International Journal of Intellectual Disability

**ISSN Print:** 2710-3889
**ISSN Online:** 2710-3897
IJID 2026; 7(3): 01-09
www.rehabilitationjournals.com/intellectual-disability-Journal
Received: 04-09-2026
Accepted: 23-10-2026
Published: 04-11-2026

**Oluwole Owolabi**
Independent Researcher, USA

**Corresponding Author:**
**Oluwole Owolabi**
Independent Researcher, USA

# A train-the-trainer framework for adapted sports and physical activity in community disability services

Oluwole Owolabi[1]

**DOI:** https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952

**Abstract**

People with disabilities face persistent barriers to physical activity, while community disability services often lack staff training and structured approaches to delivering adapted sport. This article presents a train-the-trainer framework designed to equip direct support professionals and community coaches to provide safe, person-centred physical activity. The framework integrates four adaptation domains rules, equipment, environment, and instruction with a population guide, a structured 60-minute session, and four participation levels progressing from initial exploration to community competition. A 16-hour curriculum combines classroom learning, practical activities, and supervised coaching, with competency-based sign-off and a subsequent pathway for training colleagues. Safety, safeguarding, participant choice, and individual care plans underpin delivery. A planned 12-month pilot with Open Arms Care Corporation in Nashville, Tennessee, will examine implementation and participant outcomes through baseline, three-month, and six-month assessments. Measures include physical activity, fitness, movement skills, individual goal attainment, well-being, social participation, safety, and staff capacity. No outcome data are currently available, and the proposed uncontrolled evaluation cannot establish causality. The framework offers a practical model for developing workforce capacity and extending access to adapted sport, subject to evaluation of feasibility, fidelity, sustainability, and participant outcomes.

**Keywords:** Adapted physical activity, Train-the-trainer, Intellectual and developmental disabilities, Direct support professionals, Community disability services, Inclusive sport

## 1. Introduction

### *1.1 Physical activity inequalities and participation barriers*

People with disabilities experience inequalities in physical activity participation compared with people without disabilities. Population evidence identifies higher inactivity among adults with disabilities, demonstrating unequal participation in movement, recreation and sport (American Thoracic Society, 2002) [1]. These differences must be considered alongside the diverse health conditions, abilities and support requirements of individuals (Carroll *et al.*, 2014) [2]. Physical activity recommendations recognise this variation and encourage participation according to individual abilities (CDC, 2026) [3].

Participation opportunities depend on accessible facilities, suitable equipment, understandable instructions and appropriate assistance. The importance of reasonable modifications is recognised in guidance addressing access to extracurricular athletics for students with disabilities (CDC, 2025) [4]. Applying this principle in community settings requires attention to transport, physical access, communication and staff support.

Physical activity can support health, functional ability and independence, making accessible opportunities important beyond sporting achievement (CDC, 2026) [3]. Recommendations encompass aerobic activity and muscle strengthening while recognising that some individuals require adapted approaches (CDC, 2025) [5]. However, disability should not be treated as a uniform experience. Individual assessment should inform the selection of activities and suitable fitness measures (Kiresuk *et al.*, 1968) [6]. Accordingly, the proposed framework begins with participants' interests, goals and support needs rather than assumptions based solely on diagnosis.

### *1.2 The delivery gap in community disability services*

Physical activity guidance establishes what people should be supported to achieve, including regular aerobic and muscle-strengthening activity where possible (CDC, 2025) [5]. Translating these recommendations into everyday opportunities requires practical arrangements, appropriate resources and staff who can support participation. Similarly, guidance on equal access to athletics demonstrates that inclusion requires active provision of reasonable modifications rather than an invitation to participate alone (CDC, 2025) [4].

This article focuses on direct support professionals because they help organise daily routines within residential, day and community services. The proposed framework addresses circumstances in which activity deliv



27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

ery must be coordinated alongside personal care, appointments, documentation and other responsibilities. It also anticipates differences in staff experience and access to specialist advice.

A repeatable development approach is therefore proposed, combining instruction, supervised practice, feedback and competency assessment. Staff preparation should include selecting appropriate activities, applying adaptations and recording progress. Established assessment guidance illustrates the importance of consistent procedures when measuring physical performance (Kiresuk *et al.*, 1968) [6]. The framework seeks to connect these measurement requirements with practical delivery while preserving participant choice and individualised support.

### *1.3 Article aim, scope and proposed contribution*

This article presents a proposed framework combining individual adaptation, structured sessions, staff training and outcome monitoring. Intended users include disability service providers, direct support professionals, community coaches and recreation partners. Adaptations address rules, equipment, environment and instruction, supported by a predictable session routine and participant-led progression.

A train-the-trainer curriculum is intended to develop local delivery capacity through supervised coaching and competency assessment. Evaluation draws on established fitness assessment approaches suitable for defined populations (Kiresuk *et al.*, 1968) [6]. Movement assessment instruments provide options for examining skill development within their intended age ranges and administration requirements [7]. Goal attainment scaling offers a complementary approach to evaluating individually agreed objectives (Piercy *et al.*, 2018) [8].

The framework has not yet been evaluated; consequently, no effectiveness claims are made. The article explains its design, implementation pathway and evaluation requirements. The following section establishes the principles guiding safe, inclusive and sustainable delivery, with particular attention to individual choice, workforce preparation and accountable practice.

## 2. Conceptual foundations and design principles

### *2.1 Adapted physical activity and meaningful participation*

Adapted physical activity is a multidisciplinary field concerned with modifying physical activity opportunities to address individual abilities, participation restrictions and support needs (Kiresuk *et al.*, 1968) [6]. Adapted sport applies this approach to sporting activities through adjustments that enable accessible recreational or competitive involvement [7]. Meaningful participation extends beyond attendance: participants should influence activity choices, engage actively, develop skills and experience belonging (Piercy *et al.*, 2018) [8].

