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Response to Intervention: Persisting Concerns

Abstract

Rapidly institutionalized within educational policy and practice, Response to Intervention (RTI) is a multi-tier whole school approach to universal screening, targeted evidence-based intervening, and progress monitoring for students who are struggling to keep up with grade level or behavioral standards. Although RTI has quickly become institutionalized in policy as a “best practice” and widely adopted in the U.S., there remains persisting concerns about the model. In this paper I critically examine both the RTI model and the assumptions that undergird its practices. I conclude by proposing ways to make an RTI model more responsive to the context of teaching and learning in today’s classrooms.

Response to Intervention: Persisting Concerns

Although Response to Intervention (RTI) has quickly become institutionalized in policy as a “best practice” and widely adopted in the U.S., there remains persisting concerns about the lack of scientific evidence behind the model. Although many schools have implemented RTI in recent years, for instance, far fewer can claim increased student achievement or significantly improved behavioral outcomes as a result (O’Connor & Freeman, 2012). Often touted as a way to “correct the overrepresentation” of students of color placed in special education and “decrease future referrals to special education,” there is simply no evidence of either claim (Walker, Emanuel, Grove, Brawand, & McGahee, 2012, p. 49). The lack of a research base for a practice widely assumed to be evidence based and that requires that all interventions used in the model be evidence based is nothing less than ironic. Thus, notwithstanding the inordinate resources that have been directed toward evidence-based practices or interventions (Rycroft-Malone, Seers, Titchen, Harvey, Kitson, and McCormack (2004) and the implementation of RTI, there remain many “unresolved questions that are not easy to answer as policy races ahead of science” (VanDerHeyden, Witt, & Barnett, 2005, p. 339).

In a recent manuscript, *Undermining inclusion: A critical reading of response to intervention (RTI)* (Ferri, 2012), I critically examined the discourse surrounding RTI and, in particular, the Standard Treatment Protocol Model. In that paper, I argued that RTI was “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” (p. 863). My earlier paper was in large part very critical of discourse of RTI. In this paper I broaden and extend this work by focusing on some of the more persistent critiques of the actual practices that comprise RTI.

Response to Intervention: How it “works”

Rapidly institutionalized within educational policy and practice, RTI is a multi-tier whole school approach to universal screening, targeted EBP intervening, and progress monitoring for students who are struggling to keep up with grade level or behavioral standards. It has also been authorized as an alternative model to replace discrepancy models for identifying learning disabilities in the 2004 reauthorization of the Individuals with Disabilities Education Act (IDEA).¹ There are two main versions of RTI for school wide intervention: the standard treatment protocol and the problem-solving model. The problem-solving approach is team driven and allows for more individualization and flexibility in terms of choice of interventions, although the interventions must still be considered evidence-based. The standard treatment protocol model² relies more heavily on standardized tests and predetermined protocols, such that students continue to receive the exact same intervention, but with increasing intensity as they move through the tiers (Artiles & Kozleski, 2010). The purpose of RTI is to identify students who may be at risk for failure, to provide them with targeted evidence-based academic or behavioral supports and, to monitor their progress as a result of those interventions. Regardless of model, RTI requires that teachers use instructional programs or approaches that are evidence-based, meaning the intervention has demonstrated effectiveness, as determined by a very narrow range of research methods. Evidence-based practices (EBP), often referred to educational policy as scientific-

¹ I do not have the space to discuss this aspect of RTI, which was included in the 2004 reauthorization of IDEA (Individuals with Disabilities Education Act), but it remains controversial particularly among researchers in the field of learning disabilities, who have questioned its empirical validity, its efficacy, and its lack of coherence with federal definitions of specific learning disabilities. For critiques of RTI as a diagnostic model see Reynolds & Shaywitz (2009); Kavale, Kauffman, Bachmeier, & LeFever (2008); Mather & Gregg (2006), and a white paper by Hale and 58 other accomplished scholars in the field (2010).

² See Ferri (2012) for an extended critique of the standard treatment protocol model of RTI.

ly-based research (or SBR), refer to interventions that have proven their effectiveness based on experimental or quasi-experimental research designed studies, with the large scale randomized control trial (RCT) elevated to the distinction of being the “gold standard” on, for instance, sites such as *What Works Clearinghouse* (Thomas, 2004).

