Expanding Concussion Laws Not Necessary for Return to Learning After Concussion

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The concept of returning to learning (RTL) after a concussion is relatively new in the history of concussion management. McGrath, in 2010, was 1 of the first to publish the idea of providing for academic support to student athletes recovering from a concussion.[1] The American Academy of Pediatrics provided a framework for the concept of RTL to pediatricians through a clinical report published in 2013.[2] Since 2013, several research studies support an earlier return to school but also support the need for academic adjustments to be made for students recovering from concussions.[3,4]

Return to play laws regarding concussions, first passed in 2009 in the state of Washington in response to a devastating brain injury suffered by Zackery Lystedt in football, are present now in all 50 states. In this issue, Thompson et al[5] investigated the current state of RTL laws in the United States. Currently, 8 states have passed a law specifically addressing RTL for concussions. Thompson et al[5] concluded that there is "need for legislative action on the issue of RTL." Although increase in public awareness is an immediate benefit of new legislation, RTL legislation may not be sufficient.

In medical school and residency programs, there is limited to no teaching on the inner workings of schools. There are many conditions that pediatricians deal with that have significant implications in the school setting, such as attention deficit disorder, learning disabilities, autism, and diabetes, as well as concussions. With attention deficit disorder, for example, a physician may conduct an evaluation and receive input from teachers before prescribing medication and other treatment, but the day-to-day adjustments and accommodations are carried out by the school. This may include simple adjustments by a teacher or school nurse. Over time, more formalized plans may be required such as a 504 Plan or Individualized Education Plan. Schools have legal requirements to provide assistance to students who have demonstrated substantial educational need. Guidance is found under the Rehabilitation Act of 1973 (504 Plan), which is a civil rights law protecting students from discrimination or the Individuals with Disabilities Education Act, which provides special education and related services for qualified students. Both options require school-based documentation, evaluation, team input, and can take weeks to months to execute.

Because most concussion symptoms resolve within 3 weeks, the majority of concussion management takes place within general education. Protracted concussion recovery in some cases may require a 504 Plan. But the need for intensive specialized instruction found under the auspices of an Individualized Education Plan after a concussion would be rare.

Advocating for additional state legislation for RTL is potentially an unnecessary exercise as educational

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support frameworks currently exist to aid students with medical disabilities who rise to the level of more intensive intervention. There is no question that the need for education of school administrators, teachers, counselors, school mental health professionals, and school nurses is great concerning RTL.[6–8] However, the highest yield for training would be to educate general education teachers about concussions, specifically on how to make short-term academic adjustments in the general education classroom to impact the majority of students with concussions that resolve within 3 weeks. Programs in Colorado and Pennsylvania have been successful in this effort without the need for RTL specific legislation due to unique collaborations between respective state Departments of Education and Departments of Health or Human Services. Guidance from state departments of education to develop and implement RTL practices, offering authentic training opportunities for educators, and assistance in creating policies and procedures to pair with currently state legislated existing return to play policies may be a more effective intercession than legislating RTL.

Last, pediatricians need to be better equipped to understand the process of school culture and should encourage the school to implement academic supports quickly and fluidly, with input from the pediatrician regarding the medical diagnosis and related symptom presentation. Because a concussion is not an outwardly visible injury, on-going communication between student and teacher is essential. Pediatricians can ensure time is spent during office visits encouraging students to discuss their symptoms with their teachers. Without communication between the student and teacher, students may struggle, and teachers may not be aware until academic performance begins to suffer. Ensuring that school districts develop open communication plans with local pediatricians is also key to optimal interdisciplinary concussion management.

Promotion of RTL laws, which often do not have any significant consequences if not followed, may be futile. Although it is true that legislation comes with an increase in public awareness, for RTL, it may be more appropriate to use time and funding to enhance existing educational resources. We can empower educators to understand concussion nuances through quality training and provide a venue for pediatricians and schools to work together within the existing infrastructure to assist students who sustain concussions.

ABBREVIATION

RTL: returning to learning

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