Within the framework, adaptations preserve the recognisable purpose of each sport while changing unnecessary barriers. Basketball may retain passing, shooting and teamwork while using lower hoops, softer balls or alternative movement options. Such modifications reflect individualised instruction and environmental adjustment rather than an assumption that everyone requires identical support [7].

Enjoyment, friendship and comfortable participation are legitimate outcomes alongside skill mastery and competition. Disability rights principles support access to mainstream and disability-specific recreation without prescribing a single participation pathway (Piercy *et al.*, 2018) [8]. Accordingly, progression should expand choices rather than impose competition, and continued recreational involvement should remain available to participants who prefer it.

### *2.2 Person-centred practice, accessibility and safeguarding*

Person-centred practice places dignity, autonomy and individual choice at the centre of programme design [9]. Participants should receive accessible explanations, opportunities to express preferences and appropriate support for consent. Communication access may require demonstrations, pictures, interpreters or additional processing time; accessibility extends beyond physical entry to information and participation (Special Olympics Maryland, 2025) [10].

In this framework, assessment and care-plan review guide equipment selection, activity intensity, supervision and communication strategies. Staff should consider preferences alongside mobility, fatigue, sensory needs and relevant health precautions. Safeguarding procedures should address professional boundaries, agreed physical assistance, incident reporting and escalation without unnecessarily restricting participation.

Accessible surfaces, suitable lighting, rest spaces and appropriate assistance help translate inclusion into practice (Special Olympics Maryland, 2025) [10]. Independence should mean exercising control with the support a person needs, rather than performing every task unaided (Ulrich, 2019) [11]. Adaptations should therefore be reviewed collaboratively, preserving necessary assistance while enabling participants to direct their involvement and pursue personally meaningful goals.

### *2.3 Workforce capacity and the train-the-trainer rationale*

Developing existing staff capacity may support continuity and reduce reliance on visiting specialists. Community rehabilitation guidance recommends locally available training resources and developing people who can train others (US Department of Education, 2013) [12]. The cascade begins with specialist instruction, progresses through supervised session delivery and competency sign-off, and subsequently prepares experienced staff to teach colleagues.

However, this model requires safeguards. Staff turnover can interrupt delivery, inconsistent instruction can alter adaptations, and repeated training cycles may weaken fidelity. These are implementation risks requiring monitoring rather than assumed benefits of cascading instruction.

Ongoing supervision, clear responsibilities and performance review support workforce development (US Department of Education, 2013) [12]. Competency assessment should examine demonstrated skills rather than attendance alone, consistent with broader competency-based training principles (US Department of Health and Human Services, 2018) [13]. Written checklists, observed sessions and refresher learning are therefore proposed. The next section translates these principles into practical decisions about individual assessment, activity adaptation and delivery.

Participant goals, preferences and support needs inform individual assessment, activity adaptations and staff preparation. These components guide safe session delivery. Monitoring of participation, skills, safety and staff competence feeds back into adaptation choices, training and programme improvement.

## 3. Framework components and programme delivery

### *3.1 Individual assessment and participant-led goal setting*

Assessment begins with the participant's interests, previous activity experiences and preferred ways of communicating. Staff gather information about mobility, balance, endurance, sensory access, relevant health considerations and the assistance needed to participate comfortably. Community rehabilitation guidance supports identifying locally appropriate recreational opportunities and removing participation barriers (Winnick *et al.*, 2014) [14]. Communication tools should remain available throughout assessment and activity [15].