Tier 1: Casting a Wide Net

This first phase of RTI is typically referred to as Tier 1, which includes both universal screening of students (to identify those who may be “at risk” or who are underachieving) and the provision of whole class evidence-based instruction (EBP). General classroom teachers use universal (or school wide) screeners, typically in reading fluency and math calculation, in order to identify ‘at risk’ students in their class, who are then monitored in terms of their progress (referred to as progress monitoring) as compared to their age-group peers or to criterion-based measures. Tier 1 is, thus, the point of entry to the RTI model (Johnson, Melard, Fuchs, and McKnight, 2006) and it is designed to provide all students with EBP, careful progress monitoring, and ongoing screening.

Tiers 2 and 3: Increasing the Intensity of Instruction

Students who are identified as underperforming on the universal screener undergo frequent and on-going progress monitoring to follow their improvement or response to evidence-based intervention. It is assumed by the model that certain students will continue to struggle even with EBP, so after a predetermined period of time (that is again arbitrary) students who continue to underperform (based on a locally established criteria) are then referred to Tier 2, where they receive either a more targeted or a more intensive evidence-based intervention³. Increasing intensity in Tier 2 is typically achieved by: (1) providing more 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).

Students who fail to make adequate progress in Tier 2 after a previously determined (but still arbitrary) amount of time are then either given another targeted instructional trial or they are referred to Tier 3, where the intensity of instruction

³ In the standard treatment protocol model, students are presented with the same research validated instruction with each successive Tier, but with increased intensity-typically achieved by increasing the amount of time or expertise of the person working with the child or decreasing the number of students in the instructional group. In the problem-solving model of RTI, a problem solving team meets to select an intervention plan, typically from a menu of research validated instructional programs or approaches.

is once again increased (see above). In most instances, Tier 3 may include one-on-one tutoring with a specially trained instructor, a special education teacher, or in many cases because of limited funds, a paraprofessional. In some models placement in Tier 3 triggers a referral to special education, but in others referrals occur after a student does not respond to Tier 3 instruction.

Persisting Concerns about the Model

RTI is often presented as a corrective to the belief that “student failure in the general education classroom is an indicator of a disabling condition,” presuming instead that at least some student underachievement may instead be the result of a lack of access to research-based instruction (Walker et al., 2012, p. 49). Yet, a grounding assumption of RTI is that students who are not achieving at the same pace or level as their grade level peers either have “*real* disabilities” (emphasis added) or have simply not been exposed to effective instruction (p. 53). RTI is designed to distinguish between these two groups of learners by identifying struggling students through universal screeners and then providing tiered evidence-based interventions to determine if the child can progress given this instruction. If we follow the RTI model with fidelity⁴, we should expect all learners (unless they are “*really* disabled”) to learn given the same instruction, although some may need a bit more time or more intensively delivered instruction.

In other words, RTI assumes that if an instructional practice “works” as determined by a large randomized clinical trial (RCT), then it should work for any learner, unless there is some organic deficit or disability that cannot be remediated. Ironically, this assumption that EBP can ferret out students who have disabilities from those who do not has yet to be established by the kinds of research that RTI insists of those implementing the model. Further, rather than question the efficacy of a particular educational program or practice or the evidence upon which that efficacy was determined; it is still the student in the end that is found deficient. For this reason, I would argue that RTI retains a deficit-orientation associated with traditional special education practice. It also undermines more promising practices, such as differentiated instruction (proffering instead a one-size fits all approach to selecting interventions) and inclusive practice by expanding pull out instruction (Ferri, 2012). Moreover, practitioners are given the message that they are no longer required or compelled to try to figure out *how* a particular student

⁴ Fidelity, as operationalized in RTI, generally refers to the requirement that teachers implement interventions and screeners in a standardized way, rather than varying or improvising the approach to meet individual student needs. Expectations for fidelity tend to be more stringent in a Standard Treatment Protocol Model of RTI.

learns, but only to verify *whether* they learn using whatever approach is selected as long as it fits the standard of being evidence-based.

