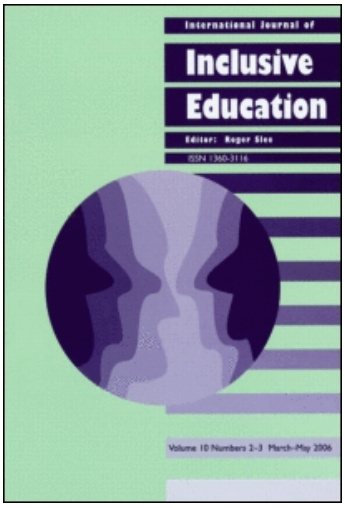

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Undermining inclusion? A critical reading of response to intervention (RTI)

Beth A. Ferri[a]
[a] Department of Teaching and Leadership, Syracuse University, Syracuse, NY, USA

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Undermining inclusion? A critical reading of response to intervention (RTI)

Beth A. Ferri*

Department of Teaching and Leadership, Syracuse University, Syracuse, NY, USA

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In this paper, I critically examine the discourse surrounding response to intervention (RTI), a US-based education reform that has garnered a considerable amount of attention (as well as controversy) in a very short amount of time. A multi-pronged reform effort, RTI is a tiered approach to delivering instructional intervention to students at risk, an on-going and systematic model of monitoring student performance, as well as an alternative to the ability/achievement discrepancy model for identifying learning disabilities. In this paper, I argue, however, that RTI is not so much a reform but a tactic, aimed at returning to the status quo of segregated special education and reinvigorating many of the foundational assumptions of traditional special education practice.

Keywords: education policy; disability; special education; inclusive education

> Might we find out too late that RTI is in reality 'a Trojan horse, outwardly appealing, but filled with risky, unproven, and, in the end, potentially harmful practices'. (Shaywitz, in Reynolds and Shaywitz 2009a, 47)

> There is 'no such thing as a proven program … nothing worked everywhere and everything worked somewhere'. (Allington 2002, 16)

Special education: reform or reformulation?

Since its inception, special education has been subject to a 'seemingly never-ending series of reforms and initiatives' (Gersten and Dimino 2006, 99). In reform after reform, however, the more the special education changes, the more it seems to remain the same. Much of this is due to the intractability of the field's most foundational assumptions (Dudley-Marling and Gurn 2010; Gallagher 1998, 2004). For example, once deemed eligible for special education, students are assumed to be '*fundamentally different*' [emphasis in original] from their non-disabled peers (Brantlinger 2004, 20). Disability labels, therefore, function as a discursively produced system of social othering that creates divisions between students who are considered normal and regular and those who are seen as deficient and disordered (Slee 2004). The foundational assumption that there are two distinct student types, one disabled and one 'typical' or 'normal', is retained in each successive educational reform.

*Email: baferri@syr.edu

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Once a student is defined as a 'problem', the mechanisms that label, rank and exclude him/her are assumed to be neutral and valid – a rational and necessary response to student difference (Brantlinger 2004, 11). But not everything falls under this clinical gaze. In its hyper-focus on aetiology, diagnosis and specialised interventions directed at individual learners, general education practice, which is often inflexible, rigid and ineffective for an increasingly wide range of learners, falls conveniently outside special education's clinical gaze (Slee 2004). Thus, because disability is presumed to be intrinsic to the child, the 'classroom context is seldom taken into account' when a child is referred to special education (Harry and Klingner 2006, 67). In this decontextualised view of disability, it is only the student, not the system or larger educational context, which is deemed deficient and in need of intervention. In other words, when traditional models of instruction fail to apply on a particular student or even groups of students, it is the student who is seen as deficient rather than the instructional model (Gallagher 2004).

One of the most recent reforms in education in the USA, response to intervention (RTI), appears to advocate a shift from locating the problem of underachievement within a student to a focus on ineffective teaching or curriculum. RTI has also garnered a considerable amount of attention in a very short amount of time, surpassing earlier reforms that, I will argue, are more consistent with inclusive practice (e.g. universal design for learning[1] or differentiated instruction). Curiously, despite an admittedly scant amount of scholarly debate or research to establish its efficacy, RTI has quickly become 'deeply entrenched in federal law and policy' (Batsche et al. 2006, 4). In this paper, I illustrate how RTI is not so much a reform but a tactic, aimed at returning to the status quo of segregated special education and revalidating many of the foundational assumptions of traditional special education practice. I begin this analysis with a brief overview of RTI, followed by a critical examination of the discourse surrounding RTI and what this discourse reveals about the foundational assumptions of RTI. I then explore the implementation of RTI and discuss how the model will affect the inclusion of students with diverse learning needs in general education.

Overview of RTI

RTI involves several somewhat interrelated aspects. First, RTI is a multi-tiered approach to instructional delivery designed to improve academic and behavioural outcomes, particularly for students who are thought to be at risk of reading or other academic or behavioural difficulties. Second, RTI involves an on-going and systematic model for monitoring student performance and targeting the intensity of intervention based on students' performance on particular benchmarks. Third, and perhaps most controversial, RTI is an alternative to the widely criticised (IQ/achievement) discrepancy model for determining eligibility for learning disabilities[2] (LDs; Reynolds and Shaywitz 2009a). RTI is offered as an alternative eligibility model for LD in the 2004 reauthorisation of (Individuals with Disabilities Education Improvement Act, IDEIA 2004), leading to much of the earliest critiques of RTI (Gallagher 2010b; Gerber 2005; Hale et al. 2010; Kavale, Holdnack, and Mostert 2006; Mastropieri and Scruggs 2005; McKenzie 2009; Reynolds and Shaywitz 2009a, 2009b).