27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

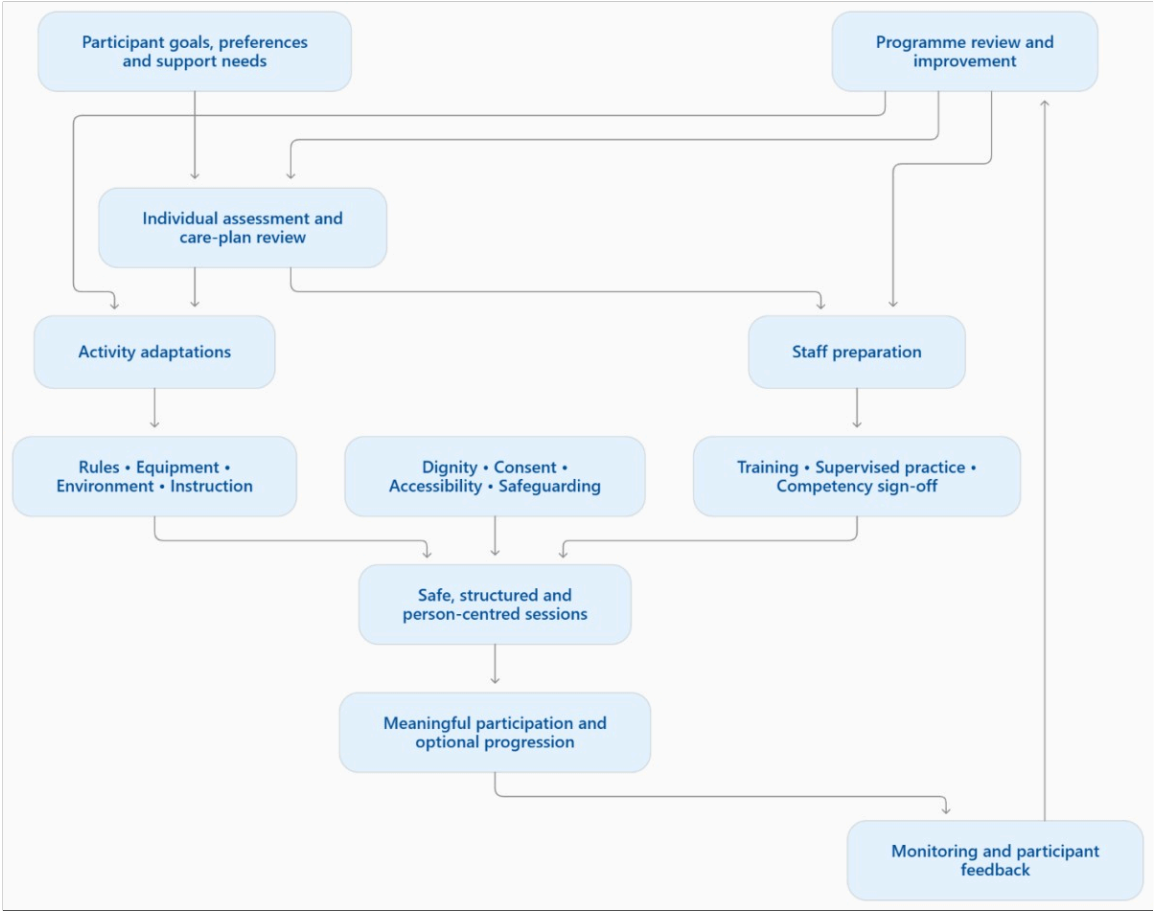



**Figure 1.** Conceptual architecture of the adapted sports framework.

Participants lead decisions wherever possible, with families, advocates and familiar staff helping interpret preferences without replacing the person's voice. Supported choice reflects the right to direct community involvement with appropriate assistance (Ulrich, 2019) [11]. Staff then agree achievable goals, such as joining a warm-up, completing several passes or attending a community session.

Goals should specify the activity, assistance permitted and indicators of progress. Initial observation establishes a starting point rather than a judgement of potential. Diagnostic labels must not determine expected ability or preferred sport. Assessment remains collaborative, allowing goals and support arrangements to change.

### *3.2 Four domains of activity adaptation*

#### *3.2.1 Rules and task demands*

Rules are adjusted to reduce unnecessary barriers while preserving the sport's purpose. Options include simplified scoring, slower pace, shorter playing periods, smaller teams and fewer simultaneous decisions. Accessible recreational provision may require adapted activities (Winnick *et al.*, 2014) [14]. Within this framework, staff explain each change, observe its effect and retain opportunities for challenge. Participants help decide whether modifications improve enjoyment, fairness and involvement.

#### *3.2.2 Equipment*

Equipment is selected according to individual reach, grip, coordination, sensory access and preferences. Options include softer balls, larger targets, audible balls and ramps. Community rehabilitation guidance recognises adapted equipment as a means of enabling participation (Winnick *et al.*, 2014) [14]. Staff check suitability, condition and safe use before sessions. Participants test alternatives, and equipment remains available whenever it supports access, confidence and meaningful choice.

#### *3.2.3 Environment*

Environmental planning considers surface accessibility, lighting, background noise, layout, rest areas and predictable activity zones. Accessible venues are essential to inclusive recreation (Winnick *et al.*, 2014) [14]. Staff inspect routes and remove avoidable obstacles before participants arrive. Quiet spaces and clear boundaries are proposed options, selected through assessment. Layout changes are explained beforehand so participants can orient themselves and communicate concerns throughout the session.

#### *3.2.4 Instruction and communication*

Instruction combines demonstration, short explanations, repetition and opportunities to practise. Visual schedules, pictures, gestures or communication devices are selected around established preferences [15]. Staff present manageable steps, allow processing time and check understanding through demonstration or supported response. Familiar symbols can assist transitions [15]. Communication support should enable questions, refusal and choice, rather than merely secure compliance with instructions given.

### *3.3 Population guide and individualised application*

The population guide identifies possible support considerations rather than assigning fixed activities to diagnostic groups. Intellectual or developmental disabilities may involve additional processing time or support with sequencing; sensory disabilities may require accessible cues; physical disabilities may require adjustments to positioning, movement or rest. These examples guide enquiry, not assumptions about capability [16].

Support needs can overlap. A participant may require both mobility assistance and an alternative communication system, making combined adaptations necessary [15]. Staff therefore use the guide alongside individual assessment, care plans and participant feedback. Community rehabilitation guidance similarly emphasises access to suitable activities and equipment (Winnick *et al.*, 2014) [14].



27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

Each chosen adaptation is recorded with its purpose and reviewed during delivery. Participants may prefer different activities as confidence, interests or skills change. Removing support is not automatically progress: the relevant question is whether the arrangement enables greater control, engagement and enjoyment.

**Table 1.** Adaptation options according to individual support needs

| Support need | Rules or task adaptation | Equipment or environmental adaptation | Communication approach | Activity example |
|---|---|---|---|---|
| Additional processing or sequencing support | Introduce one task at a time; simplify scoring | Clearly marked stations; predictable layout | Demonstration, picture sequences and processing time | Basketball passing stations |
| Reduced vision or difficulty tracking objects | Adjust pace and playing distance | Audible balls; suitable contrast; consistent layout | Verbal orientation and agreed directional cues | Goalball-style rolling |
| Reduced hearing or difficulty accessing spoken cues | Replace whistle-dependent starts with agreed signals | Clear sightlines; visual start signals | Face participants; use preferred signs or interpretation | Athletics with visual starts |
| Mobility, balance or coordination support | Offer seated play, shorter distances or additional time | Accessible surfaces; ramps; lighter equipment | Explain positioning; agree assistance before movement | Ramp-assisted boccia |
| Fatigue or reduced endurance | Use shorter activity blocks and flexible substitutions | Accessible seating and rest areas | Agree how to request breaks | Adapted throwing circuit |
| Overlapping sensory and communication needs | Reduce simultaneous demands; allow individual pacing | Adjustable noise and lighting; quieter activity area | Familiar communication tools and supported choices | Individual or small-group ball games |

### *3.4 Standard session structure and flexible delivery*

The proposed session follows six stages totalling 60 minutes: check-in, five minutes; warm-up, ten; skill practice, fifteen; adapted game, twenty; cool-down, five; and reflection, five. Check-in confirms preferences, immediate wellbeing and relevant care-plan information (Ulrich, 2019) [11]. Warm-up introduces movement gradually, skill practice develops selected techniques, and the game creates opportunities to apply them.