If I were a struggling reader, would it matter to me that a practice has the gold seal of being evidence based? I would argue that finding a strategy or approach that works for me matters infinitely more than knowing a strategy works for a large randomized group of students, who are likely not representative of my own unique learning strengths and difficulties, my classroom, school, culture, or community. Thus, EBP may be a good place to start in selecting among various approaches, but so too must we consider the learner as embodying a unique confluence of strengths, needs, learning preferences, and interests, and use this information to inform our instructional decision-making for each learner. As the popular meme attests, if a student does not learn the way I teach, I must find a way to teach the way the student learns.

RTI also does little to counter the assumption that there are two distinct student types, each with very distinct learning needs. A Council for Exceptional Children (CEC) position paper (2007) reinforces this belief by insisting that the “dual system of general and special education and the idea that the knowledge and skills of general and special education are distinct” (p. 2-3) and should be maintained in any RTI model. CEC’s position paper surmises that while a problem-solving model of RTI⁵ might be appropriate for general education, it must not usurp the imperative role of special education (Position on Response to Intervention, 2007). Interestingly, RTI is largely silent about what to do with students who are currently in special education or who are considered “non responders” after all the tiers of RTI have been exhausted. We might ask, if there no need for RTI or EBP for students who are deemed eligible for special education services or, would RTI proponents simply assert that there are distinct kinds of EBP for students with disabilities? Reviewing the paucity of evidence-based practices designated for students with disabilities on sites such as *What Works Clearinghouse* provides little guidance on this issue.

Universal Screeners: A critical component of Tier 1 involves the use of universal screeners to identify students who may be in need of more targeted intervention. The adequacy and appropriateness of the universal screeners used to identify “at risk” students remains to be established by research, however. In the early grades, it is common for schools to use phonemic awareness screeners or one-minute timed reading fluency measures, which compare the number of words that a child correctly reads in one minute from a sight word list or grade level passage. For

5 The statement is careful to support *only* the problem solving model and *only* for the purpose of intervention in Tiers 1 and 2. The statement suggests that Tier 3 and eligibility decisions should be the purview of special education, arguing that RTI is no substitute for special education.

older students screeners might be state or district level test scores or subtests of more comprehensive achievement measures. Often screeners are selected because they are either already available or because they are easy for a classroom teacher to quickly administer and are inexpensive. Certainly validity is a concern when subtests and other measures are used as screeners, particularly if they were not designed to be used for this purpose (McKenzie, 2009). Many screeners will result in false positives; others will result in false negatives. Moreover, many screeners lead to the misapprehension of a student's difficulties (Artiles & Kozleski, (2010), particularly if they are struggling in areas not captured by the overly narrow set of skills that are typically screened in an RTI model. This is certainly an issue when thinking about scaling up an RTI model to use with older students or for content areas other than early reading and basic math computation.

Attending to Context: By ignoring the social context of learning, RTI can lead to false assumptions about the validity of the model itself. Researchers have shown that simply offering a student an incentive or providing modeling and a practice trial, for example, can significantly alter student performance on screening measures (VanDerHeyden et al., 2005). Researchers have also shown how the various methods used to measure student growth in RTI could alter decisions about who was and was not in need of more intensive interventions (Burns, Scholin, Kosciol-ek, & Livingston, 2010, p. 210). Given the high stakes nature of being labeled as "at risk" or the academic and social consequences of being pulled out for instruction, these concerns have real material consequences for students.

Moreover, screeners that artificially reduce broad complex skills, such as reading achievement, to overly simplistic and crude measures of sight word recognition, phonemic awareness, or fluency can undermine the entire purpose of RTI (Gerstein & Dimino, 2006). A student struggling with comprehension or math reasoning, for instance, will not likely be identified by a screener that is designed to measure only reading fluency or math calculation even though these areas may be more reflective of the student's long-term success and achievement.

Furthermore, by downplaying or even eliminating contextual factors that often effect student performance, such as textual factors (how familiar is the text), student factors (how motivated is the child to read the particular text and how will time constraints impact this student's performance), and cultural factors (how culturally relevant is the task, the topic, or the pedagogical approach) (Artiles & Kozleski, 2010), RTI may underestimate the performance of some of the same students who often end up overrepresented in special education. Therefore, for Tier 1 to be even marginally useful, we must determine that any screener chosen is contextually valid and instructionally relevant; it should be designed to be used as a screener and must measure what we intend it to measure. Finally, we must continually interrogate whether the task being screened is actually relevant

to classroom learning, or risk hyper-focusing on artificial or low level tasks simply because they are amenable to progress monitoring or can be quickly screened?

