

Special Education Services and Response to Intervention:

What, Why, and How?

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Recently there has been an ongoing, at times acrimonious, discussion about the newest incarnation of the federal law that mandates special services for children with disabilities. At the heart of the controversy is a relatively new evaluation model referred to as *Response to Intervention* (RTI). Advocates and stakeholders have been very vocal in their opinions, leaving those down on the frontlines puzzled and confused. Teachers in particular are feeling frustration over yet another, seemingly arbitrary change in the red tape of special education, about which no one has consulted them or even really bothered to explain.

Historically, teachers have felt, not unreasonably, a bit victimized by special education law. In 1975, they were told to step aside, that they were not skilled enough to teach children with special needs. Teachers were given a clear message that their role was to keep alert for disabled children and send them on to the experts. Over time, that message has transformed into something quite different; now they hear that they are evading their responsibility by pushing children onto the special education rolls. In addition, procedures for referrals have modified almost yearly; just when they understand the process, it changes.

The purpose of this paper is to examine the circumstances that led up to the conception of RTI, and why many people believe it is a significant but necessary change to special education law. In order to understand the rationale behind RTI, it must be examined in the context of the federal laws which necessitated its creation, beginning with Public Law 94-142 (also known as the *Education for Handicapped Act*, or EHA, passed in 1975), and its subsequent reauthorizations, the most recent of which is the *Individuals with Disabilities Education Improvement Act* of 2004, or IDEIA. For purposes of brevity in this paper, the original act and its descendants will be collectively referred to as IDEIA, unless an issue specific to one particular version is under discussion.

The Problem

Public Law 94-142, or the *Education of All Handicapped Children Act* (EHA, 1975), was originally passed in 1975. The explicit purpose of this statute was to establish the right of the special child to receive an appropriate education at public expense. Adjunctive to this purpose, the law spelled out what particular disabilities were covered and how each was to be individually documented per child. Since that time, it has been reauthorized (and retitled) four times. Now past its 30th birthday, its most recent version (2004) is entitled the *Individuals with Disabilities Education Improvement Act* (IDEIA, 2004).

Throughout its history, the majority of IDEIA's language has been dedicated to procedural safeguards. The reason for this is easy to understand; historically, children with special needs have been subjected to a host of abuses ranging from denial of education, to "warehousing" without assessment. Indeed, the procedural portion has always been the part that received the most scrutiny from the stakeholders.

The service categories specified in IDEIA are a peculiar hybrid of medical and academic notions. The terminology in the 1975 document was quite similar to that in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders II* (APA, 1968), but with an academic "spin."

Since then, very little has changed regarding categorization and evaluation. This is significant when one considers the growth in psychological and educational knowledge over the last 30 years. An appropriate comparison might be the classifications within the field of medicine, where diagnostic categories and methods are frequently reviewed and revised by panels of physician-experts informed by the latest research; these standards are intended to be living documents, constantly updated as research brings new knowledge to the table.

IDEIA, however, is a federal law, and therein lies both its strength and its weakness. A federal statute is indeed a powerful tool for holding schools accountable. Unfortunately, a law is by definition a fixed, constant yardstick by which actions may be measured. The only way to change one law is to pass another. IDEIA is most truly the proverbial "act of Congress."

As a result, the categorizations of service in IDEIA have remained essentially intact throughout its history. Autism has been given its own category, a few others have been added, and some language was changed as society became more sensitive to negative labels. Critics have been the most troubled, however, about the so-called "high-incidence" classifications of learning disabilities and mild mental retardation. These categories are the most conceptually controversial, and have the poorest diagnostic reliability, of all the IDEIA categories.

Mental Retardation

The evaluation criteria for mild mental retardation require significantly-below-average ability in cognitive and adaptive skills. These are typically measured by an IQ test and an adaptive behavior rating scale. A number of concerns present themselves. First, the tests used to measure these constructs are not nearly as absolute as the general public tends to believe. Most of us, accustomed

to definitive blood medical tests, CT scans, and x-rays, seldom question the validity of anything termed a “test.” Tests are considered absolute, final, and conclusive by most of the population. To further employ the medical comparison, Down Syndrome is diagnosed by genetic testing as well as physical indicators. A lab test can determine if the child carries the chromosomal aberration that causes the disorder. Barring malfunction of the lab equipment or the technicians performing the test, the results are very conclusive. The genetic disorder is either there, or it isn’t.

The problem here is that there is no absolute test which determines retardation. Like most psychological constructs, intelligence exists on a continuum, with severe retardation on one end, giftedness at the other. The point at which a low average IQ becomes mental retardation is strictly arbitrary, decided upon by professionals with expertise in this area. This is not an issue for everyone; for example, those individuals who are obviously very low functioning and need help even for self-care are likely to score well within the designated range.

However, determining who does and who doesn’t qualify is not easy when scores fall in the borderline range (about 65 to 75). One reason is that children will seldom score exactly the same on any given test from one day to the next, and most certainly not from one measure to the next, for example, a Stanford Binet IQ test and a Wechsler IQ test. The best case scenario is that their scores will fall within the same *range* of scores, probably within about 5 points each direction of the original score. Thus, an arbitrary cut-off of 70, for example, is likely to misidentify about half the children *whose initial score fell within a few points of the cut-off*. Even when one includes the required deficit in adaptive behavior, the problem is not entirely eliminated, for the very same reason: adaptive behavior is also measured on a continuum, and tests are subject to the same reliability issues.

