Response To Intervention (RTI): A Work in Progress

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Introduction

Response To Intervention (RTI) is a general education intervention model for students who have been identified as at-risk for academic and behavioral problems, have been provided with intervention, have benefited from the intervention, and have eliminated or considerably reduced their risk status (Linan-Thompson, Vaughn, Prater, & Cirino, 2006). The theory behind RTI is that regular education teachers can identify a student's problems accurately and address the problems before they become pervasive enough to merit referring the student to special education (Samuels, 2008; Texas Classroom Teachers Association [TCTA], 2008). There is a growing body of research on the use of RTI both as an alternative to the long-standing IQ-achievement discrepancy model for identifying students with learning disabilities (Speece & Case, 2001; Vaughn, Linan-Thompson, & Hickman-Davis, 2003) and as a method of tiered instruction (Dickson & Bursuck, 1999; O'Conner, 2000). This paper discusses the results of a survey focusing on the RTI practices of Texas elementary school campuses. Educator concerns and recommendations for training are also addressed.

Background and Literature Review

The 2006 regulations for the Individuals with Disabilities Education Act (IDEA) state that districts may identify students with learning disabilities based on a child's response to scientific, research-based interventions as part of the special education evaluation procedures (20 U.S.C. 1414(b)(6)(B)). This specification, plus a growing body of research on RTI, has spawned an increased interest in the RTI process across the nation. In fact, summits have been held at both the state and national levels to disseminate information about RTI and to help stakeholders develop plans for implementation or improvement (e.g., Texas Education Agency, 2007). With the impetus from the law, the U.S. Department of Education, and educators, many districts and schools are likely to at least explore RTI implementation, while others will embrace it (Council for Exceptional Children [CEC], 2008).

RTI Implementation

The National Association for State Directors of Special Education (NASDSE, 2006) asserts that long-term implementation of RTI will require strong support (e.g., time, fiscal resources, training) from leaders at the national, state, and district levels. Several key factors will influence the success of the initiative, including the perception that school leaders value the use of RTI, the clear articulation of a relationship between RTI and student achievement, the provision of on-site coaching, and the availability of user-friendly technology to support the personnel skills required for RTI (e.g., graphing, trend/growth lines, student/class gap analyses; NASDSE, 2006).

At the district level, RTI implementation requires strong collaborative leadership to help schools develop a solid core program. Support by campus principals significantly improves the likelihood that any new instruction practice or policy will be implemented (NASDSE, 2006). Additionally, strong school leadership ensures that teachers have the resources needed to implement RTI (CEC, 2007). Samuels (2008) reports that the process of introducing a school to RTI may begin with informal conversations between district-level administrators and campus-level administrators and teachers within interested schools. Then, during daylong sessions with teams of teachers and administrators, participants can

evaluate thoughtfully their own readiness to launch the RTI process. Building consensus is crucial to program success (Samuels, 2008). To implement RTI for prevention and identification, schools must make decisions regarding the six components that constitute the RTI process: 1) how many tiers of intervention to use, 2) how to target students for preventative intervention, 3) the nature of that preventative intervention, 4) how to classify the response, 5) the nature of the multidisciplinary evaluation prior to special education, and 6) the function and design of special education (Fuchs & Fuchs, 2007). Furthermore, introducing and implementing RTI will require restructuring the day so that grade-level teachers have common planning time, changing staff members' duties so that they can work closely with students who are having problems, and introducing intensive professional development (Samuels, 2008). RTI should be applied to decisions in general, remedial, and special education, creating a well-integrated system of instruction and intervention guided by child outcome data (NASDSE, 2006).

While RTI is a special education initiative, general educators must take the lead in providing evidence-based instruction to all students as well as research-based interventions to struggling learners (CEC, 2007). A multi-tier system of intervention options is recommended as a means to integrate educational problem-solving across educational levels, consistent with federal legislation (e.g., IDEA 2004, No Child Left Behind Act 2001) and scientific research (NASDSE, 2006). Tiered instruction provides a systematic procedure, based on progress monitoring data, for providing supplemental intervention to students who require various levels of support to benefit from classroom instruction (Linan-Thompson et al., 2006). Implementation of tiered instruction requires a cyclical approach, in which assessment and instruction are aligned to ensure that students are assessed periodically and provided with intervention if they perform below a benchmark, or accepted minimum level of performance (Linan-Thompson et al., 2006). Individual responses to even the best instruction/intervention are variable. Selection and implementation of scientifically based instruction/intervention markedly increases the probability of, but does not guarantee, positive individual response. Therefore, individual response is assessed in RTI, and the modifications to instruction/intervention or goals are made depending on results with individual students (NASDSE, 2006). It is recommended that general education support staff, such as reading coaches or Title I personnel, provide interventions and assessment for Tiers II and III (CEC, 2007).

