoid talking while writing on the white board or demonstrating
- Write down keywords and new vocabulary if needed. This helps because new words are almost impossible to lip-read
- Where possible, demonstrate techniques or corrections rather than relying on verbal explanations
- If a person who is Deaf or Hard of Hearing does not reply or seems to have difficulty understanding, rephrase what you just said/demonstrated before moving on. A person who is Deaf or Hard of Hearing will usually confirm they understand by a nod of the head and you should do the same
- Inform the person of any changes in daily routine. They may be the only one in the session unprepared for such things as room changes, finishing times or changes in activity

- Repeat other people's contributions to the session
- Ask the person to teach you sport-specific signs; there is a number of these that a person who is Deaf or Hard of Hearing can teach members of your sporting club to assist with communication during matches and training
- Make sure the person who is Deaf or Hard of Hearing can identify essential signals in your sport (e.g. visual equivalents to whistles or a starting pistol). A simple example could include a referee/starter putting an arm up, then down at the same time as the whistle/starting pistol

Involve others

It would be useful to discuss the guidance described above with club members, parents/carers and/or assistants prior to, or shortly after, the person who is deaf or hard of hearing joins the club. The coach can also educate officials/umpires about what can be done to assist the person.

Combine clapping with a double-handed wave to congratulate or praise. When we see something good, the natural reaction is to clap. The Deaf community will use a raised double-handed wave to show the same appreciation, so use both methods for a mixed group.



For further information and support:
Please visit **www.deafsportsireland.com**
or **www.deafhear.ie**

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Factsheet

Intellectual Disability

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What is an Intellectual Disability?

The World Health Organisation (WHO) defines intellectual disability as "the significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope ind pendently (impaired social functioning), and begins before adulthood, with a lasting effect on development."

According to the American Association of Intellectual and Developmental Disabilities, an individual is said to have an intellectual disability if he/she meets the following criteria:

1. IQ is below 70-75
2. There are significant limitations in two or more adaptive areas (skills that are needed to live, work, and play in the community, such as communication or self-care)
3. The condition manifests itself before the age of 18.

How is Intellectual Disability classified?

The World Health Organisation classification of Intellectual disability is based on an individual's IQ and is as follows:

85 - 100+	Normal
70 - 84	Borderline normal
50 - 69	General intellectual disability
35 - 49	Moderate intellectual disability
20 - 34	Severe intellectual disability
Up to 19	Profound intellectual disability

Types of Intellectual Disability

There are a wide range of types of intellectual disabilities such as: Fragile X Syndrome, Down Syndrome, Williams Syndrome, Fetal Alcohol Syndrome, Prader-Willi and Phenylketonuria (PKU).

It is important to note that conditions such as Autism and Asperger's Syndrome are a spectrum. This means that some people who have one of these conditions may or may not have an intellectual disability. It will depend where on the spectrum that they sit.

General Characteristics of Intellectual Disability

People with an intellectual disability tend to take longer to learn and may need support to develop new skills, understand complex information, and interact with other people.

The level of support an individual needs depends on specific factors. For example, a person with a mild intellectual disability may only need support with simple tasks such as joining a sports club. However, someone with a severe or profound intellectual disability may need full-time care and support with every aspect of their life – they may also have physical disabilities.

Some other general characteristics of people with an intellectual disability may include:

- Muscle laxity
- Hypermobility at the joints
- Attention may wander

Atlantoaxial instability

People with Down syndrome are more prone to neck instability, called Atlantoaxial Instability. Approximately 15% of people with Down syndrome, over their lifetime, will develop this neck instability. It is important for a coach to make themselves aware if a participant has this and make the required adaptations to their session and activities to avoid injury.

Special Olympics requires that the athlete must have a full radiological examination, establishing the absence of Atlantoaxial Instability before he/she may participate in sports or events, which by their nature, may result in hyperextension, radical flexion, or direct pressure on the neck or upper spine.

The sports and events for which such a radiological examination is required are: equestrian sports, artistic gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift, football, and any warm-ups placing undue stress on the head and neck.

Intellectual Disability or Learning Difficulty?

Intellectual Disability is often confused with specific learning difficulties such as dyslexia, attention deficit hyperactivity disorder (ADHD) and autism. Dyslexia Association of Ireland describe dyslexia as a 'learning difficulty' because, unlike intellectual disability, it does not affect intellect.

It is important to remember that, with the right support, most people with an intellectual disability in Ireland can lead independent lives. Sport provides invaluable life skills and social contact, as long as a positive and informed environment is available to people.