There are generally two distinct models of RTI discussed in the literature: the standard treatment protocol model and the problem-solving model. The problem-solving model is an outgrowth of earlier pre-referral intervention strategies, such as regular

education initiative (REI)[3], but with greater attention to systematic progress monitoring and research-based interventions. In the problem-solving model of RTI, interventions are determined on a case-by-case basis in consultation between the general education teacher and a teacher assistance or child study team. Much of the literature on RTI, however, advocates a more standardised approach, referred to as the standard treatment protocol model.

In the standard treatment protocol model, teachers implement a universal screener in order to identify 'at risk' students, who are then monitored in terms of their progress as compared to their age-group peers. This phase of the programme is seen as the 'first gate or point of entry into subsequent tiers of RTI' (Johnson et al. 2006, 1.4). Students who fail to make adequate progress (most often in the areas of reading fluency or math) in a given amount of time are referred to Tier 2, where they receive the same intervention, but with more intensity. Increasing intensity is achieved by: (1) providing more teacher-centred, systematic and explicit (e.g. scripted) instruction; (2) providing more frequent instruction; (3) adding to the duration of instruction; (4) creating smaller and more homogeneous instructional groups; or (5) using instructors who have greater expertise (Fuchs and Fuchs 2006, 94).

At each successive tier the same research-based intervention is implemented, but in smaller and smaller groupings of students being taught by professionals who presumably have more and more specialised training or expertise. Thus, intensity of intervention is connected to placement, with an ever more restrictive pull-out model of delivery typically prescribed as you move up the tiers. For example, at Tier 2 you might have a teacher to student ratio of 1:5, with instruction provided in the general education classroom, whereas at Tier 3 you might have a teacher to student ratio of 1:3 or 1:1, with instruction provided outside the general education classroom and by a special education teacher or content area specialist. So, whereas in the problem-solving model, the interventions are individually designed for each individual student and implemented in the general education classroom, in the standard treatment protocol model, interventions are universalised as is the amount of time students are given to meet a predetermined benchmark before being moved to the next tier. In other words, all students are exposed to the same research-based instruction and, once they are referred to Tiers 2 and 3, the same model of instruction is typically provided, but with more intensity. This is often achieved by relying on a pull-out delivery model. Because of its similarity to the continuum of services, an Info Brief on RTI from the National Research Center on Learning Disabilities refers to the tiers of RTI as a 'continuum of interventions' (Johnson et al. 2006, 3.2).

Unpacking the discourse of RTI

Because it is more prevalent in the special education literature on RTI, my critique will focus on the standard treatment protocol model. First, in terms of terminology, terms such as *standard*, *universal*, *protocol*, and *treatment* predominate in the literature on RTI. Envisioning the classroom as a laboratory, under RTI everyone follows the same or *standard* treatment *protocol*, which is understood to be *universally* applicable and effective. *Fidelity* is another word that is essential to the approach and explains the penchant in RTI for scripted or 'tightly structured' commercial programmes (Kovaleski 2007, 83). The quicker and easier it is to train teachers to administer a particular programme, the easier it is to achieve fidelity. Allington (2002) voices a concern that reforms such as RTI, like Reading First,[4] allow a small set of

textbook publishers too much control in setting the curriculum. Given the proclivity of teachers to value an eclectic borrowing across programmes and textbooks, fidelity might also reflect the degree of allegiance or faithfulness that is expected of teachers to follow one district authorised, research-based programme.

If you further unpack the notion of fidelity, however, the underlying assumption is that you can actually take the teacher out of the equation, thereby reducing the variables to the intervention (which is assumed to be valid and effective) and the learner (who either responds appropriately or is targeted for more intensive instruction). To require that interventions must be evidence- or research-based implies that there is a set of agreed-upon interventions that are deemed effective for a wide range of learners. The designation of research-based also privileges a very narrow 'gold standard' of research involving large randomised clinical trials. Representing a kind of post-positivist backlash, not all research counts as 'evidence', discounting qualitative studies, single-subject and even quantitative studies with matched samples. The requirement that a programme be research-based is typically achieved on a practical level by focusing exclusively on commercial programmes. In a section on essential components of RTI, Batsche et al explain that the interventions are 'often scripted or very structured' and 'designed to be used in a systematic manner' (2006, 24). However, Allington contends that despite all the hype about evidence-based practice, 'programs don't teach, teachers do' (2002, 17). He further argues that there is no escaping the critical importance of teacher expertise, which has shown to have a much larger impact on student achievement than any particular programme, series or textbook. A large-scale study by Darling-Hammond (1999) corroborates this point. She finds that teacher preparation and certification are most strongly linked to student achievement – a finding that holds true even when you control for the language proficiency and poverty level of students.

In RTI, the term standard also refers to the set intervals at which students are evaluated (typically 8–12 weeks). Every student is given the same amount of time to 'respond' to the instruction. If a student fails to respond in an arbitrarily determined amount of time, then it is assumed that they are deficient and in need of more intensive instruction. Thus, not only are teachers expected to demonstrate fidelity to whatever programme the district authorises, so too are students held to similar expectations. Students, therefore, must remain faithful to whatever programmed instruction is offered and they must show progress in an acceptable time frame. If one is to ensure fidelity, there is no going outside these parameters. In other words, whether the intervention is working for a student or not, teachers must remain faithful to the treatment that has been prescribed under RTI.

