HHS Public Access

Author manuscript

NeuroRehabilitation. Author manuscript; available in PMC 2023 October 04.

Published in final edited form as:

NeuroRehabilitation. 2023 ; 52(4): 597–604. doi:10.3233/NRE-220211.

Using guided credible history interviews to establish special education eligibility for students with traumatic brain injury

Melissa McCart[a,*], **Deanne Unruh**[a], **Doug Gomez**[a], **Daniel Anderson**[b], **Gerry Gioia**[c], **Susan C. Davies**[d], **Juliet Haarbauer-Krupa**[e], **Lindsay S. Womack**[e], **Sally Thigpen**[e], **Linda Brown**[f], **Ann Glang**[a]

[a]University of Oregon, Eugene, OR, USA

[b]ABL Schools, San Francisco, CA, USA

[c]Children's National Hospital, Washington, DC, USA

[d]University of Dayton, Dayton, OH, USA

[e]Centers for Disease Control and Prevention (CDC), Atlanta, GA, USA

[f]Oregon Department of Education, Salem, OR, USA

Abstract

BACKGROUND: In Oregon in 2019, only 261 students were eligible for special education under the traumatic brain injury (TBI) category. Many students with TBIs are not treated by a medical provider, so the requirement for a medical statement could prevent eligible youth from receiving special education services.

OBJECTIVE: This study investigated barriers to using a medical statement to establish special education eligibility for TBI, support for using a guided credible history interview (GCHI), and training needs around GCHI.

METHODS: A survey about special education eligibility for TBI was distributed to Oregon educators.

RESULTS: Among participants, 84% reported difficulty obtaining a medical statement for TBI eligibility determination, and 87% favored the GCHI as an alternative, though they reported a need for training in TBI and GCHI.

CONCLUSION: The results support the use of GCHI to establish special education eligibility for TBI and informed Oregon's addition of GCHI to TBI special education eligibility determination.

[*]Address for correspondence: Melissa McCart, Ed.D. University of Oregon, Eugene, OR, USA. mccart@uoregon.edu.

Declaration of interest

Melissa McCart and Ann Glang are the co-directors of the Center on Brain Injury Research and Training and receive funding from federal agencies (CDC, NIDLLR) and state contracts (WA, AK) to conduct research and provide services in the area of brain injury. Linda Brown is an employee of the Oregon Department of Education. All other authors have no interests to declare.

Supplementary material

The supplementary files are available from https://dx.doi.org/10.3233/NRE-220211.

Keywords

Brain injury; concussion; special education; medical statement; policy; school; services

1. Introduction and background

After a traumatic brain injury (TBI), children often experience deficits in cognition, behavior, attention, concentration, and executive functioning (Babikian et al., 2015; Levin & Hanten, 2005) that can affect school success. For some children, the effects on their academic achievement, behavior, and peer relations are immediate and profound. For other children, those effects emerge over time (Prasad et al., 2017) as their rate of learning slows.

Students with TBI who have academic or behavioral issues that adversely affect their educational performance can qualify for special education services under the Individuals with Disabilities Education Act (IDEA, 2004). Special education delivered by well-trained teachers and service providers can facilitate long-term improvements in academic achievement, behavior, and other areas of concern (Adams & Carnine, 2003; Archer & Hughes, 2011; Coyne et al., 2011; Forness, 2001; Hurwitz et al., 2020; Landrum et al., 2003; Vaughn & Linan-Thompson, 2003). However, students with TBI are significantly under-identified for special educational services (Dettmer et al., 2014; Gioia et al., 2015; Institute of Medicine and National Research Council, 2014). A recent analysis of 44 states found that on average, only 32% (range = 19–75%, median = 33%) of students with moderate–severe TBI across the country receive special education services under the TBI category (Nagele et al., 2019).