Benchmarks: Distinguishing between response and non-response: Another key component of RTI is the presumption that we can measure student growth and distinguish responders from non-responders by establishing benchmarks for performance and then monitor student performance against those benchmarks over time. However, the cut-off scores or benchmarks associated with measures of student performance in RTI are determined locally (Reynolds & Shaywitz, 2009). It is common to see wide range of cut-off scores, percentiles, and standard deviations listed as possible benchmarks for performance (McKenzie, 2009). Students are sometimes compared to peers and other times to predetermined (but still arbitrary) cut scores. Thus, the criterion for what constitutes a “response” or the “R” of RTI can be wildly variable and haphazard (Reynolds & Shaywitz, 2009). Furthermore, even if we could establish a valid system of screening and determine appropriate benchmarks, it is not at all a given that progress monitoring is the best predictor of student achievement, according to Schatschneider, Wagner, and Crawford (2008). In other words, short-term progress on an instructional task may not be the best predictor of long-term achievement. Neither can we always predict that learning necessarily occurs in a linear fashion. In a two-year longitudinal study, for instance, Schatschneider et al. found little predictive validity associated with either the kinds of measures used in RTI or the manner in which they were used in terms of predicting future reading achievement.

Taking Teachers out of the equation: Because the randomized large scale clinical trial (RCT) has been authorized in educational policy as the “gold standard” for demonstrating that a program is evidence-based and because commercial programs are easier for teachers to deliver in a standardized way (or with fidelity), the interventions used in RTI tend to be highly scripted commercial programs (Batsche, Elliot, Graden, Grimes, Kovaleski, Prasse, Reschly, Schrag, & Tilly, 2006). These programs downplay the importance of teacher expertise and experience, both of which have been found to be one of the most significant factors associated with student achievement (Darling-Hammond, 1999). As a result, neoliberal reforms such as RTI, scripted curricula, alternative certification, etc. are “at odds with the professional knowledge” that has been the key to good practice (Davies, 2003, p. 95). They require teachers to become “automatons who parrot” rather than create or innovate new practices (Davies, p. 101).

Moreover, by framing learning as a very narrow and discrete “response” to instruction and teaching as simply delivering interventions with fidelity, RTI also ignores important factors that could help teachers understand the meaning of a student’s responses – information that is often crucial for determining the next instruction-

al move (Artiles & Kozleski, 2010). RTI also obscures the fact that classrooms are dynamic and transactional spaces where multiple variables are simultaneously at work (Pring, 2004; Thomas, 2004) and problems presented by student achievement and behavior are often multifaceted – not amenable to one-size-fits-all solutions (Eraut, 2004).

Students cannot be thought of as homogeneous – we would expect individual variability among students, even those sharing the same classification label. Students enter the learning context with irreducible differences in learning style, motivation, relationships to teachers, the subject matter, to school, etc. We would also expect that any group of students to have a wide range of diversity in terms of background knowledge, as well as cultural, linguistic, and personal experiences that they bring to the learning context. Similarly, teachers bring their own unique teaching style and set of dispositions, background experiences, and professional knowledge to the learning context. Because teachers are not robots or computers, even when using scripted programs, teachers implement instruction with some degree of variability (Sloane, 2014). Yet, RTI attempts to treat students, classrooms, and schools simply as dependent variables to be measured and observed, rather than agents or actors or subjects in their own right. Teachers too become simply a tool or vessel to deliver EBP with fidelity, rather than fully prepared professionals who bring expertise and experience to the instructional process. Nonetheless, by “framing RTI as a solely technical endeavor” (Artiles, Bal, King Thorius, 2010, p. 256) proponents of the model assume that these contextual factors can simply be bracketed out so that treatments delivered in an RTI model will or should have fixed effects (Artiles et al.; Sloane, 2014).