RTI team members can represent a range of expertise and may include the principal, counselor, special education teacher, general education grade-level teacher(s), reading specialist, psychologist, speech-language therapist, and others. The team meets regularly, often at least monthly, to share their concerns about students and problem solve (CEC, 2007; NASDSE, 2006).

In practice, RTI can look quite different from school to school. Every school has different resources, teacher strengths, and administration involved to different degrees (CEC, 2007; Samuels, 2008). However, NASDSE (2006) maintains that successful tiered intervention programs provide high-quality instruction/intervention matched to student needs using learning rate over time and level of performance to make important educational decisions.

Tier I. Tier I is the foundation and contains the core curriculum (both academic and behavioral), which should be effective for approximately 80-85% of the total school population. Tier I interventions focus on group interventions for all students in a school and are characterized as preventative and proactive (Speece & Case, 2001; TCTA, 2008; Vaughn et al., 2003). Using a universal screener that assesses grade-level skills, students are screened early in the school year to determine if they might have educational difficulties and to help teachers determine which extra lessons these children need. Parents are notified when screening shows that their child may not be learning as fast as his or her classmates (Samuels, 2008). During the course of instruction, the school continues to use universal screenings, usually three times a year (beginning, middle, and end) to identify each student's level of proficiency (NASDSE, 2006). The screening data are organized by grade-level skills and in formats that allow for the inspection of both group and individual performance on specific skills. The screening must be capable of identifying which students are proficient in the target skill, which students are in the process of developing the skill, and which are significantly deficient in the skill (NASDSE, 2006). Early identification is a critical component of tiered instruction because students who have poor reading skills at the end of first grade

rarely acquire average-level reading skills by the time they finish elementary school (Francis, Shaywitz, Steubing, Shaywitz, & Fletcher, 1996; Juel, 1988).

Instruction and intervention in Tier I must be of high quality and matched to student need and must have been demonstrated through scientific research and practice to produce high learning rates for most students. Children are given increasingly intense instruction geared to bolstering the areas where they need help. The interventions must not only be scientifically based, but also administered with fidelity (NASDSE, 2006). Additional testing, or progress monitoring, continues for those students through the school year to make sure the extra lessons are working (Samuels, 2008). Progress-monitoring assessments must be representative of the academic competence expected of students at the end of the school year. These measures must be free of floor or ceiling effects, as well as demonstrate sensitivity to change over a short period of time as students gain more skills (Fuchs & Fuchs, 1999). In addition, the assessment must have good reliability and validity (Fuchs & Fuchs, 1999). If less than 20% of peers in general education are not making satisfactory progress, it may be presumed that the foundational program is sufficiently effective and that further individualized interventions are needed at Tier II for students who are not meeting expectations on level of skills and progress (NASDSE, 2006).

Tier II. Tier II interventions serve approximately 15% of students. Interventions at this level are targeted group interventions. Students at Tier II continue to receive Tier I instruction in addition to Tier II interventions. Based on performance data, students move fluidly between Tier I and Tier II (TCTA, 2008). Parents should be notified of their child's participation in the RTI process at least by Tier II. Schools should explain the RTI process (preferably in a face-to-face meeting), give parents written intervention plans, and obtain their consent (CEC, 2007). According to the National Center for Learning Disabilities (2007), the RTI written intervention plans should contain a description of the specific intervention, the length of time that will be allowed for the intervention to have a positive effect, the number of minutes per day the intervention will be implemented, who will provide the intervention, where the intervention will be provided, the factors for judging whether the student is succeeding, the progress monitoring strategy that will be used, a progress monitoring schedule, and how frequently parents will receive reports about their child's response to the intervention. Information gathered through the RTI process about the student's performance include a file review, examination of the student's attendance, attention control, observation of the child in class, and an interview with the parents (CEC, 2007). Students can be evaluated for special education at any time during the RTI process (CEC, 2007).

In Tier II, more intense interventions occur in general education classrooms or pull-out programs supported by general, compensatory, or special education funding (NASDSE, 2006). Tier II teachers provide the students with intensive services and interventions in addition to the general curriculum instruction. Specialized personnel and special education teachers may become part of the RTI model at Tier II. Tier II interventions are designed to be used in a systematic manner with all participating students, are usually delivered in small groups, are often scripted or very structured, and have a high probability of producing change for large numbers of students. Student progress is monitored frequently and instruction is fine-tuned based on student response (NASDSE, 2006).