Surprisingly, given the discourse about teacher fidelity, there is much about RTI that is a bit of a moving target at this point. For example, there is little consensus on what constitutes the 'R' in RTI – an issue that is largely left to those implementing the model. In reviewing implementation guides for RTI, it is not uncommon to see arbitrary cut-off scores on a curriculum-based measure, last year's scores on district or state exams, a local or national norm on a standardised measure, or some combination all used as benchmarks for RTI. Obviously, the response in RTI is only as predictive and valid as the instrument used to measure student progress. Other unanswered questions regarding the implementation of RTI include:

- Who will provide instruction at Tiers 2 and 3?
- How will RTI be funded?

- Who decides whether and when a student moves up or down a Tier?
- When are the parents or guardians notified or brought into the process (Mastropieri and Scruggs 2005)?

This level of fuzziness could be seen as revealing of some of the fissures within the model – fissures that reveal a paradox between the discourse of RTI, which speaks of fidelity, universal protocols and standardisation on the one hand and a glaring lack of consensus or research behind the model on the other.

Although the discourse surrounding RTI, at least on the surface, seems to be advocating that we make sure that a student has access to good instruction before we label them as disabled. In practice, however, schools implementing RTI often maintain the same deficit-based assumptions about students (Orosco and Klingner 2010), but these assumptions are further bolstered by assertions that interventions are 'research-based'.[5] In other words, if we can assume that the instruction that is delivered by the teacher (with fidelity) is further authorised as research-based, then if a student doesn't 'respond' it must be the student (not the intervention) that is deficient. Thus, the danger in my mind is that if we take RTI seriously, there is little need to think about a lack of fit between the learner and the instruction or to consider how to accommodate or differentiate instruction, because it has already been established that the instruction is valid and effective. Yet, RTI glosses over the fact that even if research demonstrates that a particular intervention works for a *majority* of students, there is no guarantee that it will necessarily work for each *individual* student, particularly those who come from culturally or linguistically diverse backgrounds, who are ELLs, or who have diverse learning needs. A one-size-fits-all model for instruction, whether it is research-based or not, does not abdicate our responsibility to meet the needs of all learners.

Expanding the diagnostic gaze

RTI is sometimes presented as a special education reform, but the role of special education and special educators in RTI remains somewhat indeterminate. Some articulations of RTI conceive of Tier 3 as simply another iteration of special education, while others maintain that RTI should be thought of as a general education reform. The later conceive special education to be a completely separate process of referral and placement that occurs after a student has gone through all of the tiers (McKenzie 2009). Because of its initial focus on early reading, some researches presume that RTI is best limited to preventing and diagnosing reading disabilities. Others assume that the model is applicable to any content area or behavioural challenge or grade level. Some researchers believe that RTI is fine as a way to help students who are struggling in particular academic areas and to rule out students who have not been given quality instruction, but not as a replacement for a more clinical approach to determining eligibility for an LD. Regardless of whether RTI is conceived as a general or special education reform, the desire to curb the growing numbers of students who are placed in special education, particularly in the category of LD, has been a major catalyst fuelling the push for RTI.

Many of the initial architects of RTI are traditional special educators, which may explain why in many ways RTI shares quite a few aspects that are associated with special education. Under RTI no one escapes the clinical, diagnostic gaze and mechanisms of surveillance that were once reserved for students with disabilities. We might

also imagine that students who were once referred to as their disability labels (LD students, for example), and more recently by the kinds of education services they received (e.g. resource or inclusion students), will now be designated by their tier placement. In other words, the tiers in RTI will likely, in all intents and purposes, simply replace existing labels – functioning in much the same way and carrying as much stigma as disability-related designations. Moreover, general classroom teachers may view RTI as simply an extension of the special education referral process.

Orosco and Klingner (2010) find that school personnel, who have relied on referring students who struggle to special education, see RTI as simply another way to refer students for more intensive supports and eventually special education. Gerber uses the term 'tolerance' to describe the boundary that teachers use to distinguish students they perceive to be 'teachable' from those for whom they will seek 'additional resources and referral' (2005, 516). Far from being a universal distinction – each teacher has a different 'tolerance' for diverse student learning needs. Thus, it is unlikely that a teacher's tolerance for student difference, which is 'socially and historically constructed, not psychometrically derived' (516) will change under RTI. Importantly, because RTI is in effect a 'diagnosis by treatment failure' (Hale et al. 2010) and because students will no longer have to have a documented disability to be included in this designation, there is reason to believe that special education numbers may increase rather than decrease. In fact, Gersten and Dimino state:

> RTI allows teachers to judge which students need special education instruction in reading based on whether or not the student can respond to either typical classroom instruction, or the type of support that is possible in a typical classroom (e.g. brief but intensive small group interventions on key skills). (2006, 100)

Besides a concern about potential for teacher bias in this statement, the second half of the statement reveals an assumption that the student must fit the parameters of what help is seen as reasonable or 'possible' to provide in a general education classroom. The onus remains on the child to figure out a way to make the general education classroom instruction work for him/her, as is. The notion that instruction should be differentiated for the child, beyond what is typically done for everyone, is completely absent in this discourse. Thus, RTI encourages teachers/administrators to mistakenly ask questions like, 'Does this child belong?' rather than advocating for a more inclusive question, such as 'How can we ensure that this child belongs and benefits from this instruction?'