The raw data used by Nagele et al. (2019) show that the under-identification rate in Oregon is similar to the national average, with an estimated 42% of students with moderate–severe TBI identified for special education under the TBI category. That finding raised concerns among Oregon educators and the Oregon Department of Education that many students struggling after a TBI were not being appropriately identified.

There are multiple factors that may contribute to the under-identification issue (Glang et al., 2015). Multidisciplinary evaluation teams composed of the students' parents/guardians and professionals from different disciplines within a school setting work together to evaluate special education eligibility, develop Individual Education Plans (IEPs), and determine special education placements (Heward, 2009). These teams often struggle to identify students with TBI because of a lack of communication, information about TBI, lack of resources, an inefficient referral process and ineffective processes for determining eligibility (Canto et al., 2016; Glang et al., 2015). When neither parents nor school staff adequately understand TBI and its effects on a child's academic and social functioning, they are unlikely to pursue TBI as an eligibility category (Gfroerer et al., 2008). Only a few TBI experts are available in school systems to serve on multidisciplinary evaluation teams, and their rarity is compounded by the perception that educational planning for medically related disability categories such as TBI requires a high level of training and expertise (Bateman & Linden, 2012).

1.1. Medical Documentation of Injury

IDEA has 13 disability categories, each with its own set of eligibility criteria. The TBI category was added to IDEA in its 1990 reauthorization and is defined as:

> an acquired injury to the brain caused by an external physical force … that adversely affects a child's educational performance … [with] impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. ("20 U.S.C. Sec. 1401 [2004], 34 C.F.R. Sec. 300.8[c][12]),")

For students to be found eligible for TBI under IDEA, most states require medical documentation of a likely causative event (Nagele et al., 2019). A lack of official medical documentation for a TBI has emerged as a persistent barrier to students who need special education services under the TBI category (Green et al. 2018). Some children do not receive medical attention for their TBI, and others have family situations in which medical care is not clearly documented. But even in the absence of an official medical statement about a TBI, schools are legally required to evaluate eligibility in the area of suspected disability in a timely fashion ("Integrated Design & Elec. Acad. Pub. Charter Sch. v. McKinley, 570 F. Supp. 2d 28, 237 Ed. Law Rep. 194 (D.D.C. 2008)"). Given the difficulty in obtaining a medical statement, multidisciplinary evaluation teams sometimes refocus the evaluation to seek eligibility under a less accurate disability category. However, that can cause critical information about the TBI to be forgotten, minimized, or lost due to a lack of documentation, and that can cause real problems at times of transition, such as when a child moves from middle school to high school.

1.2. Credible history as an alternative to the medical statement

When a medical statement cannot be obtained, a guided credible history interview (GCHI) is an alternative way to determine eligibility under the TBI special education category. The requirements for the GCHI process are described in full in the Oregon Administrative Rules (OAR 581-015-2175). The GCHI is not a psychometrically validated instrument but a pre-determined set of interview questions that can help a school team verify that 1) a TBI occurred and 2) if the student's learning and/or behavior has been impaired since the injury. Using the GCHI process, the interviewer elicits information about a possible TBI from a reliable and credible source chosen by the multidisciplinary evaluation team. The person interviewed should have knowledge of the TBI event, such as a parent, grandparent, or guardian. The information collected in the GCHI is then used instead of medical documentation to establish a student's special education eligibility in TBI, which requires at least one reported incident and persistent symptoms related to it.

The GCHI interviewer should be familiar with the physical, cognitive, emotional, and behavioral effects of TBI, especially those that emerge over time, because the original injury might have gone undiagnosed. The symptoms of TBI often appear as ongoing, chronic physical conditions (e.g., headaches) or behaviors that look like learning problems, behavioral problems, emotional problems, social skill deficits, or executive functioning deficits. During the GCHI, the details of the reported incident should be described clearly

and consistently. If multiple injuries are reported, each injury should be well-detailed. The interviewer should establish clear changes between the child's functioning pre- and post-injury, for example: Are there changes in all areas or just some? Has there been skill regression since the injury? Has there been a change in the student's personality? Social skills? Executive functioning skills? Behavioral skills? IDEA mandates a comprehensive evaluation in the student's area of suspected disability, so the GCHI process alone cannot establish TBI eligibility, but it can add important support to other evaluation data and help validate the claim of TBI. If the multidisciplinary evaluation team determines that the interview data from the GCHI are credible then it can be used as an alternative to the medical statement requirement and the student can be found eligible for services under the category of TBI.