Learning rate and level of performance are the primary sources of information used in ongoing decision-making. Learning rate refers to a student's growth in achievement or behavior competencies over time compared to prior levels of performance and peer growth rates (NASDSE, 2006). Level of performance refers to a student's relative standing on some dimension of achievement/performance compared to expected performance (either criterion- or norm-referenced). Learning rates and levels of performance vary significantly across students. Fuchs and Fuchs (1993) identified rates of progress for typical learners in reading as well as rates displayed by students with learning disabilities. Most students with achievement or behavioral challenges respond positively to explicit and intense instruction/interventions (NASDSE, 2006). For example, systematic and explicit instruction in phonemic awareness, phonics, fluency, vocabulary, and comprehension has been linked to improved outcomes for struggling readers (National Reading Panel, 2000). Decisions about the use of more or less intense interventions are made using information about learning rate and level. Deciding when students should move to a different tier is not an exact science, even though teachers use data to make decisions. If a

student's scores are below the trend line, falling, or even flat, the team decides how to change the student's instruction. The team will often try various interventions at a level before recommending that the student be moved to the next tier (CEC, 2007).

Tier III. Tier III serves approximately 5% of students and should include both special education and general education options (TCTA, 2008). The third tier creates intensive instructional interventions to increase an individual student's rate of progress (NASDSE, 2006). Once students reach target skills levels, the intensity and/or level of support is adjusted. These students move fluidly among the tiers (TCTA, 2008). Individual diagnostic assessments are conducted to determine specific patterns of skills that the student has and does not have for the purpose of designing effective instruction to remediate the student's deficits. In the third tier, interventions will likely include longer-term interventions and may or may not include the provision of special education services. For example, a student whose performance is directly related to limited English proficiency may need a longer-term set of interventions that do not include special education (NASDSE, 2006). There are many issues and concerns to consider regarding implementation of RTI for all students, and for culturally and linguistically diverse students in particular, because the research on interventions and their efficacy with these students is limited (Vaughn & Fuchs, 2003). Finding viable ways to appropriately identify English Language Learners (ELLs) who may need special education services is of critical importance. Students from non-English speaking backgrounds have often been mislabeled for special education services due to issues such as the language of tests used to identify the IQ-achievement discrepancy (Jimenez, Siegel, & Lopez, 2003), language abilities (Gunderson & Siegel, 2001), and cultural differences (Ortiz & Maldonado-Colon, 1986; Salend, Duhaney, & Montgomery, 2002).

Students who make minimal gains or do not meet benchmarks even after receiving high-quality validated interventions are described as not adequately responding to intervention (Linan-Thompson et al., 2006). Eligibility determination for special education services occurs when a student's response to both core instructional and supplemental interventions does not result in improvement toward achieving benchmarks and peer performance levels (NASDSE, 2006). In addition, a student may be considered for special education if his/her response to intensive intervention produces a meaningful growth rate, but maintenance of that growth rate requires significant and ongoing resources beyond general education (NASDSE, 2006). The special educator's role becomes more significant for students who receive Tier III interventions. At Tier III or IV, depending on the model used, special education teachers play an integral role in evaluating and providing appropriate educational services for students who have a disability (CEC, 2007).

To examine RTI practices on Texas elementary school campuses, the researchers conducted a survey during the 2007-2008 school year.

Method

Participants

After obtaining IRB approval, the researchers contacted 109 Texas public school districts with a school district enrollment of 15,000 or more students to participate in the survey. Of these, 70 districts granted permission for their elementary school campuses to participate. The largest response rates were from Education Service Center Region I (18%) in South Texas, Region IV (17%) in East Texas, Region X (13%) in North Texas, and Region XX (11%) in South Texas. Almost three-fourths of respondents were from large school districts, classified as either 4A (i.e., a grades 8-11 school enrollment of 980-2,084 students) or 5A (i.e., a grades 8-11 school enrollment of 2,085 or more students). Approximately one-half of respondents reported being a Reading First School. A total of 289 usable surveys were returned, representing participation from each of Texas' 20 educational regions. Based on respondents' IP addresses, approximately 70% of the completed surveys were multiple submissions from individual elementary campuses. In these cases, apparently more than one intervention team member from a campus submitted a survey, although the researchers' intention was to receive one survey per elementary campus, completed collaboratively by the intervention team.

Materials

Survey instrument. Based upon a review of the literature, the researchers designed a 50-item self-administered online survey entitled Survey of Elementary Campus Intervention Teams on Response to Intervention (RTI) Practices. This survey was accessed by respondents via an e-mailed web link and was comprised of four sections. In some instances, survey items required respondents to select the one most accurate descriptor or choice (i.e., single-answer items), while in other instances, survey items required respondents to select as many choices as applicable to their program (i.e., multiple-answer items).

Section I inquired about the demographics of the elementary campus and the characteristics of the intervention team (3 single-answer items and 5 multiple-answer items). Section II addressed RTI model characteristics such as the number of intervention tiers, areas targeted for intervention, universal screeners utilized, and guidelines and timelines for each tier (5 single-answer items and 13 multiple-answer items). Section III addressed specific intervention characteristics such as how students are targeted for intervention, math and reading curricula, intervention strategies, number of instructional minutes and intervention weeks, and the method for identifying non-responders (1 single-answer item and 19 multiple-answer items). Section IV inquired about RTI implementation issues and training needs (4 open-ended questions). Content validity was established by a panel composed of university faculty teaching practitioners, school administrators, and a Reading First field training analyst.