This is not likely to affect the children who have moderate to severe retardation; as noted previously, their need for services is usually very evident, and even if their score is underestimated by as much as 10 points, it will still be low enough to allow them to receive services. However, for the children whose scores fall in the borderline range, service needs are not so clear-cut. One child with IQ and adaptive scores of 70-71 may require extensive help to succeed, while another child with the same scores may need only minimal modifications. But given the current model, it is entirely possible that the first child could be eliminated from services, while the second, higher-functioning child could be identified as eligible.

Other critics point out that children who are raised in an enriched environment will score higher on an IQ test (Bradley et al, 1993; Turkheimer, Haley, Waldron, D’Onofrio, & Gottesman, 2003). Thus, a child from an upper class family is likely to score higher than a peer with similar genetic endowment whose environment is more impoverished. As an additional complicating factor, interpretation of “retardation” is left up to each state, and so a child might qualify for services in one school, but cross the state line and no longer qualify. More than one school psychologist has been faced with the dilemma of how to inform parents that their child is no longer considered retarded.

A more global issue is that of the construct of intelligence. The categories in IDEIA were created in the mid-seventies, and based on prevalent beliefs of that time. Most IQ tests are based on the conceptualization that intelligence is an overall, global ability to acquire and employ knowledge. In the last decade or so, however, other theories have gained acceptance, such as Gardner's model of multiple intelligences (Gardner, 1983), and Goleman's theory of emotional intelligence (Goleman, 1997). Yet IDEIA remains unresponsive.

Learning Disabilities

A cognitive measure is also required for the learning disabilities categories, which are defined as, "...a disorder in 1 or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations." (IDEIA, 2004).

The evaluation criteria for the learning disability categories, while never explicitly mandated by federal law, has traditionally been something called the "aptitude-achievement discrepancy model." In this model, a measure of the child's cognitive skills, usually an IQ score, is compared to a measure of achievement in the area of concern. A discrepancy of 2 standard deviations (IQ > achievement) is considered significant, and barring a few rule-outs, a child with this discrepancy would be considered to have a learning disability.

The reliability issues of using IQ tests for mental retardation also apply to learning disabilities; children are not going to score exactly the same two days in a row on either the cognitive or the achievement measures. The fact that children from enriched environments will score higher on global measures of intelligence is also discriminatory in the learning disability categories, but in a reverse manner; a higher IQ score increases the likelihood of a severe discrepancy, thus *increasing* the probability of qualifying for services.

Concerns about the entire construct of learning disabilities abound among critics. Current research has failed to confirm the belief that there are children who are physically different in the wiring of their brains, who must be taught using different methods than their peers. While this construct is appealing to parents who seek conclusive answers for a child's problems, the fact remains that modern medical technology (CT scan, MRI, etc.) does not support this claim (Stanovich, 2005). There is no consistent pattern of brain differences among children labeled LD and those with similar learning problems who do not qualify for that category. In addition, studies using different teaching methodologies demonstrate that children who qualify for learning disability services respond to the same teaching strategies that are used with non-labeled children (Ysseldyke, 2005; Stanovich, 2005). Thus, the entire concept of learning disabilities as a diagnostic category is highly questionable.

Response to Intervention

The most recent version of IDEIA attempts to address some of these concerns for the first time in its history through the use of Response to Intervention (RTI). While IDEIA does not mandate the use of RTI, it prohibits any state from requiring the use of the discrepancy model, and specifically allows RTI as an appropriate means of evaluation (IDEIA, 2004). The purpose of RTI is to establish

whether the child is merely in need of more intensive instruction, or truly requires the very specialized program only available through IDEIA identification.

RTI was first proposed by Gresham (2002) as a viable alternative to the discrepancy model. In the RTI model, children with learning problems receive individualized, highly structured, research-based interventions designed to remediate their deficiencies. Progress data is collected frequently, graphed, and compared to baseline; the intervention may be adjusted appropriately in response to the data.

Norm-referenced, standardized tests are not suitable for progress monitoring. They are designed to tell us where a child's performance falls in comparison to a national sample of peers. When one needs to know how much a child deviates from her peers, norm-referenced tests are appropriate and provide us with good information. They are not designed to measure small gains across time; the samples of individual skills are not large enough to obtain a reliable measure of any particular competency. Progress can only be monitored through direct measurement of a skill; for example, a child who is a poor reader may be assessed through frequent measures of reading fluency, i.e., correct words per minute. A child with difficulties in math may be monitored by determining the percentage of correct digits in his response to samples of math problems.

After several data points have been accumulated, a trend line is created on the graph; its trajectory is compared to a pre-established goal line. The intervention is adjusted if necessary. If the trend line shows that at the current rate of responding, the child will meet the goal as planned, the intervention is continued. If, after several valid attempts at intervening have resulted in minimal or no progress toward the goal, the child may be deemed *unresponsive to intervention*. This would form the basis for service in the appropriate learning disability category.