1.3. Purpose

This study investigated the (a) barriers to using a medical statement to establish special education eligibility for students with TBI, (b) support for using GCHI, and (c) the training needed to use the GCHI.

2. Methods

We surveyed Oregon school administrators, special and general education teachers, educational specialists, and school psychologists about the eligibility process for students with TBI. Survey items were developed by the research team with input from Oregon Department of Education staff, regional special education administrators, and educators from local school districts. The 8-item survey collected respondents' perspectives on the need for alternatives in establishing special education eligibility under TBI, GCHI content, and professional development needs for implementing GCHI (Supplement).

The Google survey was conducted via email between January and June 2019. The survey emails were sent by the Oregon Department of Education and the University of Oregon's Center on Brain Injury Research and Training (CBIRT) to superintendents, school administrators, special education directors, and school staff (teachers, nurses, speech language pathologists, school psychologists, special educators, etc.).

2.1. Respondents

A total of 126 school personnel responded, and their roles are reported in Table 1.

2.2. Data Analysis

Both quantitative and qualitative data were analyzed. The quantitative data (e.g., types of training needed, preferred training modality) are summarized using frequency counts and percentages. Qualitative data (e.g., challenges in accessing medical statements) were categorized by theme and interpreted in the context of a critical realist epistemology (Rohleder & Lyons, 2015) using a bottom-up inductive approach to data coding (Braun & Clarke, 2006).

3. Results

3.1. Difficulty obtaining a medical statement

Eighty-five percent (n = 108) of respondents reported that obtaining a medical statement about a student's TBI was difficult. As a school psychologist explained:

> "Often, we have solid information regarding a TBI but are unable to get required medical information, which can make it difficult to complete an eligibility. In short, we have everything we need except a physician's diagnosis."

A special education director agreed:

> "This has been a roadblock in providing appropriate services for children under … TBI."

Students from impoverished communities face additional difficulties, as described by a school psychologist.

> "I work in many low socioeconomic status schools, and it is often difficult … to obtain proper documentation despite a strong case for a TBI. For example, I recently had a case in which a parent had moved so many times and doctors had switched practices so frequently that it took many weeks of work to obtain a medical statement."

A speech and language therapy provider noted that some children do not have medical documentation of their injury because they never saw a medical provider:

> "Some families do not take their student to a medical professional following a suspected TBI or the injury occurred out of country, which makes getting a medical statement nearly impossible."

3.2. Credible history interview as a viable alternative

A significant percentage (87%) of respondents favored the use of GCHI over other methods (i.e., written statement, medical statement, or health assessment statement) for establishing special education eligibility. Many respondents (47%, n = 59) reported instances in which it was not possible to obtain medical documentation.

A school psychologist commented:

> "Since a definitive diagnosis is not a requirement for TBI identification, 'credible history' makes much more sense."

Another school psychologist noted that using GCHI would help when a young child was injured:

> "So many injuries happen early in a child's life, but the impact of the injury is not seen until a behavior is or is no longer developmentally appropriate. [GCHI] would allow us to correctly identify the variety of challenges that students with brain injury experience."

Several respondents, including this special education director, indicated that GCHI would help mitigate the challenges associated with establishing eligibility for special education services:

> "I believe allowing this process will help us to better identify and find eligible students who have brain impact from a number of incidents that may [not] have led to medical documentation for a variety of reasons."