Visual schedules can support understanding of routines and transitions [15]. Accordingly, consistent sequencing is proposed to help participants anticipate activities and staff organise delivery. Its benefits within this programme require evaluation rather than assumption.

Sessions may be shortened to thirty or forty-five minutes, divided into smaller blocks or include additional rest. Duration responds to preference, fatigue and assessed needs. Staff record attendance, engagement, activity time, adaptations and incidents, including reasons for stopping early. Reflection allows participants to identify enjoyment, discomfort or desired changes. Supervision and review support consistent documentation (US Department of Education, 2013) [12]. The routine provides structure without making completion more important than consent, comfort or safety during any part of participation.

### *3.5 Progression and community participation pathways*

Progression comprises four proposed levels. Explore prioritises comfort, choice and joining activities; Develop builds selected movement skills; Participate introduces sustained adapted games; Compete offers optional entry to appropriate community events (Special Olympics Maryland, 2025) [10]. Observable indicators include choosing an activity, joining warm-up with agreed support, performing target skills and participating safely in a game.

These indicators guide review rather than compulsory promotion. Progress may vary between activities, and participants can remain at or revisit any level. Necessary adaptations should remain available. Community rehabilitation guidance recognises diverse recreational opportunities, not competition alone (Winnick *et al.*, 2014) [14].

Staff identify accessible recreation partners and relevant Special Olympics pathways. Unified Sports brings people with and without intellectual disabilities together through sport [16]. Available models include recreational and developmental formats (United Nations, 2006) [17]. Choices should reflect eligibility, preferences, support arrangements and opportunities for belonging.

### *3.6 Safety, safeguarding and emergency readiness*

Before participation, staff review consent, care plans, health information and any required clinical clearance. Special Olympics medical procedures illustrate the distinction between collecting health information and obtaining clearance from qualified practitioners [18]. Programme requirements must follow local policy and appropriate professional guidance.

Session preparation includes agreed supervision, accessible emergency information, first aid readiness and individual seizure procedures where relevant. Staff consider fatigue, hydration, environmental heat and medication-related precautions identified in care plans. They recognise concerning changes and seek assistance; they do not diagnose conditions or independently amend clinical advice.

Safeguarding arrangements cover consent for physical guidance, professional boundaries, incident documentation and escalation. Clear responsibilities and supervision support accountable delivery (US Department of Education, 2013) [12]. These operational requirements establish what staff must do; the next section explains how training develops and verifies competence to deliver.

## 4. Train-the-trainer curriculum and competency development

### *4.1 Training objectives and staff preparation*

Training will develop knowledge of disability inclusion, adaptation, safeguarding and outcome recording, alongside practical coaching and respectful communication. Learning objectives will specify observable behaviours, consistent with training standards linking assessment to intended outcomes [19]. Suitable trainees will include direct support professionals, community coaches and nominated supervisors who have organisational approval and appropriate safeguarding preparation.

Before enrolment, staff will review role boundaries, relevant care policies and prerequisite emergency training. Initial learning checks will identify experience and support needs; experienced staff will receive extension tasks, while beginners will receive additional demonstrations. Assessment before and after instruction can distinguish existing proficiency from learning gains [20]. All trainees will practise consent, accessible instruction and safe adaptation before assuming responsibility for delivering sessions with participants.

27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

### 4.2 Curriculum content and learning methods

#### 4.2.1 Foundations, participant needs and adaptation

Foundational teaching will introduce disability awareness, participation rights and individual assessment through discussion, demonstrations and realistic scenarios. Trainees will apply the four adaptation domains to participant profiles, explaining how proposed changes support choice and access. Examples will include recreational and developmental pathways within (Unified Sports) [17]. Staff will examine how mixed teams can support inclusion without assuming identical abilities [16]. Activities will require trainees to justify adaptations, identify assumptions and respond to participant preferences before planning sessions with individualised goals.

#### 4.2.2 Safety, safeguarding and session organisation

Safety teaching will cover consent, safeguarding boundaries, emergency escalation, communication and session organisation. Trainees will practise checking care plans, preparing equipment and allocating supervision. Medical clearance will remain the responsibility of appropriately qualified practitioners where required [18]. Scenarios will address distress, fatigue, environmental hazards and interruptions, with staff rehearsing when to pause and seek help. Assessment tasks will reflect actual duties, following guidance favouring relevant scenarios and feedback [19]. Group management will emphasise participation, appropriate support and respectful interactions throughout.

#### 4.2.3 Supervised coaching and outcome recording

Practical learning will combine demonstration, guided rehearsal and supported session leadership. Trainees will practise explaining activities, adapting tasks and responding to participants, followed by specific feedback linked to learning objectives [19]. They will complete sample attendance, activity, adaptation and incident records using agreed definitions. Trainers will distinguish accurate observation from interpretation and check entries for completeness. Follow-up evaluation will examine whether learning transfers into workplace delivery [20]. These activities will prepare staff for assessment without treating practice attendance as competence.

**Table 2.** Proposed 16-hour curriculum and competency requirements

| Module | Learning objective | Duration | Teaching method | Assessment evidence |
|---|---|---|---|---|
| Foundations | Explain participation rights, dignity, choice and professional responsibilities | 1 hour | Classroom discussion and scenarios | Knowledge questions and scenario responses |
| Understanding participants | Identify individual interests, communication preferences and support needs | 2 hours | Classroom learning and participant profiles | Completed assessment and goal-setting exercise |
| Four adaptation domains | Select and justify changes to rules, equipment, environment and instruction | 2 hours | Classroom explanation and planning exercises | Written adaptation plan and rationale |
| Safety and safeguarding | Explain consent, supervision, emergency escalation and incident procedures | 2 hours | Classroom scenarios and discussion | Safety checklist and scenario assessment |
| Running a session | Plan the six-part routine and accessible communication | 1 hour | Classroom walkthrough and visual planning | Completed session plan |
| Supervised coaching | Demonstrate safe, respectful and adaptable session leadership | 6 hours | Practical rehearsal and observed coaching | Two observed sessions meeting checklist criteria |
| Measuring outcomes | Complete monitoring records and follow assessment procedures within competence | 2 hours | Practical recording and assessment exercises | Accurate sample records and demonstrated procedures |
| **Total** | | **16 hours** | **8 classroom hours; 8 practical hours** | **Knowledge assessment and observed competence** |

### 4.3 Assessment, sign-off and trainer progression

Sign-off will require a knowledge assessment and two observed sessions meeting a written checklist. Knowledge questions will assess adaptation, consent, safeguarding, emergency escalation and record keeping. Observation will examine preparation, accessible communication, participant choice, appropriate supervision and accurate documentation. Assessment methods will align with learning objectives rather than course attendance [19].