Implementing RTI: at risk of being at risk

The first step of RTI involves the administration of universal screeners, which are typically given to every child in the first few weeks of school. The goal is to hunt out 'at risk' students, even before the teacher notices that they might be having problems. Common examples of screeners for young children might be phonemic awareness tasks or a one-minute timed reading fluency measure (number of words that student reads correctly in one minute from a sight word list or reading passage). For older students, screeners might include scores from the previous year's state- or district-wide test results or scores from standardised, norm-referenced or criterion-referenced tests or subtests. Validity is certainly a question both in terms of the assessments themselves and how they are used in RTI. For example, validity is an issue when individual

subtests are used as screeners when they are not designed for this purpose (McKenzie 2009). One-minute reading fluency measures (such as the widely used DIBELS[6]) constitute a very crude and narrow measure of what we might understand reading to be (Gerstein and Dimino 2006). It is also not uncommon to see a wide range of arbitrary cut-off scores, percentiles and standard deviations listed as benchmarks (McKenzie 2009). The bottom 25% might be the cut-off point for one school, whereas the school across town, particularly in a more or less affluent area might use a completely different cut-off score or even a completely different type of measure. Thus, the criterion for what separates an adequate from an inadequate response or the R in RTI is widely variable and arbitrary (Reynolds and Shaywitz 2009a).

Students who are identified as 'at risk' (via the universal screener) undergo frequent and on-going progress monitoring to measure their response to research-based instruction in the general education classroom. In addition to the lack of consensus about what constitutes a response in RTI, Schatschneider, Wagner, and Crawford (2008) also question the assumed validity of progress monitoring for predicting student achievement, a core assumptions of RTI. The authors, in a two-year longitudinal study, found that there is little predictive validity associated either with the kinds of measures or the ways these measured are commonly used in RTI in terms of predicting future reading achievement.

Yet, as Fuchs and Fuchs (2006) state, 'If students respond to the treatment trial, they are seen as remediated and *disability-free* and are *returned to the classroom* for instruction' (emphasis added, 2006, 95). On the other hand, students who do not 'respond' are referred for Tier 2 interventions. The message here is clear, the general education classroom is a 'disability-free' space *and* interventions take place outside the general education classroom. In fact, although interventions could certainly take place in the general education classroom, many published and web-based descriptions of RTI feature pull-out models of instruction and assume that only 'responders' are able to 'return' to the general education classroom (see IRIS Center, as an example). A further example of the underlying assumption of a pull-out delivery model is reflected in the following passage from Batsche et al.:

> Students who improve in critical academic skills as a result of Tier 2 interventions are typically *reintegrated* into the traditional instructional program. Some students may display significant progress, but may continue to need supports *not available in general education*. These students, as well as students who fail to display meaningful progress in spite of intensive supports, are referred for more intensive interventions and possible determination of eligibility for special education. (emphasis added, 2006, 24).

Several studies of RTI reviewed by Marston (2005) illustrate a similar pattern where only Tier 1 interventions are provided by the classroom teacher, whereas Tier 2 and 3 interventions were provided by either the researchers themselves or by special education or intervention specialists. It is unclear who would step into to provide these interventions once the researchers complete their study, however. Allington (2002), for example, warns that due to budgetary constraints and an unclear funding formula for RTI, many schools will enlist paraprofessionals and other related service providers who may have less expertise in reading instruction or other content areas than the general education teacher. In a study by Denton et al., students who:

> Continue to struggle with reading … would receive a tertiary intervention that would be delivered with high intensity over an extended period of time. Because of the need to

> intensify instruction, the flexibility that is possible in special education may be necessary to implement tertiary instruction. This 'intervention was provided during the regular school day … in a setting outside their usual classroom'. (2006, 447–8)

The hidden curriculum of RTI is that if you do not learn the way that the research says you should then *you* (not the intervention) are deficient. The role of a teacher shifts from focusing on finding out how a particular student learns best or adjusting the instruction to the student's learning preferences, styles or abilities to documenting the student's progress (or lack of progress) on the standard, research-based instruction. Ironically, evidence-based practice could actually usurp other, more inclusive practices. In other words, if an approach is research-based, then it is the student's responsibility to 'respond', rather than the teacher's responsibility to differentiate or modify – in fact, this kind of modification or adaptation to student learning needs seems to be the antithesis of RTI's demands for standardisation, fidelity and universality. Moreover, the fact that the instruction is not working for particular students does not result in a discussion about the intervention (which is assumed to be valid/effective), although it might be seen as a fidelity issue (perhaps the general education teacher is not doing it correctly or maybe they have been experimenting with other approaches on the side). Moreover, in order to get an even better handle on fidelity, other professionals, presumably more steeped in the discourse (such as reading specialists or special education teachers), might be brought in to provide Tier 2 and Tier 3 instruction.