Data Analysis

In cases where more than one team member from a campus submitted a survey, the researchers randomly chose one of the team members' surveys as a representative campus response. The focus of this study was to explore RTI practices across Texas elementary campuses; therefore, the researchers did not analyze multiple data from the same-campus surveys in an effort to ensure that the results were not biased due to overrepresentation of responses from any single campus. Data analysis included approximately 120 surveys. Descriptive statistics and qualitative analysis methods were utilized.

Results

RTI Model Characteristics

Sixty-five percent of the elementary campuses reported being in the beginning stages of RTI, with implementation occurring for one year or less. Approximately 79% of the respondents indicated the utilization of a three-tier model, with many campuses reporting that a referral to special education was made after Tier III interventions were unsuccessful. More campuses reported the implementation of an RTI model for reading intervention (86%) than for mathematics (54%). The most frequently cited schedules for intervention team meetings were monthly (32%) or as needed (35%). The most frequently cited intervention team members included an administrator, counselor, general education teacher, special education teacher, Title 1 Specialist, and At-Risk/Testing Coordinator. Differentiated tier approaches for culturally and linguistically diverse students most frequently included ESL Instruction (73%) and extra time in small groups (39%; see Figure 1). Approximately 25% of respondents indicated that the parents of a child receiving tier intervention were included in the intervention team meeting. Elementary school campuses reported the utilization of a wide variety of reading and math curricula and resources (see Figures 2 and 3 respectively). The most frequently identified reading curricula were Accelerated Reading (49%) and Reading Interventionists (33%). The most frequently identified math curricula were Accelerated Math (32%) and Saxon Math (19.29%).

Tier I. The administration of a universal screener three times a year was reported by 64% of the respondents. The most commonly reported universal screeners were a grade-level Texas Assessment of Knowledge and Skills (TAKS) test, with reading at 86% and math at 84%. The second most common universal screener (70%) was the Texas Primary Reading Inventory (TPRI), a state-mandated assessment available in both English and Spanish.

Tier II. The students most frequently targeted for Tier II intervention were those performing in the lowest 10-30% on a universal screener (see Figure 4). The most commonly reported group intervention strategies, which in some instances could also be utilized in Tier III, were explicit instruction (81%), curriculum-based measurement (61%), and the utilization of a scripted curriculum (43%; see Figure 5). The majority of campuses reported administering Tier II or targeted group interventions for either a six-

week time period (37%) or a twelve-week time period (33%) before moving the students identified as non-responders to Tier III interventions.

Tier III. The most frequently reported lengths of time spent receiving Tier III intensive individual interventions were a six-week time period (29%) and twelve-week time period (26%). The most frequently reported intensive individual intervention strategies were explicit instruction (81%), one-to-one tutoring (79%), and computer-based programs (73%; see Figure 5). The most frequently identified professionals to provide intensive intervention to students were the regular education teacher (62%) and the dyslexia and special education teachers (both at 60%; see Figure 6). Tier III interventions were most frequently reported to include an average of 120 additional instructional minutes per week (33%).

Tier III non-responders were most frequently identified by the number of weeks spent in tier (23%), failure to reach grade-level proficiency in 12 weeks (19%), dual discrepancy method (19%), and performance lower than the 25th percentile on a universal screener (17%). The most commonly reported lengths of tier intervention before a referral to special education were 12 weeks (40%) and 18 weeks (35%).

General Themes

Several significant themes emerged from an analysis of the four open-ended survey questions regarding respondents' RTI implementation issues and training needs. The themes included the following: RTI implementation, RTI training, and support from special education personnel. In the area of RTI implementation, respondent concerns fell into three categories: *RTI framework, intervention personnel, and time constraints.* In the area of training, respondent needs included the categories of *tier implementation, research-based interventions and instruction, and progress monitoring.* In the area of support from special education personnel (i.e., educational diagnosticians, school psychologists, speech and language pathologists), respondent needs included the categories of *team player, administrative guidance, intervention and instructional support, and progress monitoring*.

RTI implementation. Respondents indicated a need for an RTI framework or model to follow that would clarify and differentiate between tiers in areas such as teacher responsibilities, research-based interventions, growth rate criteria, and length of time a student participates in each tier. Resounding concerns were expressed about having enough personnel or intervention coaches to provide quality remediation to all of the children in need and at each of the tiers. Time constraints affected the scheduling of Tier II and III interventions while also maintaining a student's regular education instruction in the Texas Essential Knowledge and Skills (TEKS). Respondents found Tier III to be the most difficult to implement due to personnel needs and scheduling requirements. Progress monitoring and scheduling meetings to discuss the data further added to time constraints.