How To Include People With An Intellectual Disability In Your Coaching Sessions

- The level of support may vary pending the ability level
- The level of support may vary from person to person
- Use a range of coaching styles, including lots of visual demonstrations and visual cues
- Praise when success is achieved, encourage when not
- Build routine and familiarity into your sessions
- Plan and allow for additional time to offer support
- Give clear concise instructions and repeat them frequently
- Demonstrate specific coaching drills one element at a time, and build up slowly
- Use trigger words to condense instruction
- Only speak to parent/carer if person is unable to communicate
- Where relevant, provide accessible and easy-to read information, and consider other non-verbal communication techniques
- Where applicable pair up your participant with a supportive fellow participant who has the ability to explain concepts clearly, concisely, and patiently

For further information and support,
Please visit:
www.specialolympics.ie
www.inclusionireland.ie
www.downsyndrome.ie

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Factsheet

Vision Impairment

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What is a vision impairment?

Vision impairment is a term used to describe any kind of **vision** loss, that impacts on a person's ability to carry out activities of daily living. Some people cannot see at all or some have partial **vision** loss.

Coaching people with vision impairments can provide many challenges as every person will have varying levels of sight. Some people may see nothing; some may see outlines; some may see some light or colour; some may see a small area in detail but nothing around that area; some may see best in good light; some in low light; some may have seen in the past and have a memory of how people move; and some may never have seen and have to learn everything by description, demonstration and experience. Some people may not see well under certain conditions or circumstances such as glare, fatigue etc.

What You May Notice With People Who Have A Vision Impairment

Depending on the severity of the condition, a person with a vision impairment may have one or many of the following:

- Eyes make repetitive, uncontrolled movements. These involuntary eye movements can occur from side to side, up and down, or in a circular pattern. This condition is known as Nystagmus.
- Head tilting – 'Null point accommodation' is when a person may tilt their head to minimise the uncontrolled movements of the eye.
- Head swaying – a voluntary, learned, neurovisual adaptation to improve visual acuity.
- Gross motor skills not being as well developed.
- A lack of motivation to explore the environment.
- Being unaware of unacceptable body movements and mannerisms.
- Difficulties with orientation.
- Difficulty with depth perception and change of levels underfoot on surfaces.
- Need time to adjust when moving from darkness into bright and vice versa.

How To Include People With Vision Impairments In Your Coaching Sessions

- Communication is key when coaching people with a vision impairment.
- Talk to the participant prior to the session, to understand their sight level and personal support needs.
- It is very important that trust is developed quickly between the coach and participant.
- It is important that the player is not over accommodated.
- Use the individual's name to get their attention.
- Allow adequate time for the participant to orientate the environment and equipment, prior to the session and throughout.
- Always begin teaching any new skill or technique with verbal descriptions (try to paint a picture in participants mind) before moving on with the activity.
- Always ask if physical contact is wanted with a guide.
- Offer support instead of grabbing, pushing or pulling participant
- Allow time for tactile exploration of equipment and environment as well as continued verbal description.
- If possible, you, as the coach, should picture the skill and describe it as accurately as possible; communication and patience are key.
- Ensure a quiet learning environment so the participant is able to interpret, locate and identify different sounds.

Sound

The use of equipment and cues with a sound can often help.

Examples: having a sound source that beeps to identify and orientate the direction of play or bells or beads within a ball itself to generate a sound etc.

Tactile Aids

These can also be used to assist the participant in identifying the playing area, direction of play and where balls or targets are located in relation to the participant etc.

Examples: using string/rope to mark the perimeter of the court in Goalball or flat rubber directional arrows or markers to orientate the direction of play, or a scaled down tactile model/version of the playing area/targets to give participant greater understanding.

The use of tactile markers on the floor, walls and equipment can be helpful, where appropriate.

Contrast

Use equipment that has a contrasting colour to that of the playing surface or background. Try use strong **contrasting colours** to help distinguish between playing surfaces, playing equipment and the participants. As the coach, you should wear a different coloured top, in a colour the participant can see

- People with a severe vision impairment cannot learn by imitation. As this is the usual way in which most people will learn movement from an early age, be aware of using different methods of communication.
- Be aware that some people with vision impairment's sight may vary from day to day or at different times of day, going from dark to bright or vice versa. It is therefore important to check with your participant prior to each session.
- Avoid low-hanging objects in the coaching environment and keep the floor space free of any potential hazards or obstacles.
- Have relevant materials available in large print, braille or electronic form depending on the preference of the participant(s) with a vision impairment.
- In swimming, people with visual impairments may find backstroke difficult, and may feel very uncomfortable when starting to do backstroke. Ensure the participant has complete water confidence before backstroke is attempted.
- To fully understand the outcomes, some participants may need to experience practices, events and routines **repeatedly**.

