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Implementation of 30 minutes of daily physical activity in facilities for disabled children

Summary and recommendations

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No. 2022-088R

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No. 22-23 055A

April 2023

SUMMARY

[1] The IGAS-IGESR mission on the rollout of 30 minutes of daily physical activity (DPA) within facilities admitting disabled children set out to identify the conditions that ensure the effectiveness and sustainability of the approach. Indeed, while the stakeholders in the sector seem convinced of the benefits of increasing physical and sporting activity (PSA) within medical and social services and facilities (ESMS), the effective and generalised rollout of 30 minutes of DPA does not seem to be a given in a context where other priorities are prevailing: responding to recruitment difficulties and financial pressures, implementing the overhaul of the medical and social offering.

[2] Furthermore, while, as demonstrated by a survey produced in 2018 by the General Directorate of Social Cohesion and the Sports Directorate, PSA are already fully present within almost all facilities for children (94%), with practices that are often diversified and enriched by external partnerships (principally with the network of adapted sports and parasports federations), these activities do not currently reach all children within the facilities and they are far from being daily. According to the survey, 25% of the children and teenagers in facility practised PSA, and for a duration usually varying from 1 to 2 hours per week. The practice is significantly lower in facilities admitting children with multiple disabilities. It should also be noted that fewer than half of all facilities for children have a sports teacher or adapted PE teacher within their teams, although a number of them bring in qualified external staff.

[3] The "step" to cross in order to roll out the 30 minutes of DPA is therefore potentially too big for many facilities, particularly since PSA is perceived as one activity among numerous others. Rolling out DPA in ESMS requires firstly detailed individualisation according to the children's disability status, and also adjusting the individual and collective timetables of the children, evolving the practices of the educational teams to bring more physical activities into their support on a daily basis, establishing new partnerships in order to enhance the activities offering, and putting in place the logistical conditions for this daily practice (premises, equipment, etc.). The establishment of DPA cannot be taken for granted and will gain from being facilitated and supported within a dynamic supported at both national and territorial level.

[4] The two key ideas upheld by the mission to enable effective and sustainable rollout of the 30m of DPA are as follows:

- To bring the ESMS and the federations on board with the approach, DPA must be placed within a systemic and sustainable approach of promotion of PSA in the medical social support, in line with the Law of 2 March 2022 and beyond the expiry of the 2024 JOPs;
- To facilitate the rollout of PSA and inspire the field staff to commit to it, we need a flexible conception of DPA, adaptable to the diversity of disabilities and local contexts, and offering simple and easily accessible tools which foster its practice.

[5] Various priority actions recommended by the mission, in the short and medium term, arise from this:

- Develop DPA in ESMS over time according to three areas: the daily physical practice to be integrated into the everyday support, a practice of structured and diversified sporting activities carried out both internal and external to the facilities, and a more inclusive approach to sports through the collaboration of local athletes.
- Qualify the practices by reinforcing the presence of sports professionals within ESMS, as members in their own right of their multidisciplinary teams, and financially support this presence within the framework of a progressive increase in numbers.
- In the initial and continuing training of educational professionals, tackle DPA as a dimension of the medical and social support (with in particular the support of OPCO Health); further raise awareness among these professionals in the dimension of sports for health;
- Continue to develop a local parasports offering to enable ESMS to diversify the DPA practised, involving the specific federations and also the sports federations;
- Develop a "DPA in ESMS platform" to provide the field staff with facilitator tools, built jointly by practitioners and experts of the medical and social sector and of adapted physical activity (APA); the Disabled Sports expertise centre of the Ministry of Sport could coordinate these works.
- Visibly launch the rollout of 30 minutes of DPA nationally and regionally, organise awareness raising sessions at territorial level, provide for progressive rollout but publishing a desired target of generalisation so as to avoid dilution (for example mid-2025, to be negotiated with the federations of the medical and social sector).
- Support the applied research and experimentation in the field of PSA in ESMS and parasports.

[6] It is not easy to estimate the costs of 30 minutes of DPA: the field staff have not yet given this much thought; the parameters of the costing are difficult to model (lack of data on current practices, diversity of supervision needs depending on type of disability, unequal presence of sports professionals in the facilities, etc.). Furthermore, the costs depend on the ambition given to the 30 minutes of DPA, to be conceived either as an isolated measure put in place as part of an adjustment to the support practices, or as a lever to reinforce and qualify the DPA practices within the facilities. The mission therefore addressed the matter of costs through two costed scenarios in order of magnitude (for the HR impact):

- **A scenario of "routine DPA in educational practices" accompanied by targeted financial support for facilities with higher supervision needs.** This scenario works from the principle that DPA integrates everyday activities, with the same staffing levels, through an adjustment to practices and substitution of activities. However, the implementation of DPA with the same staffing levels seems a little unrealistic where the facilities admit children with significant disabilities seriously affecting their motor function and their autonomy (particularly in the case of multiple disabilities). An envelope of around €10m, to be made available by the ARS, would make it possible to fund targeted reinforcements of sports teachers or adapted PE teachers.
- **A scenario of "DPA: levers for structural reinforcement of PSA" which aims to develop a more qualified practice.** This scenario targets both support with the rollout of DPA but also

reinforcement of the structured PSA practised in and outside of the facility. It is based on a greater presence of sports teachers and adapted PE teachers in the facilities, funding their presence where they do not already exist (around half of all facilities for children). Depending on the number of FTE sports teachers that the State would be prepared to fund, such a scenario would correspond to an envelope of €30 to 50m to be implemented according to an increase in numbers which could be staggered over two years, in exchange for the commitment of the beneficiary facilities to draw up a formalised PSA project integrating DPA.

[7] Targeted equipment support could be given to facilities with the greatest need by the ARS (on non-renewable loans) and by the National Sports Agency (within the framework of partnerships with sports clubs and associations). More structurally, and in line with the Law of 2 March 2022 which makes reference thereto, the CPOMs would be better off taking PSA into account for the managing associations integrating it into their support practices ambitiously and in a structured manner.

[8] Lastly while, in compliance with the letter of engagement, the mission has focused on its works on DPA in facilities for children, it is convinced that there is a strong case for adults too. PSA is significantly less developed in facilities for adults and sports professional resources are much rarer within the teams. And yet it will be just as important to ensure the continuity of practice of PSA after these young people who have integrated it into their daily life become adults; furthermore, the benefits of the practice are at least as important for adults as for children. We should therefore ultimately be able to announce a target for increased PSA in these facilities too.