The “I” of RTI: Although universal screeners are the entry point to RTI, the targeted provision of evidence-based interventions is the real foundation of the model across each of the tiers. Proponents of RTI and policy makers voiced a common refrain that education should be more like medicine, which in the 1990s spearheaded a movement to base clinical decision-making on randomized control group studies (Hammersley, 2004). Calls for EBP positioned education as “broken and in need of repair” (Freeman, de Marrais, Preissle, Roulston, & St. Pierre, 2007, p. 25). The “fix” of course, was to make education more like medicine and educational research more like a clinical drug trial (Glenn, 2004). Ironically, “there is little evidence that evidence-based practice really works” (Lather, 2004, p. 20). Instead we are left with mostly empty promises and little to show for the huge investments⁶ in EBP, leaving many to wonder if the underlying goal wasn’t

⁶ The American Institute for Research was awarded 18.5 million dollars to develop the *What Works Clearinghouse*, which is mostly known for its “paucity” of EBP. We can only conclude that the “cost of assembling an evidence base may outweigh the [actual] benefits to students (Lather, 2004, p. 29).

financial after all (Goding & Edwards, 2002; Lather). Interestingly, within medicine, EBP was not without its own controversy. In fact, nursing researchers have been at the forefront of noting how EBP has been oversold to the public and to practitioners (Goding & Edwards, 2002; Griffiths, 2005; Rycroft-Malone et al., 2004; Zeeman, Aranda, & Grant, 2014).

Critiques of evidence-based practice (EBP) can be seen across a range of fields, including the so-called hard sciences, where researchers are quick to acknowledge that scientific discovery has more often than not involved a bricolage of “breakthroughs, inventions, and discoveries,” emerging from practice and even intuition and play (Thomas, 2004, p. 3). The randomized control group study, which is the basis of EBP in RTI on the other hand, plays a rather mundane, confirmatory role in science. Thus, this type of study is not credited with “remarkable advances” in science and medicine, which are more likely the result of “inspirational thinking and serendipitous events” (p. 11), but rather a method in which those advances simply get confirmed. Although proponents of RTI often look to medicine to justify why education must follow dictates of EBP, it is hardly a universally accepted or agreed-upon best practice in medicine (Glegg, 2005) or science.

Should we therefore assume that only a very narrow range of research methods are able to predict which interventions will be effective in an educational context (Lykins, 2012)? The type of research that proponents of RTI call the “gold standard” for educational research has, in fact, been drawn so narrowly that we are left with the unfortunate impression that nothing actually “works” in education (Lykins, 2012). Moreover, EBP does not ensure practical validity or generalizability of the skill, which can lead to “clinically superficial” and artificial interventions, despite meeting the criteria of being EBP (Goding & Edwards, 2002, p. 54). In other words, we can show how a particular practice is evidence-based, without demonstrating that the skill is important or necessary in terms of actual learning or long-term achievement.

Education-based critiques of EBP generally fall into two broad categories. First, critics argue that the social context of education is too complex for simple causal relationships to be drawn between intervention and outcome, which are better suited to the natural world (Gallagher, 2004; Hammersley, 2004; Pring, 2004). Second, critics argue that the insistence on EBP results in a narrowing of research and an ignoring and neglecting of other potentially useful research that does not conform to large scale randomized clinical trials (Lykins, 2012). In many ways a more nuanced question largely ignored in EBP discourses is not simply “what *worked*, but what *will* work, for whom, under what contexts, and at what cost” (Italics in original) (Lykins, 2012, p. 507). It is not that we should ignore EBP, but rather see this as one type of evidence, that may or may not have practical significance or contextual validity. Finally, because EBP focuses on mean rather

than individual effects, it leaves us completely “in the dark about what works for whom and in what contexts” (Sloane, 2014, p. 43).

