Implementing RTI for Early Intervention and Disability Identification

by Douglas Fuchs and Lynn S. Fuchs

When the Individuals with Disabilities Education and Improvement Act was revised, the law changed in at least one important respect. Whereas practitioners were previously encouraged to use IQ achievement to identify children with learning disabilities (LD), they now may use Response to Intervention (RTI), a tool used to provide early interventions for students.

RTI has implications for the number and type of children identified; the kinds of educational services provided; and who delivers them. Yet, much still needs to be understood to ensure that RTI will promote effective early intervention and represent a valid means of LD identification.

Six RTI Dimensions and Implementation Recommendations

To implement RTI, schools must make decisions about six major procedural features:

1. How many tiers of instruction? The first dimension of RTI requiring specification is the number of its intervention tiers, or levels. General education, or the “regular” classroom, is considered by virtually everyone as the first RTI tier. After the first tier, RTI frameworks can include any number of additional tiers prior to special education. Some RTI frameworks incorporate the general classroom and only a second tier of preventive intervention that is more intensive than the instruction in the first tier, but less intensive than special education. Students must show poor progress in both the general classroom and at this second tier before special education is considered. Other RTI approaches incorporate two or more tiers of increasingly intensive instruction that separate the general classroom and special education.

Recommendation: Schools should employ three tiers: the first two conducted by general educators and the third conceptualized as special education managed by special educators. It is difficult to design more than one tier of relatively intensive, preventive instruction that can be reliably distinguished in format and substance from instruction provided in the general classroom and special education. A second tier of instruction, we believe, should be conceptualized and implemented so that a student’s responsiveness at that level signals the likelihood that, upon his or her return to the classroom, the student will benefit from instruction there. Unresponsiveness at tier 2 should indicate a need of the most intensive instruction—special education. The second tier’s format, nature, and intensity should permit general educators, including support staff such as reading teachers, speech clinicians, or school psychologists, to implement it with fidelity and effectiveness without extensive training and ongoing support.

2. How are students screened for preventive intervention? Some RTI frameworks employ one-time universal screening during which all children in a school are assessed on a brief measure at the beginning of the school year. Students who score below a norm-referenced cut-point or below a performance benchmark associated with poor long-term outcome enter preventive intervention.

In other RTI versions, universal screening is conducted to identify a subset of at-risk students whose response to tier 1 general education is then monitored for a relatively

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**RTI and Special Education: Working Together for Common Goals**

Although the use of Response to Intervention (RTI) is not a requirement, the 2004 reauthorization of the Individuals with Disabilities in Education Act (IDEA) identifies it as a general education function that states may choose to adopt to determine eligibility for specialized services for students with specific learning disabilities (SLD). The recently released regulations allow states to use RTI to determine SLD eligibility, but do not
short five- to eight-week period to test or explore the risk status of those identified by the universal screening. In this version of RTI, only the subset of students who both perform below the universal screening cut-point and demonstrate poor rates of improvement over a period of tier 1 instruction in the general classroom are deemed in need of preventive (tier 2) intervention.

Recommendation: Schools should use universal screening in combination with at least five weeks of once-per-week progress monitoring during general classroom instruction. A one-time universal screening at the beginning of the year can over-identify students who require tier 2 instruction. Identifying students for tier 2 instruction with only one-time screening means schools may be pressed to deliver costly preventive intervention to a large number of students who do not need those services, thereby watering down the nature of preventive intervention for those who truly need it. By contrast, our research at the National Research Center on Learning Disabilities (Compton et al. 2006) shows that five weeks of weekly progress monitoring can reduce or even eliminate the provision of tier 2 instruction to children who appear at risk but are not.

3. What is the nature of preventive intervention? There are two prominent models of preventive intervention at tier 2: problem-solving and standard treatment protocol. To date, most practitioners conducting RTI use a problem-solving approach to intervention. Researchers, by contrast, favor the use of a standard treatment protocol.

The problem-solving process works like this:

1. Determine the magnitude of the problem and analyze its causes;
2. Design a goal-directed intervention and conduct it as planned;
3. Monitor student progress and modify the intervention as needed based on student responsiveness; and
4. Evaluate its effectiveness and plot future actions.

Throughout this problem-solving process, “data about a student’s responsiveness to intervention becomes the driving force” (Grimes 2002). It is the student’s relative classroom performance, rather than test performance, that determines responsiveness and eventually special education eligibility.

The problem-solving approach’s popularity among practitioners is no doubt due in part to its idiopathic nature: For each child, an effort is made to personalize assessment and intervention. But this individualized approach is a potential weakness as well as strength. The problem-solving approach presupposes considerable expertise among practitioners in assessment and intervention.
Whereas the problem-solving approach differs from child to child, a standard treatment protocol is standard. Implementation usually involves a fixed-duration instructional trial delivered in small groups or individually.