Trainers will record strengths, unmet criteria and agreed development actions. Staff who do not meet requirements will receive targeted coaching and reassessment before independent delivery. Observation-based mentoring is consistent with supportive supervision approaches, although evidence from community health workers requires cautious transfer to this setting [21].

Competence to deliver sessions will not automatically establish competence to train colleagues. After three months of delivery, eligible staff will complete a separate four-hour trainer module addressing demonstration, feedback, assessment and fidelity. They will initially teach under supervision. Sign-off records will identify the assessor, dates, evidence, restrictions and review arrangements. Programme evaluation will examine training acceptability and feasibility separately from participant outcomes [22].

### 4.4 Maintaining fidelity and supporting staff retention

Mentoring, refresher learning, periodic observation and peer discussion will support continued development. Supervisors will review delivery records and participant feedback, consistent with guidance emphasising coaching and observation [21]. Replacement staff will receive induction, supervised practice and assessment before independent delivery; previous experience will inform preparation but not bypass competency requirements.

Managers will allocate protected delivery time, manageable workloads and access to equipment. Staff feedback will identify barriers to applying learning, including insufficient time or supervisory support [20]. These arrangements will support retention without assuming training alone prevents turnover.

Fidelity monitoring will distinguish essential components from justified adaptations, recognising that delivery quality and participant responsiveness influence implementation [23]. Documented adjustments will preserve choice and safety. The next section explains how organisational implementation and evaluation will examine programme feasibility and potential benefits.

## 5. Implementation and evaluation plan

### 5.1 Setting, recruitment and organisational readiness

The planned pilot will involve Open Arms Care Corporation in Nashville, Tennessee. Sites will be selected according to participant interest, accessible space, staffing capacity and managerial commit



27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

ment. Eligibility will require an individual assessment confirming that activities can be offered safely with appropriate adaptations. Recruitment will be voluntary, using accessible information and supported decision-making.

Readiness checks will establish staffing arrangements, equipment availability, transport, emergency procedures and protected session times. Supervisors will receive defined responsibilities, consistent with supportive supervision principles [21]. Participation in activities will not automatically constitute agreement to research.

Before evaluation data collection, the organisation will obtain an appropriate determination of whether the work constitutes research or service evaluation and establish applicable approvals (WHO, 2018) [24]. Separate information will explain service participation and evaluation consent, including withdrawal arrangements. Declining optional evaluation will not remove access to otherwise available activities or care services.

### *5.2 Twelve-month phased implementation*

Implementation will proceed through four phases with progression gates. During Months 1–2, partners will finalise agreements, confirm resources, recruit participants and complete baseline assessments. The programme lead and site manager will resolve readiness problems; progression will require appropriate permissions, safe delivery arrangements and completed assessments for the initial cohort.

During Month 3, staff will complete training and competency assessment. Delivery responsibility will transfer only after sign-off, with unresolved learning needs addressed through supervised practice. This gate will establish delivery readiness rather than demonstrate programme effectiveness [22].

During Months 4–10, trained staff will provide supported sessions, maintain monitoring records and undertake follow-up assessments. Three-month and six-month reviews will be scheduled from each participant's activity start date, with baseline completed beforehand. Recruitment cut-offs will ensure six-month follow-up fits within the pilot; later entrants will have explicitly reported shorter observation periods.

During Months 11–12, the team will analyse findings, consult participants, revise materials and report results. Managers will maintain an issue log identifying responsible staff, deadlines and decisions. Fidelity monitoring will examine whether intended programme components were delivered throughout implementation as planned [22].