3.4. Improved access to services

Respondents reported that using a CHGI would allow more students to be made eligible for special education services under TBI. A speech-language pathologist elaborated:

> "If there is a credible history, as often there is, and we can demonstrate that history in writing, it would allow the student access to services, which will help them receive special education support services that they desperately need. It would also help educators understand their students' limitations and needs."

3.5. Content of a guided credible history interview

Respondents indicated that the most critical elements of a GCHI were documented academic, social, and/or behavioral changes from pre- to post-injury. They also suggested that health and developmental history questions be used and that the interviewer ask about dates and descriptions of the injuries, including specific symptoms of the brain injury.

A special education service provider noted that getting details about health and daily living functioning would be important:

> "The interview should include questions about a child's developmental history, including any injury(s), accidents, especially falls; medical history: care, treatment, therapies; [and] current functioning, i.e., vision, hearing, intellectual, emotional and motor."

3.6. Professional development needs

Respondents indicated that educators looking to implement GCHI would require training in a variety of areas (Table 2). They requested training to better understand brain injury, techniques for implementing a GCHI, and strategies for serving students with TBI (Table 3). In-person professional development was the most preferred modality for training (Table 4), though websites such as CBIRT's were also deemed a potentially useful resource.

4. Discussion

The persistent challenges faced by multidisciplinary teams working to identify students under the TBI category continue to contribute to inadequate service delivery for these students. Most Oregon educators who completed this survey indicated that a key barrier to properly identifying students is the requirement for medical documentation of the injury. Nearly half the respondents indicated that they had been unable to obtain medical documentation for one or more students with known brain injuries. The GCHI is a promising

solution for this problem. Survey respondents suggested items to include in the interview and indicated the type of training required to implement it.

During the past two decades, researchers and clinicians have offered guidance on designing effective services for students with TBI (Arroyos-Jurado & Savage, 2008; Dettmer et al., 2014; Glang et al., 2004). Two key recommendations have been evidence-based identification practices and professional development for school personnel (Dettmer et al., 2014). These findings validate those recommendations and suggest an implementation approach.

Continuing to require medical documentation to establish eligibility for special education could sustain the persistent under-identification and education of children with TBI (Dettmer et al., 2014; Dettmer et al., 2007; Glang et al., 2006; Greene et al., 2018). Requiring a physician to attest that an injury is the source of a student's learning problems can be a problematic obstacle to establishing timely special education eligibility under TBI. Although school multidisciplinary teams often assign a child to another disability category with which they are more familiar (Glang et al., 2015), that is not best practice or legally correct and does not always ensure appropriate educational services for the student.

TBI is a unique health condition because it occurs unexpectedly, usually to a typically developing child, and parents might not seek care at the time of injury or understand the injury's long-term effects on school performance. Some children are seen by several medical specialists (e.g., emergency room doctors, pediatricians, specialty clinicians), and providers can be hesitant to sign the required medical statement (Arbogast et al., 2017). Furthermore, misidentification for the sake of expediency contributes to the persistent discrepancy between the incidence of TBI and the identification of children with TBI in the special education census (Glang et al., 2015). The high incidence of TBI in children demands further identification at school, where children spend most of their time.

As a result of this investigation, the Oregon Administrative Rule (OAR 581-0152175) was changed to allow a GCHI as an alternative to the medical statement when one cannot be obtained by a special education eligibility team. Additionally, a GCHI form was created and approved by the Oregon Department of Education, along with video-based training and a technical assistance manual for implementing the GCHI. In the year since the implementation of the GCHI process, the number of Oregon students identified under the TBI eligibility category has increased significantly. Prior to the implementation of the GCHI (in 2019), 261 students in Oregon were identified for special education services under the primary category of TBI. One year after implementation of the GCHI, TBI eligibilities increased to 314, a 20% increase (Oregon Department of Education Regional Managers Meeting, March 18, 2021).