Training. Respondents desired training in both general and specific aspects of RTI implementation. Training was requested on the organization of a tier model such as levels of intervention, instructional time and scheduling recommendations, timeframe for receiving intervention in each tier (i.e., number of weeks), and teacher responsibilities in each tier. A willingness to provide research-based interventions and differentiated instruction was clearly evident by the respondents' overwhelming request for training on effective programs and curriculum to utilize at each tier of intervention. They desired training that would provide them with the rationale, instructional strategies, and sample materials to use, along with on-going coaching while they practice and improve their intervention skills. Respondents repeatedly requested in-depth training on effective implementation of Tier III interventions (prior to making a referral to special education). More information on research-based interventions for mathematics was also specifically requested by respondents. Training needs in the area of progress monitoring included data collection, documentation, and analysis. Respondents wanted to increase their skills in interpreting and utilizing this information, so they could plan effective lessons and create intervention materials.

Special education personnel support. The phrase "be a team player" was referenced multiple times when respondents were asked how special education personnel (i.e., educational diagnosticians, school psychologists, speech and language pathologists) could be supportive of RTI implementation. Respondents strongly desired the expertise of special education personnel on their campus intervention team and throughout the RTI process. Specific administrative requests for special education personnel

included creating guidelines for RTI documentation in each tier of intervention and for reporting RTI data in an Admission, Review, and Dismissal (ARD) meeting. Numerous intervention and instructional requests were made for special education personnel to provide training on and modeling of interventions that could be utilized in Tiers II and III, with differentiated instruction training being specifically identified as a need. In the area of progress monitoring, respondents requested specific training on progress monitoring and data interpretation, as well as examples of graphs and acceptable progress monitoring documentation.

Discussion

Texas elementary schools report that they are in the beginning stages of RTI implementation, with specific aspects of the process being a work in progress. Many of the reported RTI practices and concerns mirror the recommendations and needs reported in RTI research. For example, NASDSE (2006) states that long-term implementation of RTI requires time, resources, and training. Texas elementary schools have voiced concerns in each of these areas. Further, Samuel (2008) found that RTI implementation requires restructuring the day so that grade-level teachers have a common planning time, changing staff members' duties so that they can work closely with struggling students, and introducing intensive professional development. Similarly, respondents are concerned about time constraints and personnel needs associated with Tier II and III intervention and would like to receive professional development in scientifically based interventions and progress monitoring.

Reported RTI practices in Texas elementary schools suggest that the schools have made some definitive decisions about the RTI process while continuing to make progress towards fulfilling all six components of the RTI process recommended by Fuchs and Fuchs (2007). To fulfill the first component (determining how many tiers of intervention to use), the majority of Texas elementary campus respondents have decided on a three-tier model. To fulfill the second component (how to target students for preventative intervention), the majority of Texas elementary schools administer a universal screener three times per year to target students performing in the lowest 10-30%. To fulfill the third component (the nature of the preventative intervention), Texas elementary schools appear to be moving toward the use a standard treatment protocol for academic deficits. This finding is based on respondents' reported desire to receive training on and utilize research-based instructional strategies that have been shown to improve most students' academic achievement, as well as respondents' current use of scripted curricula and explicit instruction. To fulfill the fourth component (determining how to classify the response), Texas elementary schools are most frequently identifying non-responders either by the number of weeks spent in a tier, the dual discrepancy method, or performance lower than the 25th percentile on a universal screener. The fifth component (the nature of the multidisciplinary evaluation prior to special education) is still a work in progress. Educators are trying to combine RTI information with traditional assessment procedures in an effective manner (i.e., IQ and achievement testing). Furthermore, elementary educators have requested that special education personnel (e.g., special education directors, educational diagnosticians, school psychologists) create guidelines for RTI documentation for each tier of intervention and for reporting RTI information to the Admission, Review, and Dismissal (ARD) committee. The sixth component addresses the function and design of special education. Although this study focused on the RTI process prior to a referral to special education, respondents issued a resounding request for help from special education support personnel, which suggests that the roles and responsibilities of these professionals and the function and design of special education may evolve as the RTI process develops in Texas.

Limitations of the Study

Limitations of the study are typical of those associated with survey research. The respondents were Texas elementary campus intervention team members, so the results may not generalize to elementary campuses elsewhere. Moreover, responses are the perceptions of those volunteering to participate, which may differ substantially from the perceptions of other elementary campuses within the same district. The highest response rates were from large districts, classified as either being a 4A (29%) due to a grade 8-11 school enrollment of 980-2,084 students or 5A (43%) due to a grade 8-11 school enrollment of 2,085 or more students; therefore, the results may not be representative of RTI practices in smaller districts.