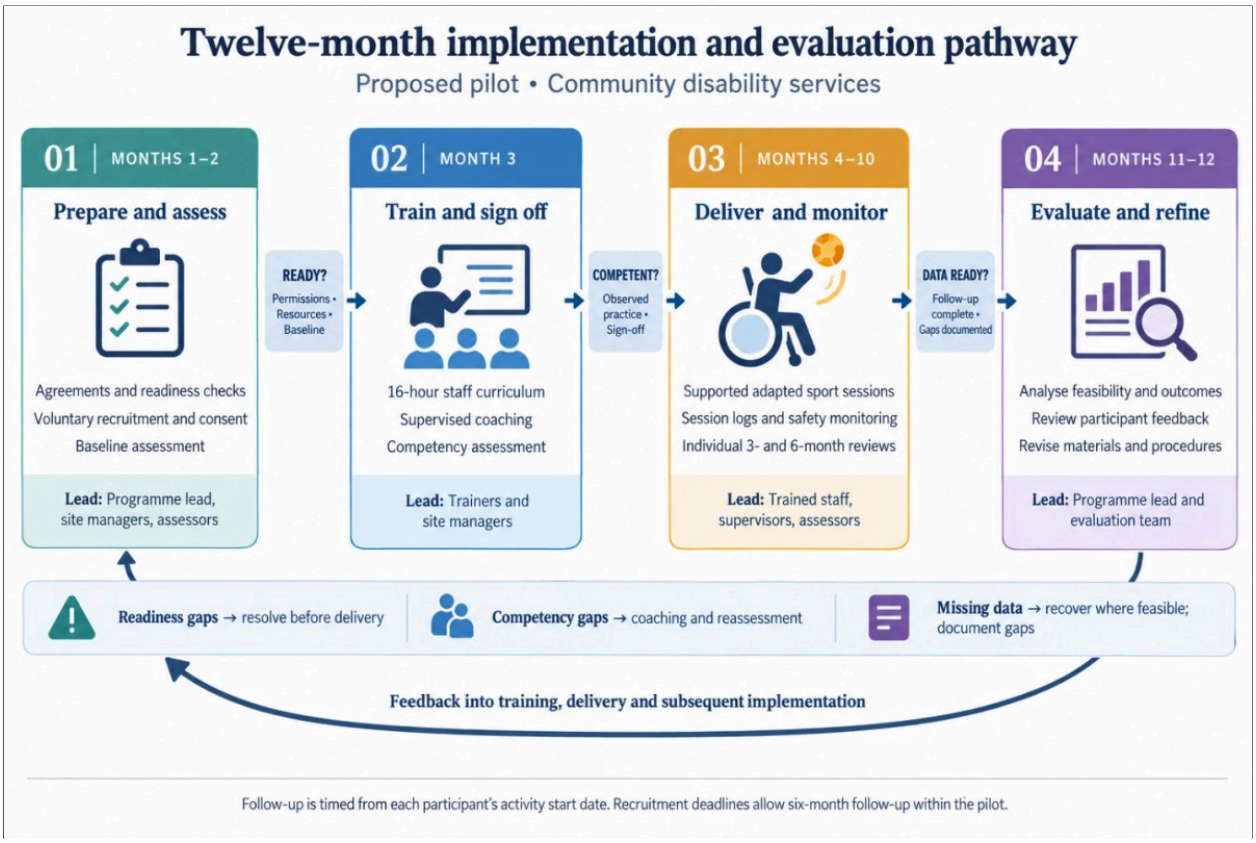



**Figure 2.** Twelve-month implementation and evaluation pathway.

### *5.3 Outcomes, instruments and assessment schedule*

#### *5.3.1 Participation, fitness and movement skills*

Staff will record attendance and activity minutes at every session, distinguishing active participation from total session duration. Adult aerobic assessment may use the Six-Minute Walk Test when appropriate [25]. Eligible younger participants may receive suitable Brockport assessments [26]. Children within the instrument's intended age range may receive TGMD-3 assessment (CDC, 2024) [27]; adults will use a documented skill checklist. Trained assessors will follow relevant protocols, record assistance and adaptations, and avoid interpreting modified scores against unsuitable norms at baseline and follow-up assessments.

#### *5.3.2 Individual goals, well-being and social participation*

Participants will select one to three meaningful goals, with achievement levels specified before delivery using goal attainment scaling principles (Carroll *et al.*, 2007) [28]. Accessible self-report will explore enjoyment, confidence and wellbeing, using a clearly specified instrument where suitable. Structured observation will supplement rather than silently replace self-report, with the source of each rating recorded. Staff will document community activities attended, opportunities declined and support required. Reviews will consider whether involvement reflects participant preference rather than simply increasing attendance or meeting organisational participation targets.

#### *5.3.3 Safety, staff capacity and delivery fidelity*

Staff will record incidents, injuries and responses during every session. Training records will show completion, competency sign-off and refresher needs. Fidelity checks will examine the proportion of ses



27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

sions meeting defined delivery criteria, including consent, appropriate adaptations and documentation. Implementation outcomes require distinction from clinical outcomes [22]. Supervisors will review findings regularly and agree corrective actions using supportive supervision approaches [21].

**Table 3.** Evaluation measures, collection responsibilities and assessment schedule

| Outcome domain | Measure | Collection method | Responsible person | Timing | Interpretation considerations |
|---|---|---|---|---|---|
| Participation | Attendance, active minutes and session exposure | Standardised session log | Delivering staff | Every session | Distinguish attendance from engagement; record shortened sessions |
| Adult aerobic fitness | Six-Minute Walk Test, where appropriate | Protocol-based assessment | Appropriately trained assessor | Baseline; three and six months after activity starts | Record assistance and deviations; consider suitability |
| Youth fitness | Selected Brockport measures | Manual-based assessment | Appropriately trained assessor | Baseline; three and six months | Select measures appropriate to age, ability and safety |
| Movement skills | TGMD-3 for eligible children; documented adult checklist | Individual assessment and observation | Trained assessor | Baseline; three and six months | Respect instrument age limits; distinguish standardised scores from local checklist results |
| Individual goals | Achievement of one to three agreed goals | Goal attainment scaling | Assessor with participant and chosen supporters | Baseline; three and six months | Define achievement levels beforehand and document permitted assistance |
| Well-being | Specified accessible self-report; supplementary observation | Supported questionnaire and structured observation | Trained assessor and support staff | Baseline; three and six months | Identify rating source; do not assume proxy ratings equal self-report |
| Social participation | Community opportunities offered, attended or declined | Participation log | Direct support professional | Monthly | Interpret attendance alongside preference, access and support |
| Safety | Incidents, injuries and responses | Session records and organisational reporting system | Delivering staff; manager oversight | Every session; regular review | Report severity and exposure; avoid treating absence of reports as proof of safety |
| Staff capacity | Training completion, sign-off and continuing delivery | Training register and observation checklist | Trainer and programme lead | Training completion; quarterly | Distinguish course attendance from demonstrated competence |
| Delivery fidelity | Sessions meeting specified essential criteria | Checklist, observation and record review | Supervisor | Sampled sessions; quarterly summary | Record justified adaptations separately from unplanned omissions |

### *5.4 Data management and analysis*

Evaluation records will use participant codes, with identifying keys stored separately. Approved secure systems will restrict access by role, and reports will use aggregated or appropriately anonymised information. Data protection planning will consider disclosure risks, consent commitments and safeguards before any sharing (Alebiosu, 2023) [29].