4.1. Implications

Two states (Oregon and Colorado) now use the GCHI process to establish special education eligibility for students with TBI. Their experiences open a pathway for other states to improve the TBI eligibility determination process and improve their educational practices (e.g., teacher in-service training, interfacing with families) for students with TBI. A key

component of the GCHI process is that a school-based professional interview someone knowledgeable about the student and TBI event (OAR 581-015-2121). It is helpful to have a consistent, established school-based professional, such as a school psychologist, to conduct these interviews and serve as the point person for TBI referrals. Engaging parents as partners in the GCHI process strengthens the family–school partnership, which is critical because parents are the decision makers for all aspects of their child's well-being (Haarbauer-Krupa et al., 2017).

Although most states require a medical statement to establish special education eligibility for TBI, some states do not. For example, the Ohio Department of Education does not explicitly require a medical statement/diagnosis for TBI; however, many school districts in Ohio still require it because TBI is viewed as a medical condition, as opposed to an educationally related disability such as specific learning disability. School districts could use the GCHI process in the absence of state policy to establish special education eligibility more efficiently and consistently for students whose brain injury is significantly affecting their educational performance. In Oregon and Colorado, the GCHI is typically conducted by the school psychologist; however, training administrators and other specialists, such as a special education teacher or speech-language pathologist, could improve the multidisciplinary team's capacity to collect information when the school psychologist is unavailable. In addition to professional development for current practitioners, training can be provided in school psychology and special education graduate preparation programs to equip future school-based multidisciplinary team members. The more educational professionals who are informed and trained to use the GCHI when a medical statement cannot be obtained, the more potential there is to facilitate its use.

4.2. Limitations

This study has several limitations. The purpose of this survey was to assess state administrative rules and subsequent practitioner practice. One key limitation is that the structure of the survey might not meet rigorous psychometric standards; there was no prior evidence of construct validity or measurement variance across key demographic groups. However, the measure was also largely open-ended and designed to provide general feedback, rather than to gather precise estimates of a latent construct. Because the survey informed policy and practice changes in Oregon, this report provides important information for other states. Second, no response rate could be calculated due to the method of survey distribution. Also, because the sample was restricted to Oregon, the findings might not generalize to the broader field of education. Because this was a convenience sample, those who chose to participate might differ in meaningful ways from those who did not participate; for example, those already interested in TBI might have been more motivated to answer the survey than potential respondents with no knowledge or awareness of service needs among students with TBI. Third, the findings about the preferred modality for professional development should be reviewed with caution because these data were collected before the global COVID-19 pandemic. Most aspects of educational services shifted to remote delivery during the pandemic, so the preferences of school personnel for training might also have shifted in ways not reflected in our survey data.

5. Conclusion

This survey was conducted to learn about the experiences of Oregon educators with the TBI special education eligibility process, explore the use of a GCHI as an alternative to a medical statement of injury, and inform a potential change in Oregon administrative rules. Although TBI service delivery has improved in the thirty years since TBI became an eligibility category, challenges with establishing TBI eligibility remain. The findings of this survey provide support for the GCHI process, which was added as an option in Oregon through a change in the administrative rules. That change led to increased rates of eligibility and more appropriate services for students with TBI. The GCHI process could be considered in other states to address the significant, national under-identification of these students for special education services (Nagele et al. 2019). Further evaluation to standardize the GCHI process and establish its effects on the identification of students with TBI for special education could improve these processes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

The research team would like to acknowledge the Oregon Department of Education for their tireless efforts to remove barriers to obtaining services for students with traumatic brain injuries.

Funding

This study was supported by the Centers for Disease Control & Prevention (CDC), grant number RFA-CE-19-003, Evaluation of Return to School Programs for Traumatic Brain Injury. The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the CDC.