Useful Equipment Suggestions:

- Sound Sources
- Tethers

- Coloured Tapes
- Large Print

- Braille
- Bumpons

Forms of Vision Impairment:

Explanation for the figures below:
If somebody is 6/60 (Registered Blind in Ireland), they need to be at 6m to see what you can see at 60m.

- **Partially Sighted:** A visual impairment that adversely affects a participants' performance even when corrected to the extent possible.
- **Low Vision:** If someone's vision is between 20/70-20/160 and cannot be corrected, the participant has moderate to low vision.
- **Registered as Blind:** From 6/60 is registered blind in Ireland. From 20/400-20/1000 is profound vision impairment, and is very close to total blindness.
- **Totally Blind:** The lack of light perception is known as total blindness or total visual impairment.

NCBI offer awareness training and guidance to staff and coaches. Please visit their website below to learn more.

For further information and support:
Please visit **www.ncbi.ie**
or **www.visionsports.ie**

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Factsheet

Manual Wheelchair User

This factsheet has been developed in consultation with key national agencies with experience and knowledge in the specific areas. The information is provided for **guidance** only, allowing you to be more informed in your approach to being a more **inclusive** coach. No two people are the same, as such, please ensure your first step is to speak directly to the person – understand their abilities and goals and never assume.

Manual Wheelchair Users

People use manual wheelchairs for different reasons.

- **Congenital** (present from birth) e.g. Spina Bifida
- **Acquired** e.g. Spinal Cord Injury, Stroke, Cerebral Palsy etc.

Some people use a manual wheelchair full time, whereas others use it part time or for particular activities/journeys etc.

Strapping

Straps may be used to help improve sitting balance for wheelchair users:
Foot Strap - to keep feet on footplate when turning
Knee Strap - to keep central in chair
Lap Strap - to secure hips to be at one with the chair
Waist Strap - to give core balance. Straps can be varied, but for beginners simple Velcro straps work quickly and effectively and provide security and confidence when playing sport. Similarly, taping/strapping for those with upper limb impairments enable rackets to be held securely (e.g. table tennis/tennis/badminton) and gloves with tactile surface and textured push rims enable those with upper limb impairments to push more effectively.
Be careful with strapping in areas with no sensation as they may cause skin lesions - check regularly.

How To Include Manual Wheelchair Users In Your Coaching Sessions

These coaching considerations may not apply to all wheelchair users but are common characteristics for an athlete with a physical disability. For greater clarity, it is recommended you ask the participant.

- If participants are not using a sports wheelchair, they may not have an anti-tip system fitted to their chair. If this is an option on their chair, ensure it is fitted. If no anti-tip is fitted, it may be appropriate to reduce the risk of the chair tipping back during an activity (e.g. by reducing speed and quick turns) as this may cause injuries
- Check participants' range of movement; they may, for example, find it difficult to raise their arms above their head
- There is a common assumption that if a participant is in a wheelchair, they cannot bear weight on their legs. Participants may be able to bear weight, depending on their disability
- Participants may or may not tire easily during a session due to their lack of motor skill efficiency
- Some participants may struggle with temperature regulation – both hot and cold, therefore, may require monitoring and in some cases, water to be sprayed on them to avoid overheating
- Make sure participants take in plenty of fluid during sessions
- There may be a decrease in a participant's range of movement due to, for example, a rod in the spine/ spinal fusion
- Be aware of hot and cold surfaces, as participants may have poor or no sensation
- There is the potential for damage such as cuts and bruises due to poor or no sensation
- Be aware that some participants may require equipment for toileting and personal care
- Be aware that it may be appropriate to source a physically accessible venue with accessible WC/ Bathroom Facilities for participants that are wheelchair users
- Participants may have a decreased breathing efficiency due to muscle weakness (tetraplegic/ quadriplegic)
- If transferring to a different wheelchair or sporting equipment (throwing frame/ handcycle), participants might prefer to do this independently or with the assistance of a parent/guardian/ personal assistant, or with a trained individual. With higher levels of dependency/assistance, a hoist may be required for transfer.

In some cases, no assistance may be required

For further information and support:

Please visit **www.hadd.ie**

or email **info@hadd.ie**

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