References

Council for Exceptional Children. (2007, March 20). *Response to intervention – The promise and the peril.* Retrieved December 1, 2007, from http://www.cec.sped.org/AM/PrinterTemplate.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=7617

Council for Exceptional Children. (2008, January 29). *RTI summit delves into implementation, current and future issues.* Retrieved January 29, 2008, from http://www.cec.sped.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=9639

Dickson, S. V., & Bursuck, W. D. (1999). Implementing a model for preventing reading failure: A report from the field. *Learning Disabilities Research and Practice, 14,* 191-202.

Francis, D. J., Shaywitz, S. E., Steubing, K. K., Shaywitz, B. A., & Fletcher, J. M. (1996). Developmental lag versus deficit models of reading disability: A longitudinal, individual growth curves analysis. *Journal of Educational Psychology, 88,* 3-17.

Fuchs, L. S., & Fuchs, D. (1993). Formative evaluation of academic progress: How much growth can we expect? *School Psychology Review, 22(1),* 27-49.

Fuchs, L. S., & Fuchs, D. (1999). Monitoring student progress toward development of reading competence: A review of the three forms of classroom-based assessment. *School Psychology Review, 28,* 659-671.

Fuchs, L. S., & Fuchs, D. (2007). A model for implementing responsiveness to intervention. *Teaching Exceptional Children, 39(5),* 14-20.

Gunderson, L., & Siegel, L. S. (2001). The evils of the uses of IQ tests to define learning disabilities in first and second language learners. *Reading Teacher, 55(1),* 48-55.

Jimenez, J. E., Seigel, L. S., & Lopez, M. R. (2003). The relationship between IQ and reading disabilities in English-speaking Canadian and Spanish children. *Journal of Learning Disabilities, 36,* 15-23.

Juel, C. (1988). Learning to read and write: A longitudinal study of 54 children first through fourth grades. *Journal of Educational Psychology, 80,* 437-447.

Linan-Thompson, S., Vaughn, S., Prater, K., & Cirino, P. T. (2006). The response to intervention of English Language Learners at risk for reading problems. *Journal of Learning Disabilities, 39(5),* 390-398.

O'Conner, R. E. (2000). Increasing the intensity of intervention in kindergarten and first grade. *Learning Disabilities Research and Practice, 15,* 43-54.

Ortiz, A. A., & Maldonado-Colon, E. (1986). Recognizing learning disabilities in bilingual children: How to lessen inappropriate referrals of language minority students to special education. *Journal of Reading, Writing, and Learning Disabilities International, 2(1),* 43-56.

National Association of State Directors of Special Education. (2006). *Response to intervention: Policy considerations and implementation.* Alexandria, VA: National Association of State Directors of Special Education, Inc.

National Center for Learning Disabilities (2007, October). A parent's guide to response-to-intervention. Retrieved November 1, 2007, from http://www.ncld.org/images/stories/downloads/parent_center/rti_final.pdf

National Reading Panel. (2000). *Teaching children to read: An evidence-based assessment of scientific research literature on reading and its implications for reading instruction.* Bethesda, MD: National Institutes of Health.

Salend, S. J., Duhaney, L. M., & Montgomery, W. (2002). A comprehensive approach to identifying and addressing issues of disproportionate representation. *Remdial and Special Education, 23,* 289-299.

Samuels, C. (2008). Embracing response to intervention. *Education Week, 27(20),* 22-24.

Speece, D. L., & Case, L. P. (2001). Classification in context: An alternative approach to identifying early reading disability. *Journal of Educational Psychology, 93,* 735-749.

