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Application of the RtI Model in Learning Disability Diagnosis: Perceptions of Current Practices by New Jersey Special Education Administrators

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Abstract

This paper examines current practices in implementing a Response to Intervention (RtI) in diagnosing specific learning disabilities. The use of the aptitude achievement discrepancy model, RtI model or a combination is reviewed. A survey of special education administrators in New Jersey compares methods of identification and consistency of application across districts. Findings indicate that few districts are currently implementing RtI along with the discrepancy model in determining eligibility with a specific learning disability. No district is using RtI as the sole determinant for this classification category. RtI models differ across districts with no consistency in interventions or screening tools.

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The reauthorization of the Individual with Disabilities Education Act in 2004 (IDEA) has raised questions regarding identification of students with a specific learning disability. While the definition remains relatively the same, IDEA 2004 includes using a Response to Intervention (RtI) in its diagnostic criteria for a Specific Learning Disability (IDEA, 2004). IDEA allows states to choose between the intelligence - achievement discrepancy diagnostic method and response to research based interventions model for eligibility under the classification category of specific learning disability (SLD). This ability to choose will allow for differing diagnostic practices, prevalence rates, and symptom constellations across geographic locations (Brueggermann, Kamphaus, & Dombrowski, 2006). The problem of identification has been ongoing with critics of the discrepancy model referring to it as the wait to fail model (Fuchs & Fuchs, 2007). Critics of RtI state that it cannot identify the basic psychological processes addressed in the SLD definition (Kavale et.al, 2008). A question that arises is whether the use of RtI in identification of a specific learning disability, with or without the use of a discrepancy model, will yield more consistent results.

In addition, IDEA does not provide guidelines for incorporating RtI as a method for diagnosing eligibility for special education services, under the category of specific learning disability. Fuchs and Fuchs (2007)

suggest that there are six components for which schools must make decisions regarding implementation of the RtI process.

School districts must determine: “how many tiers of intervention to use; how to target students for preventative intervention, the nature of that preventative intervention, how to classify response, the nature of the multidisciplinary evaluation prior to special education and the function and design of special education” (Fuchs & Fuchs, 2007). With this many options, critics challenge the validity of a diagnosis of a specific learning disability based on RtI. Special education articles and court rulings have served to confuse rather than clarify the role of RtI in diagnosing a SLD (Zirkel, 2011). Universal screening, progress monitoring, scientifically based instruction and interventions are identifiable components of RtI. What is not clear is how extensively they are implemented (Fuchs, 2012). Many professionals have indicated that there is too much variability among and within the RtI models for it to provide a reliable indication of a learning disability (McKenzie, 2009). RtI has too many problems for it to be the sole mechanism for identifying a SLD. There are many reasons why a child might not respond to an intervention besides SLD (Hale et. al., 2010). “The RtI model can provide useful information . . . it cannot be used as the sole basis for determining whether a student has learning disabilities” (NJCLD, 2011).

This study focuses on the actual application of the RtI model among New Jersey school districts. Examination of its use in the prereferral process and actual application in eligibility considerations was conducted. Administrators, of special education programs in New Jersey, were surveyed to determine the components of RtI in their respective districts, the extent to which RtI data is used to determine eligibility for special education services – specific learning disability, and the training received by the decision makers in the identification process. Comparisons were made among responding districts to examine consistency of implementation of the RtI model and its use as a diagnostic tool. The potential of use of the RtI model to improve consistency in diagnosis of a specific learning disability is also discussed.

Method

The purpose of the study was to examine the actual implementation of the RtI model in New Jersey school districts. Whether or not the district has developed a model, the design of the model, consistency of the model design among districts, and its use in determining eligibility was explored.

Participants were randomly selected from the list of Special Education Administrators provided on the New Jersey Department of Education website. Survey instruments were mailed both electronically and in paper form. Sixteen New Jersey special education administrators representing 16 different districts responded to the survey. The respondents represent elementary districts, secondary districts, and districts that have both elementary and secondary schools. Respondents represented districts with student populations ranging from 250 to 17,000.