Descriptive analysis will summarise recruitment, attendance, retention, exposure and safety, reporting denominators and reasons for withdrawal. Exploratory analyses will examine within-participant changes from baseline, presenting estimates and uncertainty where feasible. Results will acknowledge differing abilities, goals and programme exposure.

Missing observations and their reasons will be reported rather than concealed. Test adaptations will be tracked, and incompatible measurements will not be combined indiscriminately. Interpretation will separate implementation feasibility from participant improvement [22]. Without a comparison group, observed changes cannot establish programme causation; maturation, concurrent services and measurement variation will remain plausible explanations requiring consideration in subsequent research.

### *5.5 Sustainability and wider adoption*

Continuation will depend on organisational ownership, sufficient resources and staff competence after specialist involvement decreases. Managers will review equipment, training, supervision and replacement staffing costs, alongside opportunities for community partnerships. Supportive supervision will remain necessary rather than ending at initial sign-off [21].

Expansion will require acceptable recruitment and retention, manageable delivery demands, documented safety and credible competency arrangements. These criteria concern feasibility and sustainability, not proof of effectiveness [22]. Proposed open resources and trainer networks will require evaluation of accessibility, uptake and delivery quality. Additional providers will adopt revised materials only after readiness checks and agreement on monitoring responsibilities. This implementation plan creates a route to evidence, while its design also limits what can responsibly be concluded about programme effects.

## 6. Discussion, limitations and future research

### *6.1 Potential contribution to community disability services*

The framework connects individual adaptation, workforce development and routine delivery within a single proposed service model. Its potential contribution lies in translating participation commitments into repeatable planning, coaching and review processes. Consistent routines may help staff organise sessions, while individual adapta



27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal for rules of use; OA articles are governed by the applicable Creative Commons License

tions preserve access and choice. These are plausible mechanisms, not demonstrated outcomes; complex intervention guidance requires attention to context, implementation and underlying programme theory [30].

Training existing staff could reduce dependence on external specialists, but this advantage depends on protected time, supervision and manageable responsibilities. Services must determine whether delivery fits alongside personal care and other commitments without displacing essential support. Evaluation should therefore examine staffing demands and acceptability alongside participant experiences.

Governance decisions must distinguish research from service improvement and establish appropriate permissions (WHO, 2018) [24]. Secure information handling will also require explicit responsibilities and safeguards (Alebiosu, 2023) [29]. Ultimately, the framework's value will depend on feasible delivery that expands meaningful opportunities rather than adding unsustainable tasks or prioritising organisational targets over preferences.

### *6.2 Methodological and practical limitations*

No outcome data are available, so claims about fitness, wellbeing or independence would be premature. The planned single-provider pilot will limit transferability across organisational cultures, staffing arrangements and participant populations. Its uncontrolled pre–post design cannot separate programme effects from concurrent services, maturation or measurement variation. Pilot research should address feasibility questions rather than substitute for definitive effectiveness evaluation [31].

Staff turnover and inconsistent delivery may reduce programme exposure. Assessors who also deliver sessions may introduce expectancy effects, particularly when rating engagement or goal attainment. Adapted standardised tests may improve access while weakening comparability with published norms; changes in assistance between assessments could also affect scores (Glasgow *et al.*, 2019) [32].

Proxy observations require careful interpretation. Research identifies differences between self-reported and proxy-rated quality of life among adults with intellectual disabilities (Skivington *et al.*, 2021) [33]. Other findings likewise caution against treating staff ratings as interchangeable with personal accounts (Eldridge *et al.*, 2016) [34]. Participants requiring extensive communication, mobility or behavioural support may face unequal recruitment or retention. The evaluation must therefore document who participates, who is excluded and whether support resources shape access.

### *6.3 Future research and programme refinement*

Research should begin with feasibility testing and participant-informed refinement before stronger comparative evaluation. Complex intervention guidance supports iterative development and examination of contextual influences [30]. Participants and chosen supporters should help review activities, communication materials, outcome relevance and burdens.

Subsequent studies should examine costs, maintenance of participation and trainer fidelity across sites. RE-AIM highlights reach, implementation and maintenance alongside effectiveness (Schmidt *et al.*, 2010) [35]. Longer follow-up will assess whether opportunities continue after specialist support decreases. Programme modifications should record what changed, why, when and by whom, drawing on adaptation-reporting principles (Koch *et al.*, 2015) [36]. Findings should guide revised training and delivery before wider adoption. The concluding section therefore brings together the practical proposal and the evidence needed to judge its value for community disability services responsibly (Wiltsey Stirman *et al.*, 2019) [37].

## 7. Conclusion

### *7.1 Framework summary and practical relevance*

Community disability services need practical ways to translate physical activity recommendations into accessible opportunities. The proposed framework addresses this delivery gap by linking individual assessment and adaptation with structured sessions, competency-based staff training and routine monitoring. Its design places dignity, safety, choice and meaningful participation at the centre of activity provision. Existing direct support professionals and community coaches will receive preparation to deliver sessions, recognise their professional boundaries and seek appropriate assistance. A train-the-trainer pathway is intended to develop local capacity while retaining supervision and accountability. Together, these components offer an organised approach to supporting diverse interests, abilities and goals within everyday service arrangements without making competition a compulsory destination.

### *7.2 Conditions for responsible adoption*

Effectiveness remains to be established through evaluation. Initial implementation should prioritise feasibility, fidelity, safety, sustainability and participant outcomes, with attention to unequal access and delivery burdens. Staged introduction, appropriate governance and competent supervision will allow problems to be identified before expansion. Participants should help assess acceptability and guide revisions to activities, communication and support. Wider adoption should follow evidence that services can deliver the programme responsibly and maintain provision. With these conditions, the framework may help build lasting opportunities for physical activity and community sport that reflect participants' own priorities.