When an approach proves ineffective for a particular student, proponents of RTI doggedly suggest more of the same. Students who do not progress at an 'acceptable rate' are given a 'standard treatment … [which typically involves] more structured and intensive' instruction 'delivered in small groups of three to six children on a *pull-out basis*' (emphasis added, Batsche et al. 2006, 13). In the standard treatment protocol model, a single validated intervention is selected by the school (universal/standard) – this same intervention is provided across the tiers with increasing intensity. Therefore, when a child moves from Tier 1 to Tier 2, the teacher does not provide an alternative to this approach, but rather delivers the same instruction, this time with more 'intensity' – as stated, in practice, this is typically a more restrictive setting (often pull out) and/or small group instruction of the same research- or evidence-based instruction. Thus, Tier 2 is more intensive than Tier 1, which simply means more of the same approach that the student did not respond to in the first place. At the second tier, however, the instruction might or might not be implemented by the classroom teacher. Tier 2 service providers could be the classroom teacher, reading specialist, special education teacher, supervised paraprofessional, tutor or trained volunteer, as long as they were trained to *faithfully* implement the instructional programme. As Allington (2010) notes, an irony in the implementation of RTI is that the person providing Tier 2 and 3 instruction are likely to have less expertise in reading instruction than the general education teacher.

Another aspect of the hidden curriculum of RTI is revealed in its unwavering assumption about who belongs in general education and who does not. For example, if students 'demonstrate adequate progress' in Tier 2 they:

- 'are not disabled and can be *integrated back into the general classroom*' (Batsche et al. 2006, 13); and
- are '*returned to the classroom*' (emphasis added, Fuchs and Fuchs 2006, 95).

On the other hand, students who do not respond to instruction in Tier 2:

- are considered 'difficult to remediate' and further [special education] evaluation is warranted (Fuchs and Fuchs 2006, 97); and
- 'cannot survive in the mainstream classroom' (Fuchs and Fuchs 2006, 97).

Thus, the underlying assumptions revealed by these statements are clear. First, remediation is assumed to require that a student be pulled out of the general education classroom. Second, students with disabilities *cannot* be taught in the general education classroom, which is seen as a 'disability free' space! Thus, it appears that a student's RTI is the ticket required to enter back into the classroom. In other words, because the instructional approach must be rigidly applied, pull-out models of instruction are seen as the appropriate and rational way to deal with students who are struggling. Thus, RTI appears to go against a more inclusive philosophy of classroom practice.

Locating dis/ability

RTI fails to question how 'individual differences in responsiveness to instruction are not in any sense *inside* students' (Gerber 2005, 516), but rather reflect a lack of fit between the learner and the instructional model (Kavale, in Batsche, Kavale, and Kovaleski 2006). Instead, the lack of fit becomes the *evidence* of the student's disability status. As Fuchs (in Gerber 2005) states, 'If you have a classroom in which most students succeed, then the student who does not must have "some underlying deficit"' (519). In other words, eligibility for special education under RTI is determined by 'how well or how poorly a student responds to an evidence-based intervention that is implemented with integrity' (Gresham 2007, 10). A student is considered to have an LD when he/she does not 'respond' to research-based academic interventions in a predetermined amount of time.

Shinn and Shinn (2001) compare curriculum-based assessment, often a hallmark of RTI, to 'key health indicators in medicine, allowing teachers to make vital decisions about the academic health of students with learning disabilities' (107). Like all medical- or deficit-based approaches, when a child does not respond to an intervention, the problem is assumed to be intrinsic to the child. Thus, RTI is, in the end, a tool for determining eligibility for special education and ultimately for labelling the child, not the educational context, as deficient.

More importantly, RTI does not challenge the efficacy of the intervention itself, which, because it can claim to be research based, is not called into question. Thus, it is telling that under RTI we label students rather than classroom practices as deficient, disordered, disabled. Likewise, once a child falls under this clinical gaze, intervention efforts are typically directed at the individual student, rather than at the instructional practices. Borrowing another medical analogy, RTI is often presented as a version of educational triage, where by interventions under RTI are divided up into ever more intensive tiers. In practice, after the first tier, however, the 'intervention' prescribed most often in descriptions of RTI involves removing students from the general education classroom for 'specialised' or 'intensive' instruction, rather than requiring the classroom teacher to implement differentiated instruction, universal design for learning or other inclusive practices.

Although admitting an 'unfortunate absence of research confirming the benefits of special education programs' for students with high incidence disabilities or those from

minority backgrounds (Batsche et al. 2006, 9, 11), RTI has been championed by many of the 'traditionalists' in the field of special education (Brantlinger 1997). Often referred to as the *new* continuum of special education services, RTI, in aligning with the current emphasis on accountability and high-stake testing, appears largely inconsistent with more progressive movements in education, such as constructivism, qualitative research methods, full inclusion and whole language.

Yet, advocates posit RTI as a fix to all that is wrong with special education. RTI was originally intended as alternative to the IQ/achievement discrepancy model for determining LD eligibility (Gresham 2007), which has been the target of much criticism, particularly for unnecessarily delaying service provision to students who might benefit from it.[7] Yet, as Schatschneider, Wagner, and Crawford explain, we should remain 'skeptical of the myth that RTI models [will] provide realistic solutions to the problems associated with the traditional discrepancy model, until convincing evidence is available to the contrary' (2008, 314). Others are hopeful that RTI will reduce the number of 'educational casualties', who are either mistakenly identified for special education when they have simply not been given adequate instruction or who must 'wait to fail' before schools respond to their learning needs. As Donovon and Cross (in Wright and Wright 2008) contend, the 'wait-to-fail' model is ineffective in 'closing the achievement gap for most students placed in special education. Many students placed in special education … show minimal gains in achievement and few actually leave special education' (2008, 6). Of course, because RTI is championed as an improved method for determining eligibility for special education, we might do well to ask how this new approach will increase gains for those who receive special education services. In other words, if special education tends to be ineffective in terms of raising achievement, how will changing the way students are deemed eligible change this lack of efficacy? Moreover, I have yet to see any attention to RTI, progress monitoring, or research-based instruction once a child is placed in special education – a curious absence in the literature on RTI.