**Recommendation:** A standard treatment protocol is used for children with academic difficulties and a problem-solving approach for students with obvious behavioral problems. Standard treatment protocols can be highly effective for academic deficits, especially for reading problems in the primary grades.

With a standard treatment protocol, the nature of the preventive intervention is public, clear, and represents instruction that benefits most students. By contrast, when a problem-solving approach is applied to remedy reading or math difficulties, there is:

- Greater responsibility on the RTI system to maintain records about the design of a student’s preventive intervention;
- More parental responsibility to judge whether an individually tailored preventive intervention is viable; and
- A weaker basis for presuming that inadequate response eliminates poor instruction as its cause.

For these reasons, there is the possibility that problem-solving may morph into something that resembles prereferral intervention, whereby schools rely on idiosyncratic and watered-down interventions, such as moving seats or adding homework, to address serious academic difficulties.

4. **How is nonresponsiveness defined?** Problem-solving and standard protocol approaches promote a different implicit meaning of nonresponsiveness. The standard protocol may be considered a relatively rigorous test for nonresponsiveness and disability. Nonresponders appear much more likely to have a learning disability. The standard protocol seems to facilitate the identification of “true positives,” or children truly in need of special services.

Problem-solving, with its typically less intensive and less systematic instruction, seems less likely than the standard protocol approach to identify false negatives and more likely to identify false positives, or children who appear nonresponsive and disabled but, with more intensive instruction, can demonstrate they are neither. Which raises the following question for practitioners and policy-makers: Is it more desirable to err by identifying more false negatives (standard protocol) or by identifying more false positives (problem solving)?

Regardless of which RTI approach is adopted, two components of the assessment process must be specified:

1. Methods must be determined for measuring students’ responsiveness to instruction; and
2. A criterion must be applied for defining nonresponsiveness.

Various methods are available for specifying these two assessment components. One method establishes a cut-point for responsiveness and then has staff rank-order slopes representing children’s growth in responsiveness to tutoring, perform a median split on the slopes, and designate the bottom half as nonresponsive. Another method evaluates student performance at the end of the intervention, designating nonresponsiveness as failing to achieve so-called normalized status.

**Recommendation:** Dual discrepancy should be used to designate nonresponsiveness. The use of both slope of improvement and final level of performance supports a nonresponsive classification only when a student fails to make adequate growth and completes the intervention below the normalized or benchmark criterion. Additional research is required to determine how alternative methods perform for classifying learning disabilities within an RTI framework.

5. **What is the nature of the multidisciplinary evaluation?** A contentious debate concerns whether and how to design the multidisciplinary evaluation required for special education
placement. In some schools, there is no multidisciplinary evaluation. In others, practitioners use RTI as part of a comprehensive multidisciplinary evaluation that includes a standard battery of assessments administered to all students. In yet other school districts, multidisciplinary evaluations focus on only questions that arise during a student’s participation in tiers 1 and 2. Another way in which multidisciplinary evaluations differ is whether they attempt to distinguish among the disabilities responsible for the student’s nonresponsiveness.

**Recommendation:** An abbreviated multidisciplinary evaluation should be designed for use with RTI, specifically to answer questions that arise during instruction at tiers 1 and 2. This evaluation should include a process for distinguishing among the various high-incidence disabilities. A specifically tailored, abbreviated multidisciplinary evaluation is more efficient than a traditional evaluation. It is more likely to provide distinctions among the high-incidence disability categories that may prove helpful to special educators when deciding on grouping arrangements and determining an appropriate pace and explicitness of the instruction.

6. **What is the role of special education?** Most discussions about RTI focus on strengthening general education and rarely mention special education, except as a final outcome to be avoided. This is unfortunate because special education in many districts is as much in need of strengthening, or reform, as is general education, and because the relatively small subset of students who prove chronically nonresponsive to the tiers of preventive intervention deserve a revitalized tier of special education to address their serious and unique learning disabilities.

**Recommendation:** RTI should be configured to incorporate special education as an important third tier that delivers the most intensive, data-driven, and iterative (inductively constructed) instructional programs designed to address individual learning needs. This reformed special education would be accountable and flexible, permitting students to move in and out as their needs change in relation to the demands of the general education curriculum.

**References**


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**On the Same Page**

Here are suggested questions related to this article that principals and teachers can use to spark discussion about how to apply the points made in this article to their particular schools.

1. What are some common attributes associated with implementing RTI?
2. To what extent does our school provide additional tiers of instruction prior to referring students for special education services?

3. What is our process for identifying students who might benefit from a second tier of instruction other than what is provided by special education services?

4. What are the advantages of using a standard treatment protocol for students with academic difficulties rather than using a problem-solving protocol?

5. What are some of the formative assessments teachers in our school use to a) monitor student progress on the benchmarks, and b) design instructional interventions?

6. In what ways might we improve special education services as an important third tier to address individual disabilities?

—Created by Stephen Gould, a consultant and leadership coach with 20 years experience as an elementary school principal.