The Players

Proponents of RTI believe it to be a more reliable, sensible way of identifying children for services. The omission of an IQ score makes the procedure less discriminatory across diverse populations, and is of little use in treatment planning anyway. Direct methods of assessing academic skills allows us to better identify those who truly need services. Critics of the RTI approach tend to be traditionalists, those who are very comfortable with conventional methods of diagnosis. They argue that the information provided by an IQ test is very important in developing an understanding of how a child learns, and thus is essential for developing a treatment plan (Hale, Naglieri, Kaufman, & Kavale, 2004; Reschly, 2004). Besides, they say, research is on the cusp of important breakthroughs, which will indisputably prove the existence of learning disabilities.

It is difficult not to suspect that some of these criticisms are rather self-serving. Some of the most vocal critics are people who have a financial investment in the sale of these tests. People who have strongly defined themselves as administrators and interpreters of IQ tests may feel very threatened; some have functioned in that capacity almost to the exclusion of every other role, and have lost any sense of efficacy in using other skills. Psychologists who have not kept current through professional development may well lack the consultation skills and behavioral knowledge

necessary for effective intervention design. They have a valid fear that as the need for IQ testing is diminished, the need for someone to administer those tests will likewise dwindle.

Because RTI is so new, there is a lack of training and information which leads to unnecessary apprehension among stakeholders. Some teachers, wearied by years of revolving changes in special education procedures, may fear that the intervention aspect will require more work on their part. Others suspect that RTI is just a tactic to delay giving services to children. Administrators may worry that RTI will open the floodgates, allowing excessive placements in the LD categories. They may also be reluctant to leave the “safety” of the discrepancy formula model: decisions were made very cut-and-dried through a mathematical computation, taking the responsibility off the shoulders of committee members.

What now?

In the short term, it is important that training be made available to all service providers, administrators, and adjunctive personnel. Administrators need to understand that RTI does not lead to wholesale placement of all referrals (Tilly, 2003). Psychologists who have little training in intensive intervention techniques will indeed be less valued if they do not swiftly acquire some of these skills.

Teachers in particular should not be left out of the training loop. They will continue to feel victimized and be reluctant participants unless they are given plenty of structured training and concrete support from special personnel. Opportunities to learn about the purpose of RTI as well as data-collection methods will give them the tools they need to cope with yet another change in procedures. We must *empower them*, not reproach them, if we want this latest revision of IDEIA to lead to any meaningful improvements for our children.

References

- American Psychiatric Association (1968). *Diagnostic and statistical manual of mental disorders*. American Psychiatric Publishing: Washington, DC
- Bradley, R., Whiteside, L., Caldwell, B., Casey, P., Kelleher, K., Pope, S., et al. (1993). Maternal IQ, the Home Environment, and Child IQ in Low Birthweight, Premature Children *International Journal of Behavioral Development*, 16, 61-74.
- Education for All Handicapped Children Act. (1975). Public Law 94-142. Retrieved November 4, 2006, from <http://users.rcn.com/peregrin.enteract/add/94-142.txt>
- Gardner, H. (1983). *Frames of mind: The theory of multiple intelligences*. New York: Basic Books
- Goleman, D. (1997). *Emotional intelligence: Why it can matter more than IQ*. Bantam: NY
- Gresham, F. M. (2002). Responsiveness to intervention: An alternative approach to the identification of learning disabilities. In R. Bradley, L. Danielson, & D. P. Hallahan (Eds.), *Identification of learning disabilities: Response to treatment* (pp. 467-519). Mahwah, NJ: Erlbaum.
- Hale, J.B., Naglieri, J.A., Kaufman, A.S., & Kavale, K.A., (2004). Specific learning disability classification in the new Individuals with Disabilities Education Act: The danger of good ideas. *The School Psychologist*, 58, 6-13.
- Individuals with Disabilities Education Improvement Act. (2004). Public Law 108-446 (20 U.S.C. 1400 *et seq.*). Retrieved November 4, 2006, from: <http://edworkforce.house.gov/issues/108th/education/idea/conferencereport/confrept.htm>
- Reschly, D. (2004). Commentary: Paradigm shift, outcomes criteria, and behavioral interventions: Foundations for the future of school psychology. *School Psychology Review*, 33, 408-416.
- Stanovich, K. (2005). The future of a mistake: Will discrepancy measurement continue to make the learning disabilities field a pseudoscience? *Learning Disability Quarterly*, 28, 103-105.
- Tilly, D. (2003, December). *Heartland Area Education Agency's evolution from four to three tiers: Our journey - our results*. Paper presented at the National Research Center on Learning Disabilities Responsiveness-to-Intervention Symposium, Kansas City, MO
- Turkheimer, E., Haley, A., Waldron, M., D'Onofrio, B., & Gottesman, I. (2003). Socioeconomic status modifies heritability of IQ in young children. *Psychological Science*, 14, 623.
- Ysseldyke, J. (2005). Assessment and decision making for students with learning disabilities: What if this is as good as it gets? *Learning Disability Quarterly*, 28, 125-128.