## References


1. American Thoracic Society. ATS statement: guidelines for the six-minute walk test. Am J Respir Crit Care Med. 2002;166(1):111–7.
2. Carroll DD, Courtney-Long EA, Stevens AC, Sloan ML, Lullo C, Visser SN, *et al.* Vital signs: disability and physical activity—United States, 2009–2012. MMWR Morb Mortal Wkly Rep. 2014;63(18):407–13.
3. Centers for Disease Control and Prevention. Disability impacts all of us infographic. Atlanta: CDC; 2026.
4. Centers for Disease Control and Prevention. Physical activity for people with disability. Atlanta: CDC; 2025.
5. Centers for Disease Control and Prevention. Chronic conditions & disabilities activity. Atlanta: CDC; 2025.
6. Kiresuk TJ, Sherman RE. Goal attainment scaling: a general method for evaluating comprehensive community mental health programs. Community Ment Health J. 1968;4(6):443–53.
7. Office of Disease Prevention and Health Promotion. People with disabilities: Healthy People 2030. Washington (DC): US Department of Health and Human Services.
8. Piercy KL, Troiano RP, Ballard RM, Carlson SA, Fulton JE, Galuska DA, *et al.* The Physical Activity Guidelines for Americans. JAMA. 2018;320(19):2020–8.
9. Special Olympics Ireland. Atlantoaxial instability (AAI) information.
10. Special Olympics Maryland. Special Olympics US—Maryland athlete medical form. 2025.
11. Ulrich DA. Test of gross motor development–third edition: examiner's manual. Austin (TX): PRO-ED; 2019.
12. US Department of Education, Office for Civil Rights. Dear colleague letter: students with disabilities in extracurricular athletics—background and fast facts. Washington (DC): US Department of Education; 2013.
13. US Department of Health and Human Services. Physical activity guidelines for Americans. 2nd ed. Washington (DC): US Department of Health and Human Services; 2018.
14. Winnick JP, Short FX. Brockport physical fitness test manual: a health-related assessment for youngsters with disabilities. 2nd ed. Champaign (IL): Human Kinetics; 2014.
15. International Federation of Adapted Physical Activity. Definition.




27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License

16. International Federation of Adapted Physical Activity. What is APA [Internet].
17. United Nations. Convention on the rights of persons with disabilities [Internet]. New York: United Nations; 2006.
18. World Health Organization, United Nations Educational, Scientific and Cultural Organization, International Labour Organization, International Disability and Development Consortium. Management. In: Community-based rehabilitation: CBR guidelines [Internet]. Geneva: World Health Organization; 2010.
19. World Health Organization, United Nations Educational, Scientific and Cultural Organization, International Labour Organization, International Disability and Development Consortium. Recreation, leisure and sports. In: Community-based rehabilitation: CBR guidelines [Internet]. Geneva: World Health Organization; 2010.
20. World Health Organization, United Nations Children's Fund. Foundational helping skills training manual: a competency-based approach for training helpers to support adults [Internet]. Geneva: World Health Organization; 2025.
21. Special Olympics. Unified Sports [Internet].
22. Special Olympics Switzerland. Unified Sports: inclusion through sport [Internet].
23. American Speech-Language-Hearing Association. Augmentative and alternative communication [Internet]. Rockville (MD): ASHA.
24. World Health Organization. WHO guideline on health policy and system support to optimize community health worker programmes [Internet]. Geneva: World Health Organization; 2018.
25. Special Olympics. Athlete registration forms [Internet].
26. Centers for Disease Control and Prevention. Quality training standards [Internet]. Atlanta: CDC.
27. Centers for Disease Control and Prevention. Evaluate training: measuring effectiveness [Internet]. Atlanta: CDC; 2024.
28. Carroll C, Patterson M, Wood S, Booth A, Rick J, Balain S. A conceptual framework for implementation fidelity. Implement Sci. 2007;2:40.
29. Alebiosu O. Quantifying regulatory delay risk transmission across utility-scale renewable energy projects in hydrocarbon-dominant economies. Int J Hydropower Civ Eng. 2023;4(1):35-47.
30. US Department of Health and Human Services, Office for Human Research Protections. Quality improvement activities FAQs [Internet].
31. National Institutes of Health. Data sharing approaches [Internet]. Bethesda (MD): NIH.
32. Glasgow RE, Harden SM, Gaglio B, Rabin B, Smith ML, Porter GC, *et al.* RE-AIM planning and evaluation framework: adapting to new science and practice with a 20-year review. Front Public Health. 2019;7:64.
33. Skivington K, Matthews L, Simpson SA, Craig P, Baird J, Blazeby JM, *et al.* A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. BMJ. 2021;374:n2061.
34. Eldridge SM, Chan CL, Campbell MJ, Bond CM, Hopewell S, Thabane L, *et al.* CONSORT 2010 statement: extension to randomised pilot and feasibility trials. BMJ. 2016;355:i5239.
35. Schmidt S, Power M, Green A, Lucas-Carrasco R, Eser E, Dragomirecka E, *et al.* Self and proxy rating of quality of life in adults with intellectual disabilities: results from the DISQOL study. Res Dev Disabil. 2010;31(5):1015-26.
36. Koch AD, Vogel A, Becker T, Salize HJ, Voss E, Werner A, *et al.* Proxy and self-reported quality of life in adults with intellectual disabilities: impact of psychiatric symptoms, problem behaviour, psychotropic medication and unmet needs. Res Dev Disabil. 2015;45-46:136-46.
37. Wiltsey Stirman S, Baumann AA, Miller CJ. The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. Implement Sci. 2019;14:58.

**How to cite this article:** Owolabi O. A train-the-trainer framework for adapted sports and physical activity in community disability services. *International Journal of Intellectual Disability*. 2026;7(3):01-09. doi: https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952

27103897, 2026, 7(3), Downloaded from https://www.doi.org/10.22271/27103889.2026.v7.i3a.89952 by International Journal of Intellectual Disability on [04/11/2026]. See the Terms and Conditions (https://www.rehabilitationjournals.com/intellectual-disability-Journal) for rules of use; OA articles are governed by the applicable Creative Commons License