Data analysis was performed using Microsoft Office Excel 2007. Districts that reported no RtI model did not complete subsequent questions regarding its implementation in the district. Results reported regarding implementation reflect the percentage of those districts that responded to the questions.

Results

Discrepancy Model

Of the responding districts, 86% use the discrepancy model either solely or as part of the process to determine eligibility as a student with a Specific Learning Disability. Most districts, 63% use 1.5 standard deviations (SD) as the criteria to determine eligibility in that classification category. Twenty five percent use less of a discrepancy (1 SD) while 12% are more stringent using a 2 or 2.5 SD discrepancy to determine eligibility.

RtI Models

Survey results indicate that 69% of the reporting districts have developed and use an RtI model. However, only approximately one third indicated the development of written guidelines to define its implementation.

Supervision of the implementation of RtI falls outside of the Special Services department in 92% of districts. One respondent commented, “RtI is a general education responsibility not special education, yet general educators know little to nothing about it.”

The purpose of the RtI model differs across districts. Most (60%) districts use the RtI model to provide scientifically based interventions for academically at risk students and assist in determining eligibility for special education services. Approximately half of the districts specified using RtI data in determining eligibility for classification with a specific learning disability. However, none of the reporting districts indicated that it was used as the only means to determine eligibility with a SLD without Child Study Team (CST) assessment. One special education administrator suggested, “It is unclear what (instructional strategies) truly constitutes ‘research based’ and what will hold up in court.”

Most districts (57%) indicated that they used a three tier RtI model. Approximately one quarter (29%) reported a four tier model. Districts reported a variety of instruments used for universal screenings. Dynamic Indicators of Basic Early Literacy Skills (DIBELS) was reported to be used by most reporting districts. Other instruments reported were Diagnostic Reading Assessment (DRA), portfolio assessments, Fountas and Pinnell Benchmarks, AIMS web and Curriculum Based Measurements. Some districts reported using more than one screening instrument.

Districts reported a variety of supports at different tier levels. Tier 2 supports included small group instruction, targeted strategy lessons, and study skills. One to one tutoring and direct instruction targeting deficit areas were reported Tier 3 supports. Other tier supports reported were extra math or language arts periods, mentoring, and tracking. Positive Behavior Supports (PBS) systems were also reported. Reading interventions such as Pathways, Orton Gillingham and Wilson were also identified. One respondent reported observing many discrepancies in the planning of RtI instruction.

RtI Data in the Referral Process

Most districts, 62% reported always using RtI data for early remediation with 25 % using RtI data for remediation sometimes. Twenty five percent always use RtI data to determine referral to the CST for assessment. Another 75% indicated that RtI data is sometimes used to refer students to the Child Study Team (CST). Whether or not the data is provided to the CST varies among districts with 40% stating they always provide the data to the team. Forty percent indicated that they sometimes provide the data and 20% stated they never provide the data to the CST.

In considering a student’s eligibility for special education services, with a specific learning disability, none of the districts indicated that they always incorporate RtI data into the decision making process. Eighty percent indicated that they sometimes consider RtI data with 20% stating that they never use RtI data when determining classification with a specific learning disability. When RtI data is considered along with individual CST assessment results, RtI data is usually given less weight in 62% of reporting districts. Equal weight is given in 25% of districts and in only 12 % of districts is it given more weight than assessment results. Thirty eight percent of the respondents indicated that none of the CST members have been trained to use RtI data in considering eligibility. Other districts reported that all (27%) or some (23%) CST members have been trained in RtI process.

Model Comparison

Special education administrators were equally divided in their opinion that the discrepancy model is sufficient to determine the existence of a learning disability. Approximately one third suggested that it is sufficient; one third indicated it is not sufficient and approximately one third remained neutral. Again, special education administrators were divided when asked if moving through the tiers of an RtI model was enough to determine eligibility with a specific learning disability. Thirty-eight percent of the respondents indicated that progressing through RtI tiers is not sufficient to determine the existence of a learning disability. Approximately one quarter (27%) of the respondents indicated that that RtI alone is sufficient to determine eligibility with a specific learning disability, with 23% remaining neutral. More than half (52%) did not agree that adding the RtI model to the criteria for determining the existence of a learning disability would improve consistency of diagnosis across school districts.