A repeated mantra for why we need RTI is the claim that that 'at risk' students will not have to 'wait to fail' before given access to 'scientifically based instructional interventions at the first indication of learning difficulties' (*Response to Intervention*, 2008, 5). This charge is typically made in response to the fact that most students with LDs are not identified before second grade. But, the rhetoric around 'wait to fail' does not explain why we need to label students in order to give them access to accommodations or supports or why we should not be differentiating instruction for all students. It also disregards that the delay is motivated by a desire not to label students too early – particularly given the fact that early school years marked by uneven development and assessments are less valid at younger ages (Gersten and Dimino 2006). In other words, this delay was motivated by a desire not to label students unnecessarily or inappropriately, particularly give the level of stigma typically associated with special education labels, as well as a lack of efficacy of such placements (Allington 2010).

As Schatschneider, Wagner, and Crawford (2008) suggest, there is reason to be sceptical that RTI models will address the problem of 'wait to fail'. They suggest that the 'wait-to-fail' criticism would apply equally to RTI, which:

> (a) are most likely not to be implemented before first grade; (b) take a substantial amount of time to measure a child's response to tier one effective classroom instruction; and (c) require failure in the form of failing to respond to instruction and intervention before identification of a reading disability (Schatschneider, Wagner, and Crawford 2008, 313–4).

This may be why Reynolds and Shaywitz have referred to the push to RTI as moving from a 'wait to fail' to a 'watch-them-fail' model (2009b, 130). We might do well to ask why so much time is allocated to document that a student cannot do something rather than finding out ways to ensure that they can (Allington 2002).

As stated earlier, RTI has been promoted as a way to curb burgeoning special education costs (Fuchs and Fuchs 2006) by reducing the number of students who will need special education services. One curious omission in the literature is the fact that rather than curtailing the number of students placed in special education, RTI may actually expand pull-out service provision to a wider range of students. In fact, because the first task of RTI is to screen and monitor *all* students, RTI may result in identifying more rather than less students for special education. At minimum, it will most likely over-identify non-phonemically aware students for special education, because this is the approach that is easiest to demonstrate that it is evidenced based. Likewise, RTI will likely result in the under-identification of students with difficulties in listening, writing, oral language, math reasoning, reading comprehension and meta-cognitive areas (Kavale and Flanager 2007), which are harder to assess with quick screeners and are less efficient to teach with scripted programmes.

Perhaps the real value of RTI to school administrators is that proponents claim to be able to predict how many students will require special education services. Gresham (2007), for instance, suggests that 25% of students who currently experience reading difficulties will continue to struggle despite being exposed to research-based instruction. This number represents 4–6% of the general school population (a number consistent with the percentage of students currently identified as learning disabled). This number does not account for students with other academic or behavioural needs, who we might also predict will fail to respond given the lack of evidence of effective practices in these areas and will thus be placed in special education. Gresham suggests that additional numbers of students may demonstrate growth, but will still not keep pace with their age peers. This may explain why studies of special education identification before and after instituting RTI, although limited, show no significant reduction in the number of students identified for special education services as a result of RTI (Wansek and Vaughn 2010). As Allington rightly notes, despite the push for evidence-based interventions in RTI, there is 'no such thing as a proven program' – what research we do have shows that nothing works with all students and everything works with some students (2002, 16). Of course, the way to shift attention away from what amounts to little documented efficacy of evidence-based interventions is to suggest that those students who do not respond to instruction are the ones who are 'truly' disabled.

Addressing overrepresentation

RTI has also been touted as a solution to the disproportionate identification of students of colour in special education (Gresham 2007). As Gresham writes, RTI has the potential to 'reduce and even eliminate overrepresentation' of students of colour (2007, 17). Because the teacher is factored out – he/she simply delivers the scripted intervention with fidelity – RTI is also said to reduce the possibility of teacher bias in referrals to special education.

Yet, according to Klingner and Edwards (2006), however, there are many questions that we should be asking in relation to RTI and its impact on students of colour. For example:

- Will the 'evidence-based' instruction be responsive to diverse learners?
- Will students be afforded an adequate opportunity to learn?
- Are the research-based interventions also culturally responsive?
- Do the same interventions that 'work' for students in the dominant group also work for culturally and linguistically diverse or urban students?
- Can we ignore or discount contextual factors that might explain why an intervention is not working, such as teacher bias or cultural mismatch?

Despite all of the hype surrounding RTI, there remains a surprisingly small research base supporting its efficacy (Gersten and Dimino 2006; Reynolds and Shaywitz 2009a). As Vanderwood and Nam contend, the 'assumption that what 'works' for native English speakers will work with students from diverse language backgrounds' is largely unfounded (2007, 408). Ososco and Klingner (2010), in one of the few studies on RTI with ELLs, found that RTI was implemented in a one-size-fits-all fashion with little attention to the appropriateness of instruction or the assessments used for ELLs. In fact, in implementing RTI, school personnel operated under the same deficit-based assumptions as they had previously. In other words, teachers continued to locate deficits within students as a justification for referring them for ever-more restrictive placements.