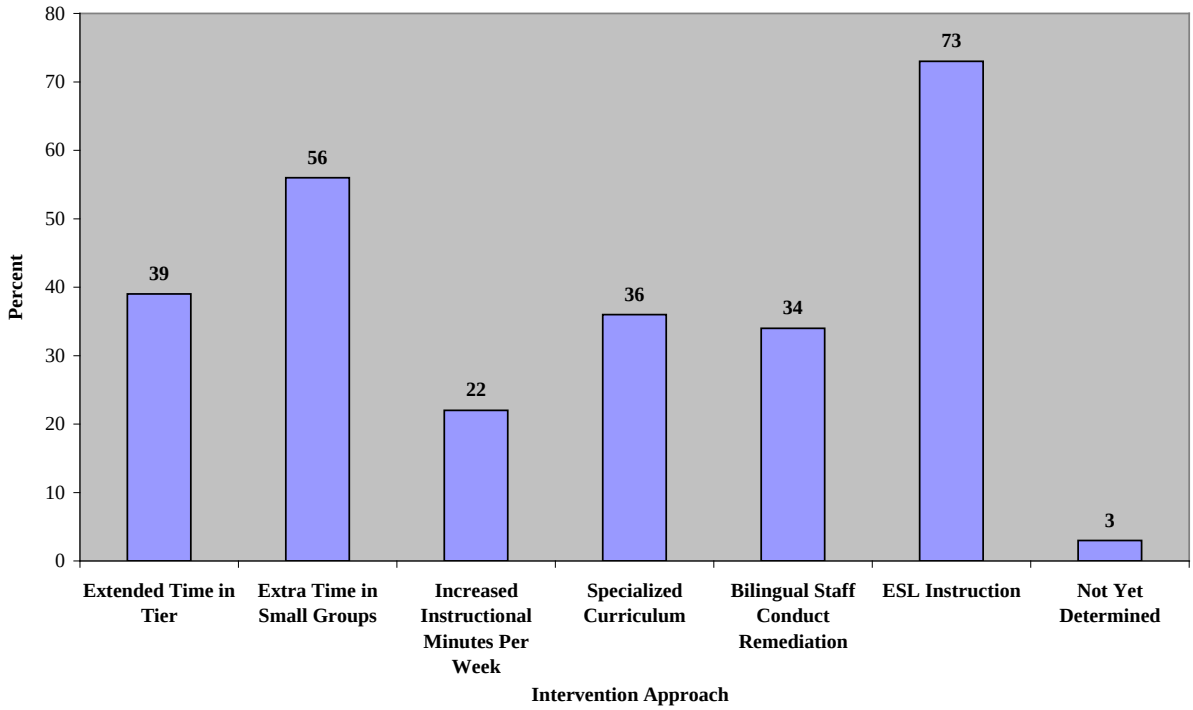
Texas Classroom Teachers Association. (2008, April 8). *Tectonic shift in general ed vs. special ed responsibilities.* Retrieved November 15, 2007, from http://www.tcta.org/edmatters/TectonicShift.htm

Texas Education Agency. (2007, June 14). *Special education in Texas: Part B state performance plan (spp) for 2005-2010 | January 2006.* Retrieved November 1, 2007, from http://www.tea.state.tx.us/special.ed/spp/reports/ind01spp.html

Vaughn, S., Linan-Thompson, S., & Hickman-Davis, P. (2003). Response to treatment as a means of identifying students with reading/learning disabilities. *Exceptional Children, 69,* 391-410.

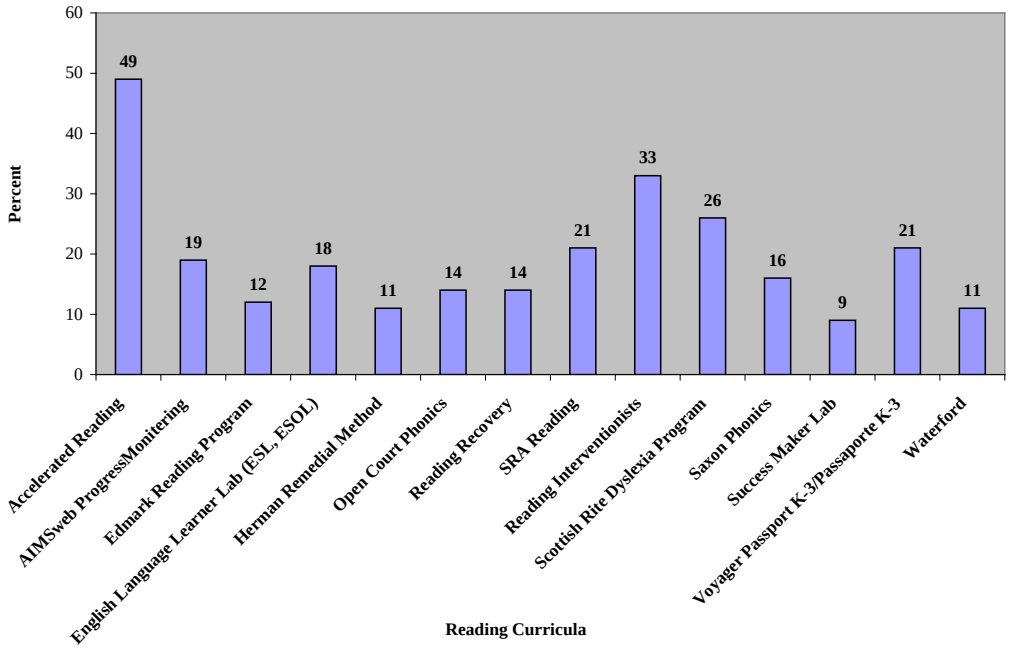
Vaughn, S., & Fuchs, L. S. (2003). Redefining learning disabilities as adequate response to treatment: The promise and potential problems. *Learning Disabilities Research and Practice, 18,* 137-146.

