



Enhancing Educational Experience through Physical Therapy: A Case Study of Sweta with Cerebral Palsy

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Introduction:

Sweta, a 13-year-old student, faces significant challenges due to spastic cerebral palsy and multiple disabilities, including moderate to severe cognitive impairments and severely limited motor abilities. These disabilities have resulted in her age-equivalent performance of motor skills being less than 12 months. During Sweta's Individualized Education Program (IEP) meeting, her parents advocated for physical therapy interventions to prevent the dislocation of her hips, a common concern in individuals with cerebral palsy. Specifically, they requested 30-minute range of motion/stretching sessions three times per week.

The IEP team must carefully consider various factors when discussing the parents' request. Foremost among these factors is determining whether Sweta's hip stability limitations significantly impact her school performance or ability to participate in her educational program. The team should evaluate Sweta's goals and performance at school to assess the educational impact of her hip stability deficits. If Sweta's limitations are minor, do not affect curriculum access, have not progressed significantly, and do not predispose her to complications affecting her education, the team may conclude that addressing these issues is not educationally relevant. However, if Sweta's limitations severely interfere with school performance, such as difficulty with transfers, maintaining hip integrity may be deemed educationally relevant, prompting the team to incorporate interventions into her IEP. Evidence supporting intervention strategies for individuals like Sweta is increasing, emphasizing the importance of evidence-based practice in school-based interventions. For Sweta, a supported standing program is recommended to address her parents' concerns. Research suggests that a supported standing program, involving at least 60 minutes per day in 30 degrees of abduction, can be beneficial. However, ongoing research is necessary to advocate effectively for children like Sweta and make informed recommendations to educational personnel. In the implementation of a supported standing program, the physical therapist plays a crucial role. This includes involvement in selecting standing equipment, training staff for transfers and stander use, developing a compliance monitoring system, and monitoring and updating the program parameters based on Sweta's response. Factors such as the severity of hip involvement, osteopenia or osteoporosis risk, and behavioural concerns must be considered. Once support staff are trained and documentation completed, the physical therapist may not need to be present during Sweta's use of the supported standing device.

Case Description:

A 13-year-old student named Sweta has spastic cerebral palsy and multiple disabilities, including moderate to severe cognitive impairments and severely limited motor abilities. Her age-equivalent performance of motor skills is less than 12 months. While attending Sweta's IEP meeting, her parents asked for physical therapy for 30-minute range of motion/stretching sessions three times per week to prevent dislocation of her hips. • What factors should the IEP team consider when discussing the parents' request? The primary factor to be determined in consideration of the request is whether or not limitations in Sweta's hip stability impact her performance at school or her ability to participate in her educational program. Therefore, the IEP team should examine Sweta's goals and performance at school in an effort to examine the educational impact of Sweta's hip stability deficits. If Sweta's limitations are relatively minor, do not affect her ability to access her curriculum, have not progressed significantly, and do not predispose her to significant complications that could potentially impact her education, then the IEP team would likely conclude that addressing these issues would not be educationally relevant. If, however, the limitations are more severe and interfere with Sweta's school performance (e.g., inability to assist with transfers), then the maintenance of hip integrity may be deemed educationally relevant. In this case, the team would then progress through the IEP process and determine how the maintenance of hip stability can best be met in Sweta's school environment. • Is there evidence in the literature to support or refute this requested service? Evidence to support these intervention strategies is improving, and therapists must increasingly use the evidence to support their school-based interventions.

In Sweta's case, evidence is best for the use of a supported standing program in order to address her parents' concerns. A supported standing program consisting of at least 60 minutes per day in 30 degrees of abduction is recommended. Continued research is needed if we are to advocate appropriately for children and make effective recommendations to educational personnel. • What is the role of the physical therapist in the implementation of a supported standing program? The physical therapist may be involved with the selection of standing equipment, staff training for transfers and use of the stander,

developing a compliance monitoring system (e.g., chart to track time in stander and level of assistance needed), and for monitoring and updating the parameters of the standing program on the basis of student response. Issues to consider with the delegation and implementation of this program are the severity of the hip involvement and other risk factors that might include osteopenia or osteoporosis and behavioural concerns. Once the support staff has been trained and the training has been documented, the physical therapist should not need to be present when the student is using the supported standing device.

References:

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