References

Arbogast KB, Curry AE, Metzger KB, Kessler RS, Bell JM, Haarbauer-Krupa J, Zonfrillo MR, Breiding MJ, & Master CL (2017). Improving primary care provider practices in youth concussion management. Clinical pediatrics, 56(9), 854–865. [PubMed: 28521519]

Archer AL, & Hughes CA (2011). Explicit instruction: Effective and efficient teaching Guilford Press.

Arroyos-Jurado E, & Savage TA (2008). Intervention Strategies for Serving Students With Traumatic Brain Injury [Article]. Intervention in School & Clinic, 43(4), 252–254.

Babikian T, Merkley T, Savage RC, Giza CC, & Levin H (2015). Chronic aspects of pediatric traumatic brain injury: Review of the literature [Article]. Journal of Neurotrauma, 32(23), 1849–1860. [PubMed: 26414654]

Bateman BD, & Linden MA (2012). Better IEPs: How to develop legally correct and educationally useful programs (5th ed.). Attainment.

Braun V, & Clarke V (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. 10.1191/1478088706qp063oa

Canto AI, Crisp MA, Larach H, & Blankenship AP (2016). Inclusion and students with traumatic brain injuries. In Obiakor FE & Bakken JP (Eds.), General and special education Inclusion in an age of change: Impact on students with disabilities (pp. 157–177). Emerald Group Publishing Limited.

Centers for Disease Control and Prevention. (2018). Report to Congress: The Management of Traumatic Brain Injury in Children National Center for Injury Prevention and Control; Division of Unintentional Injury Prevention. https://www.cdc.gov/traumaticbraininjury/pdf/reportstocongress/managementoftbiinchildren/TBI-ReporttoCongress-508.pdf

Coyne MD, Kame'enui EJ, & Carnine DW (2011). Effective teaching strategies that accommodate diverse learners (4th ed.). Pearson.

Dettmer J, Ettel D, Glang A, & McAvoy K (2014). Building statewide infrastructure for effective educational services for students with TBI: Promising practices and recommendations. The Journal of Head Trauma Rehabilitation, 29(3), 224–232 [PubMed: 23982791]

Dettmer JL, Daunhauer L, Detmar-Hanna D, Sample PL, & Wilkins LW (2007). Putting Brain Injury on the Radar: Exploratory Reliability and Validity Analyses of the Screening Tool for Identification of Acquired Brain Injury in School-Aged Children. Journal of Head Trauma Rehabilitation, 22(6), 339–349. [PubMed: 18025966]

Forness SR (2001). Special education and related services: What have we learned from meta-analysis? Exceptionality, 9(4), 185–197.

Gfroerer SD, Wade SL, & Wu M (2008). Parent perceptions of school-based support for students with traumatic brain injuries. Brain Injury, 22(9), 649–656. [PubMed: 18608201]

Glang A, Ettel D, Todis B, Gordon WA, Oswald JM, Vaughn SL, Connors SH, & Brown M (2015). Services and supports for students with traumatic brain injury: Survey of State Educational Agencies. Exceptionality, 23(4), 211–224. 10.1080/09362835.2014.986612

Glang A, Tyler J, Pearson S, Todis B, & Morvant M (2004). Improving educational services for students with TBI through statewide consulting teams [Article]. NeuroRehabilitation, 19(3), 219–231. [PubMed: 15502255]

Glang AP, Dise-Lewis JP, & Tyler JP (2006). Identification and Appropriate Service Delivery for Children Who Have TBI in Schools. [Abstract] Journal of Head Trauma Rehabilitation Highlights From the 2nd Federal TBI Interagency Conference. September/October, 21(5), 411–412. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=yrovfth&AN=00001199-200609000-00013

Greene D, Sample PL, Johns N, & Palmer M (2018). Readiness to recognize: A qualitative case study of educational identification of TBI. NeuroRehabilitation, 42(3), 277–288. 10.3233/nre-172382 [PubMed: 29660963]

Haarbauer-Krupa J, Ciccia A, Dodd J, Ettel D, Kurowski B, Lumba-Brown A, & Suskauer S (2017). Service delivery in the healthcare and educational systems for children following traumatic brain injury: Gaps in care. Journal of Head Trauma Rehabilitation 10.1097/htr.0000000000000287

Heward WL (2009). Exceptional Children: An Introduction to Special Education Upper Saddle River, New Jersey: Person Education.