Despite the contention that RTI will reduce overrepresentation and misidentification of students of colour, there is a similar lack of research to back these claims. As Donovan and Cross (in Artiles 2007) explain, the current knowledge base on evidence-based practices sheds little light on the effect of race/ethnicity because too much of this research either includes too few students from racial/ethnic minority groups or fails to report the racial/ethnic make up of the sample studied. An evidence-based practice does not in any way imply that it is culture free or culture neutral. All interventions must be responsive to the socio-cultural contexts in which they are implemented (Artiles 2002). Leonard Baca, a director of a centre for multicultural education, who claims that RTI is an excellent model also admits that 'the most important drawback … of the RTI system … is that it does not in any place speak to culturally responsive education' (IRIS Center). Thus, we should be asking, what is the responsibility of RTI to be responsive to difference (Gerber 2005)? I would argue that a model that places so little emphasis on racial, linguistic and cultural difference will not get us any closer to the 'elusive quest for equity' in special education (Artiles 2007).

Moving beyond early reading

Like the paucity of research on evidence-based interventions for English language learners and students of colour, there is also a lack of research on evidence-based interventions in content areas besides a very narrow definition of literacy (Vanderwood and Nam 2007) despite the fact that proponents suggest that it is appropriate for a wide range of academic and behavioural areas. Because behaviour is an area that is supposed to be applicable to an RTI model – we are left to ask what exactly would an evidence-based intervention for challenging or troubling behaviour, (Kratochwill, Clements, and Kalymon 2007) middle school social studies, or high school algebra or English (Mastropieri and Scruggs 2005)?

Lists of evidence-based interventions rarely include serious discussion about what counts as evidence or what standard each has met in order to be included in the list.

As a clinical model, we should also be asking whether interventions that are considered research-based will easily generalise to school settings, which are idiosyncratic and complex? Is the same intervention appropriate for a wealthy suburban school as an under-resourced, multicultural urban centre? RTI procedures ignore contextual and cultural variables as well as teacher and classroom dynamics and opportunity to learn (Artiles 2007; Gerber 2005). Moreover, as Kavale and Flanager (2007) argue, the assumption that 'non-responsiveness equates to SLD' (specific LD) is unwarranted and has no relation to the federal definition of LDs. Finally, as Gerber (2005) argues, the 'fatal flaw' of RTI is its lack of a theoretical basis for the model, which amounts to simply an operationalised set of procedures. Thus, because it relies on circular logic, mistaking 'the measurement of the construct for the construct itself', RTI does not lead to any better understanding of LDs than the previous discrepancy model.

Despite these limitations and areas of concern, RTI seems to have very quickly become the newest of special education's bandwagons (Kauffman and Hallahan 1995). Before we all jump on this latest bandwagon; however, it we might stop to ask some important questions about the underlying assumptions of the model.

Conclusion: scaling up or scaling back

In some ways, RTI has been instructive for how to scale up a particular instructional approach or intervention model. In the end, however, it might also prove to be a more cautionary tale. As, Shaywitz (in Reynolds and Shaywitz) asks in the epigraph, could RTI be a kind of modern day Trojan horse, 'outwardly appealing, but filled with risky, unproven, and in the end, potentially harmful practices' (2009a, 47). Allington, too, questions whether 'ideology isn't trumping evidence' in the push for evidence-based interventions (2002, 4).

RTI was first presented as an alternative to the discrepancy model for identifying students with LD. Widely criticised from the start, in some ways the discrepancy model was an easy target. Yet, without any research to speak of, RTI was then written into IDEIA (2004) as an alternative model for determining eligibility for LDs. Given that IQ-achievement discrepancy scores were criticised for not being reliable measures for determining LDs and given that 'RTI models have been proposed as a better alternative, it is disconcerting that there appear to be no published studies that assess the reliability of an RTI approach' (Schatschneider, Wagner, and Crawford 2008, 314). As a result, RTI is proving to be as contentious as previous eligibility models for determining the presence of an LD (Hale et al. 2010; Kavale, Holdnack, and Mostert 2006; McKenzie 2009). Implementing RTI for all children, in all grade levels, and across all academic areas, including behaviour required that it move beyond simply a special education reform (Kratochwill, Clements, and Kalymon 2007). Thus, including RTI in IDEA was simply about laying the groundwork for this larger project (Fuchs and Fuchs 2006). The ultimate goal was to infuse RTI in No Child Left Behind (2002), and aligning it with Reading First (see Footnote 4) proved an excellent tool for achieving this aim.

From the beginning, RTI and Reading First became interesting bedfellows. According to Fuchs and Fuchs (2006), many of the same policy-makers behind RTI were also responsible for Reading First, a major component of No Child Left Behind (2002), which required schools to use scientific knowledge to guide selection of core curricula and to use valid screening measures and progress monitoring to identify students in need of more intensive instruction. In a sense, RTI could be understood as

an important component of Reading First (Fuchs and Fuchs). For example, both RTI and Reading First require that curricula reflect scientifically based instruction. Both have set in motion a whole industry of professional development enlisted to train teachers on correct implementation. Both share a similar set of procedures for the diagnosis and prevention of reading difficulties, which include: (1) valid, reliable screening measures; (2) empirically validated intensive interventions; and (3) progress monitoring of struggling students.