Special education administrators were also asked if adding the RtI model to the criteria for determining the existence of a learning disability would improve consistency of diagnosis across school districts. Forty two percent agreed that it would improve consistency. One quarter of the respondents disagreed.

Discussion

This study was prompted by discussions regarding the limitations of the discrepancy model in diagnosing a learning disability and the inconsistencies of diagnostic procedures across districts. The RtI model is identified in special education code as a method that may be used in determining eligibility as a student with a learning disability. The study describes how the RtI model is currently used in school districts in New Jersey. The study focused on the current use of the RtI model, what constitutes the RtI model, how it is used, and perceptions of accuracy in diagnosing a specific learning disability.

The study results indicated that the RtI model is not currently developed or used in a majority of New Jersey school districts. Comments by respondents indicated that the New Jersey Department of Education has not provided guidelines for a particular RtI model or its implementation at the district level. Respondents indicated that in most districts, implementation of RtI activities do not fall under the supervision of the special education administrator. Approximately one third of the reporting districts indicated that they have developed and use a RtI model and have written guidelines in place.

In describing the RtI model there is little, if any, consistency across districts. Most districts indicated that the RtI model in place consists of three tiers. Beyond that there is little similarity with regard to the interventions provided at the different tier levels. Universal screening procedures are also inconsistent among the districts. These results alone raise the question as to the reliability of the RtI model in determining a specific learning disability and whether or not it is providing appropriate prereferral interventions.

The results of the survey indicated that in New Jersey the majority of students classified with a specific learning disability are diagnosed through the use of the discrepancy model. Individual standardized assessments are used to determine a discrepancy of 1.5 standard deviations between IQ and achievement. However, special education administrators differ in their opinion on the efficacy of this model in determining a specific learning disability. Most CST members, who are charged with diagnosing a specific learning disability, are not trained to incorporate RtI data in the diagnostic process. Without proper training, the use of this data will be haphazard at best and not defensible in court.

Most special education administrators feel that neither the discrepancy model nor the RtI model alone can identify the existence of a specific learning disability accurately. They are split in their opinion as to whether or not adding the RtI model to the discrepancy model will improve consistency of diagnosing a specific learning disability. One special education administrator stated, "State departments should take a leadership role in establishing criteria and guidelines so that there will be consistency among districts. If not, data cannot be interpreted with any reliability."

Limitations and Future Research

This study narrowly focused on special education administrators in New Jersey. Admittedly, there is little guidance at the state level regarding RtI models and implementation. For this study, only special education administrators were surveyed while study data indicated that in some districts RtI implementation falls under the auspices of general education. Therefore, special education administrators may not be aware of the particulars of the RtI model in place or the elements of that RtI model. Special education administrators, as supervisors of CSTs, are a good source of information regarding the use of RtI data in diagnosing a student with a specific learning disability, as they are responsible for CST supervision.

These findings suggest the need for further research into the design and application of an RtI model. Research should be expanded to include both general and special education administrators. Also, examination into the practices of incorporating RtI data into the diagnostic criteria for eligibility as a student with a SLD should be considered. Actual practice would be determined by surveying CST members.

Consistency of diagnosis will require well developed RtI guidelines at the state and or federal level. Also, guidelines for incorporating RtI data along with data obtained from individual assessments need to be developed. Finally, CST members will need to be trained to interpret and include this data as they consider student eligibility with a specific learning disability. Further research should include examination of actual practice for including RtI in the diagnostic criteria across states with specific guidelines and those states that have not developed RtI guidelines.

Conclusion

Despite the limitations cited above, this study is a first step in examining the actual practice of implementing an RtI model. The study gives some insight into how the RtI model is used in some school districts and how special education administrators view its use as a diagnostic tool for determining a SLD. It highlights inconsistencies of implementation and use of RtI data across school districts.

Most special education administrators agreed that neither the discrepancy model nor the RtI model alone can accurately and consistently diagnose a SLD. However, a process that includes both individualized assessment and data garnered from a well developed and consistent RtI model may actually provide the best method for diagnosing SLD. Training for those who would be implementing this process is needed to ensure accurate diagnosis.

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