Hurwitz S, Perry B, Cohen ED, & Skiba R (2020). Special education and individualized academic growth: A longitudinal assessment of outcomes for students with disabilities. American Educational Research Journal, 57(2), 576–611.

Individuals With Disability Act. 20 U.S.C. Sec. 1401 [2004], 34 C.F.R. Sec. 300.8[c][12])

Integrated Design & Elec. Acad. Pub. Charter Sch. v. McKinley, 570 F. Supp. 2d 28, 237 Ed. Law Rep 194 (D.D.C. 2008).

Landrum TJ, Tankersley M, & Kauffman JM (2003). What is special about special education for students with emotional or behavioral disorders? The Journal of Special Education, 37(3), 148–156.

Levin HS, & Hanten G (2005). Executive functions after traumatic brain injury in children. Pediatric Neurology, 33(2), 79–93. [PubMed: 15876523]

Nagele DA, Hooper SR, Hildebrant K, McCart M, Dettmer J, & Glang A (2019). Under-Identification of Students with Long Term Disability from Moderate to Severe TBI. Physical Disabilities: Education and Related Services, 38(1), 10–25.

Oregon Department of Education (n.d.). Traumatic brain injury information: OAR 581-015-2121 (Revised 3/21/2020). https://www.oregon.gov/ode/students-and-family/SpecialEducation/RegPrograms_BestPractice/Documents/tbioar.pdf

Prasad MR, Swank PR, & Ewing-Cobbs L (2017). Long-term school outcomes of children and adolescents with traumatic brain injury. The Journal of Head Trauma Rehabilitation, 32(1), E24–E32. 10.1097/htr.0000000000000218

Rohleder P, & Lyons AC (Eds.). (2015). Qualitative research in clinical and health psychology Palgrave Macmillan.

Vaughn S, & Linan-Thompson S (2003). What is special about special education for students with learning disabilities? The Journal of Special Education, 37(3), 140–147.

Table 1

Survey Respondent Demographics (N = 126)

Role	Frequency	% of Sample
Psychologist	55	43.6%
Special Educator	52	41.3%
Administrator	11	8.7%
Speech and Language Pathologist	5	4.0%
School Nurse	3	2.4%

Table 2

Areas of Training Needed to Conduct a Guided Credible History Interview

Area of Training Need	Frequency*	% of Sample
Acute symptoms of TBI	78	62%
Symptoms that develop over time	96	76%
Interviewing techniques	85	67%
Family impact of TBI	2	< 1%
Completing the eligibility statement	2	< 1%
None of these areas	2	< 1%

Note. $N = 126$.

*Frequencies are greater than *N* because respondents selected all items that applied.

Table 3

Areas of Training Needed to Develop an IEP Using Credible History

Areas of Training Need	Frequency*	% of Sample
Components of an evaluation	77	61%
Components of present level of performance	20	16%
Components of IFSP/IEP goals	42	33%
Components of accommodations	41	36%
Components of IFSP/IEP modifications	46	37%
Instructional techniques	59	47%
Other	2	< 1%
No area applicable	2	< 1%

Note. $N = 126$.

*Frequencies are greater than *N* because respondents selected all items that applied.

Table 4

Preferred Type of Training

Preferred Type of Training	Frequency*	Total %
In-person training	95	75%
Live webinars	43	33%
Pre-recorded webinars	62	49%
Informational websites	51	40%
All of the above	2	< 1%
No preferred type	2	< 1%
Other	2	< 1%

Note. $N = 126$.

*Frequencies are greater than *N* because respondents selected all items that applied.