Interestingly, the very scholars, many of whom railed against inclusionists for not being research-based and criticised the field for jumping on the bandwagon of inclusion, are now pushing very hard for an approach that has yet to demonstrate that it is effective. Even some of its staunchest supporters admit that RTI has a 'critical mass of professionals willing to forge ahead despite the unanswered questions surrounding the details of implementation' (Bradley, Danielson, and Doolittle 2007, 11). Another proponent of RTI, Sharon Vaughn, claims that 'over the next 5 to 10 years we're going to learn a lot of "craft knowledge" from the expert practitioners who are [implementing RTI]' (IRIS Center).

Although we do not have similar data on RTI, the latest U.S. Department of Education IES (Institute of Education Sciences) study reveals some of the inflated claims behind Reading First. The report shows no difference in reading achievement between Reading First schools (which were required to implement evidence-based reading programmes) and schools that did not receive this funding (Gamse et al. 2008). The study finds that despite increases in time spent on research-based reading instruction, a hallmark of both Reading First and RTI, reading comprehension scores did not improve significantly between schools getting Reading First funding and those that did not (Gamse et al. 2008; Manzo 2008). It is not a stretch to say that these findings would be instructive to consider in weighing the claims currently being made regarding RTI. We should be careful, in other words, not to overstate the significance of any particular instructional approach or model (Kavale, Holdnack, and Mostert 2006).

Even proponents of RTI admit that even with research-based instruction, we might expect that 25% of students who currently experience reading difficulty will continue to fail to demonstrate adequate progress under RTI. This figure would represent approximately four to six percent the school population (Gresham 2007), a very similar number to the five to six percent of students who are now labelled as learning disabled (Lyon 1996). Thus, in an average class of first-grade students, we would expect approximately five students to struggle with reading. Of those five students, four will need additional or more intensive instruction. Of those four students, one will require even more intensive, individualised reading instruction (IRIS Center). This group would likely represent the same group that we now identify as learning disabled. As stated earlier, in the lexicon of RTI, when a research-based approach fails to demonstrate effectiveness, however, it is either the child who is seen as deficient or the teacher who is not delivering the instruction with enough intensity or fidelity. Thus, RTI does little to dislodge deficit models of disability.

It is important to acknowledge that Reading First, the billion-dollar-a-year reading programme and 'pillar of the Bush administration's education plan', was the subject of a congressional investigation into whether top advisers improperly benefited from contracts for textbooks and testing materials they designed, and whether the advisers kept some textbook publishers from qualifying for funding (Toppo 2008, 1). A report from this investigation found that four of the five 'Reading First Regional Technical

Assistant directors had significant financial ties to education publishers while they held Reading First positions' representing serious conflicts of interest (press release 3; see also Paley 2007; Toppo 2008).

While interrupting the exponential growth of RTI, would be like stopping a moving train at this point, it would be prudent to demand full and honest disclosure of any conflict of interest behind any of the 'research-based' interventions and universal screeners being promoted by advocates of RTI. We should also question the assumption that we do not need to really prove RTI works, because the people advocating it are such 'giants' in the field. Finally, I also think it is important to question RTI's impact on diverse learners – is it truly the case that RTI will reduce overrepresentation of students of colour or will this prove to be an empty promise? Finally, we might question the irony behind the fact that those pushing hardest against the inclusion of students with disabilities found a way to push themselves into general education practice with such ease – all it took was to push students with disabilities back out.

Notes

1. See the Center for Applied Special Technology (CAST) website for more information on Universal Design for Learning at http://www.cast.org/research/udl/index.html
2. As RTI is a US-based reform, the use of LD in this article reflects the more narrow definition of LD common in the USA.
3. REI (Regular Education Initiative), an initiative of the Office of Special Education and Rehabilitation Services, was sponsored by Madeline Will in 1986. REI was initially designed with the ultimate goal of creating a merged general and special educational system that would serve all students. REI was often implemented by forming child study or support teams made up of general and special education teachers. These teams were designed to support general education teachers by suggesting strategies and interventions for students who were experiencing difficulties in the general education classroom. The goal was to implement interventions before students were referred to special education.
4. Reading First is a US-based educational mandate of the No Child Left Behind Act. It requires that all schools that receive Reading First funds must use research-based reading programmes.
5. See Gallagher (2010a) for an excellent discussion on the politics of 'evidence-based' practice in relation to special education.
6. DIBELS stands for Dynamic Indicators of Basic Early Literacy Skills (http://www.dibels.org/dibels.html). DIBELS is a widely used early reading fluency screening tool.
7. Of course, the assumption that students benefit from special education services should also be questioned given the lack of efficacy studies, poor transition outcomes, and high drop-out rates associated with special education.

Notes on contributor

Beth A. Ferri, PhD, is an assistant professor at Syracuse University, where she also coordinates the doctoral program in special education. Her book (co-authored with David J. Connor), *Reading Resistance: Discourses of Exclusion in Desegregation and Inclusion Debates* examines how the concept of disability was used to resegregate students of colour after the historic Brown decision and traces how special education played a role in undermining school desegregation in US schools. She is currently working on an edited book titled *Righting Educational Wrongs* with Arlene Kanter (SU Press).

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