Is a Tier a Place or a Level of Instruction: In implementing RTI, the intensity of instruction is often confused with what is referred to in the special education discourse as restrictiveness of setting or placement. What this means is that with each successive Tier in RTI, it is often assumed that the child will be taught in smaller and smaller groups – ending with one-on-one instruction in Tier 3. Fuchs and Fuchs (2006), who have been instrumental in articulating and promoting the model, for instance, use terminology that presupposes a pull-out model of instruction for Tiers 2 and 3. They 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, p. 95). Although there is nothing in the model that stipulates where Tier 2 and 3 instruction should take place, statements like these and actual practice often presuppose that more intensity requires more and more segregated settings (in the form of pull out instruction), often with a different teacher than the classroom teacher. Operationally, this is often mistaken to mean: Tier 1 is whole group instruction in general education; Tier 2 is small group pull aside or pull out instruction with a different instructor;⁷ and, Tier 3 is one-on-one instruction with a specially trained teacher or special educator. Because many of the architects of RTI were special educators, it is not surprising that level of service is confused with restrictiveness of placement. As a proponent of inclusion, I would argue that RTI, like special education, should be thought of as a set of services and supports that are not tied to a place. In other words, there is no reason that intensive instruction cannot be provided in a general education classroom or by a general education teacher. Yet, because at its core RTI is a procedure for referral and removal of students who are struggling, aimed to either confirm or deny a deficit within the student, it maintains many of the foundational deficit-based assumptions associated with traditional special education (Ferri, 2012; Kozleski & Huber, 2010).

The pull out impulse embedded in RTI also ignores how students actually learn (Artiles & Kozleski, 2010) – not by more and more teacher-focused instruction, but by more active participation and meaningful engagement in the social context of learning. It mistakenly assumes that struggling learners need more direct instruction and less peer mediated learning. RTI also ignores salient and “systemic issues such as poverty and racism” that contribute to “inequality of educational opportunity” by standardizing how all children should be expected to respond to

⁷ Again, it is assumed that in Tiers 2 and 3 students will be taught by teachers that are either specially trained, but it is often the case that schools must rely on teacher aides and related service providers, rather than highly qualified teachers.

instruction (Cochran-Smith & Lytle, 2006, p. 680). Likewise, teaching is redefined under RTI in ways that position teachers as deficit-focused “remediators” (Cochran-Smith & Lytle, 2006, p. 679) resulting in “an impoverished view of the curriculum” and the profession (p. 680).

Due Process No Man’s Land: In researching due process rights in relation to RTI in the U.S. context, I could find only two assurances have been put in place. First, schools cannot use RTI to delay or deny eligibility decisions; and, second, parents retain the right to request a formal evaluation to determine special education eligibility. This means that none of the obvious transition points in RTI (i.e. movement from one tier to the next) necessarily triggers due process rights or legal requirement for parental notification or consent. Thus, schools can institute RTI without any of the parental protections ensured by IDEA. As Daves & Walker (2012) warn, “There is professional confusion, as well as case law confusion” over RTI (p. 68). It is thus foreseeable that a child could be screened, their progress monitored, followed by placement in any of the Tiers without parental notification or consent. A child could also be pulled out for specialized instruction as a part of an RTI process without parental approval or notification, because RTI is not by law a special education practice, but part of the general education curriculum. Yet, given this lack of parental protection and its frequent reliance on the use of pull out instruction, a continuum of supports, screening, and progress monitoring, I would argue that RTI is basically instituting special education practices on a wider group of students, without being held to any parental notification requirements, or due process rights guaranteed by special education law. Even if a school does notify a parent that they are instituting RTI or that their child is being referred for more intensive instruction, it is not clear that a parent would have any recourse if they did not want their child pulled out of class.

Conclusion:

Designing a More Responsive Response to Intervention

Because policy makers have embraced RTI with a fervor, the speed of uptake of RTI has exceeded the ability of scholars to actually demonstrate its effectiveness or test its underlying assumptions. Rather than simply critiquing what I find lacking in current models of RTI, however, I want to conclude by proposing ways that a problem-solving model of RTI could and should be flexible enough to engage teachers in considering creative and innovative ways to meet diverse student learning needs. I begin by acknowledging that there is certainly much to be gained by research-based intervention studies and we must continue to use a range of tools

to determine efficacy of particular approaches. What I am arguing for is a more expansive view of what counts as evidence, however, and the acknowledgement that teachers must be empowered to use all resources at their disposal, including clinical judgment.

First, support systems, such as RTI, must be grounded in “multiple understandings” of evidence-based interventions and a more expansive view of student learning. These are “critical goals for an education system that serves increasingly diverse student populations” (Artiles & Kozleski, 2010, p. 950). Interventions, for instance, must take cultural or school and classroom contexts into account. Interventions must also be targeted (rather than universal) – responsive to a student’s unique learning strengths and needs. In other words, I would argue that RTI frameworks must respect the irreducibility of students as unique learners and teachers as more than deliverers of instruction or remediators, but rather professional and reflective practitioners. Removing teachers as a factor by demanding fidelity to an instructional protocol or script removes one of the most influential aspects of the learning context (Artiles & Kozleski, 2010). Thus, a problem-solving model of RTI should create a context in which practitioners are empowered to make nuanced and reasoned decisions about contextually relevant best practices. Rather than demanding fidelity, teachers would be encouraged to “hybridize and transform the RTI model for their own specific classroom context” (Kozleski & Huber, 2010, p. 261).

Beginning with Tier 1, it may be useful to use a variety of screening measures to try to highlight students who may be experiencing difficulties with particular areas of instruction. This said, it is important not to over-rely on any measure or place too much stock in its ability to provide meaningful and valid information about a student’s learning needs. In other words, the use value of any measure must be considered in terms of its validity and instructional relevance. A reasonable step to add to the process might be to require that teachers triangulate any measure – looking for confirming as well as disconfirming evidence of performance. This would encourage teachers to use data to inform instructional decisions, but expand the kinds of data that might be seen as relevant. Finally, as teachers monitor student progress, they should consider that learning might not proceed in linear ways. Thus, an RTI model must allow for the fact that students may not achieve at the same pace or rate as their age level peers for any number of reasons.

If a student seems to be struggling and his/her difficulties can be corroborated across various sources of data, a teacher might then draw on a range of resources to help determine the next instructional move for this learner. The teacher might, for instance, consider their own instructional expertise or past experience with learners. They would be encouraged to consult an RTI problem solving committee of peers and/or avail themselves of instructional or curricular resources and relevant research. This modification would require that we acknowledge that by definition

practices can only be evidenced-based for *groups* of students; therefore, it is quite possible that a less studied intervention might still be better suited to a *particular* learner's strengths and needs. In consulting the research, interventions should also not be thought of as evidence-based in and of themselves – but rather that they have simply demonstrated effectiveness in a particular context, with a particular experimental group, and at a particular moment in history (Lemons, Fuchs, Gilbert, and Fuchs, 2014). Thus EBP is never “transcendent” of context or history (Lemons et al.), but always already located within a particular social and cultural context. Thus, a problem solving approach to RTI should focus on learning as much about a particular student's strengths and needs and using this information to inform instructional practice. It is not enough to know that something “works.” Teachers must make informed inferences about why a particular approach might or might not work for a particular learner. Ultimately RTI must be responsive to student's individual learning needs – not to particular practices, interventions, or research designs.

Somewhat related to expanding the kinds of evidence that counts, a modified RTI would require that we consider a broader “bandwidth of learning indicators” as well (Artiles & Kozleski, 2010, p. 953). In line with universal design for learning, a modified RTI would embrace multiple modes of expression – allowing students to work to their strengths as they develop and consolidate areas of difficulty. RTI should embrace inclusive practice and engage peers as necessary partners in the learning context. Because there is little to no evidence that pull out instruction is more effective than inclusive practice, there would be no “location” tied to any Tier or intensity of intervention. In other words, a reformulated RTI would be seen as a “system of supports within the classroom,” rather than a process of referral and removal (Kozleski & Huber, 2010, p. 262). We would also assume that classroom teachers are likely the most suited to provide targeted interventions because they would have more direct experience with and knowledge of both the curriculum and the student.

Finally, EBP must be seen as an important part of a healthy research base for educational practice, but defining evidence as *only* a randomized clinical trial has not served us well. When other kinds of evidence are ignored, we risk stagnating the field and limiting innovation in education. Moreover, because the direction of EBP proceeds from research to practice, it can only increase the kinds of gaps between research and practice that have frustrated researchers for years. Instead, we must create a research base that is more responsive to students, teachers, and the changing context of science itself. As medicine, too, moves from EBP to more targeted models of individualized medicine, we too might also consider how to incorporate a wider range of research paradigms and expand practice-based research.

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