Figure 1: Differentiated Intervention Approaches for Culturally and Linguistically Diverse Students (*n* = 93)



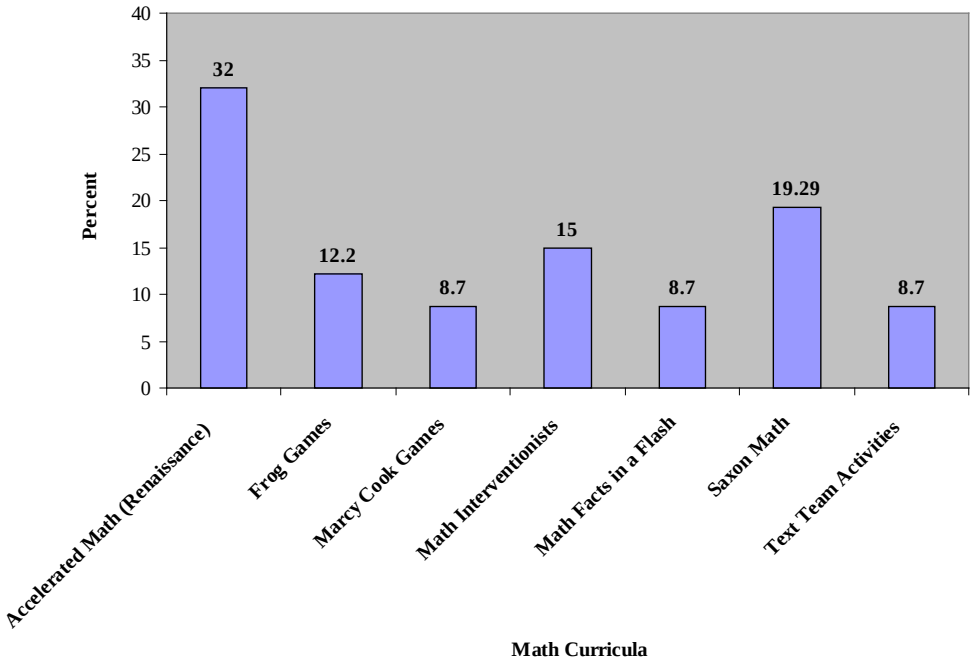
Note. The columns do not total 100% because multiple responses were permitted.

Figure 2: Reading Curricula Utilized for Intervention (n = 114)



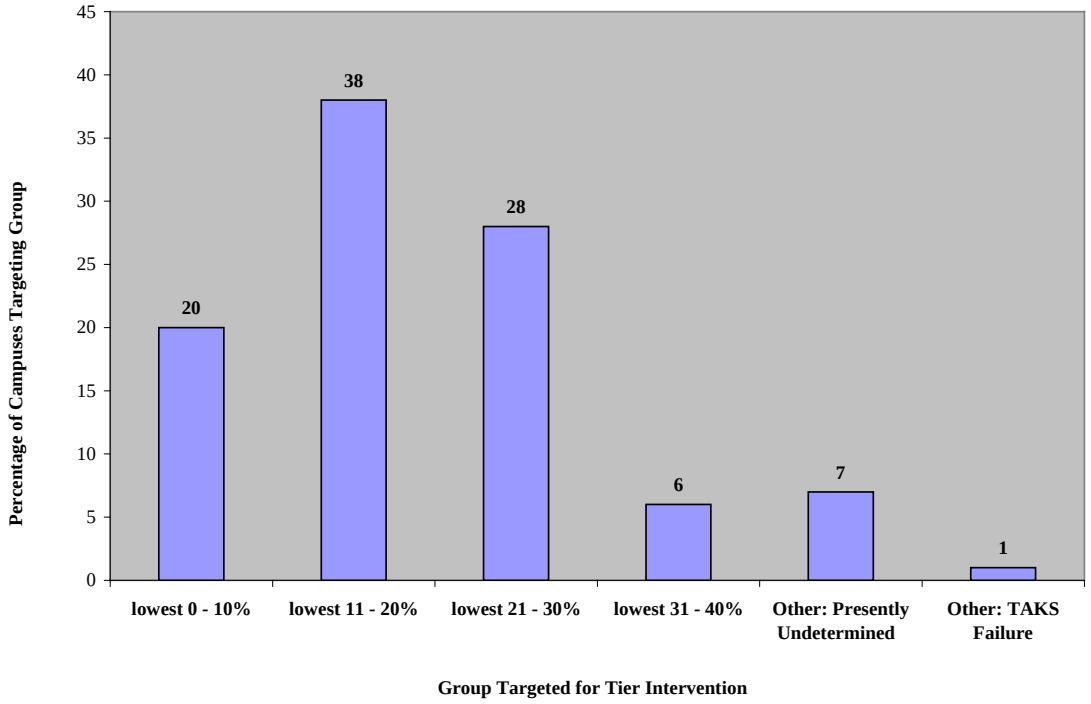
Note. The columns do not total 100% because multiple responses were permitted.

Figure 3: Math Curricula Utilized for Intervention (n = 114)



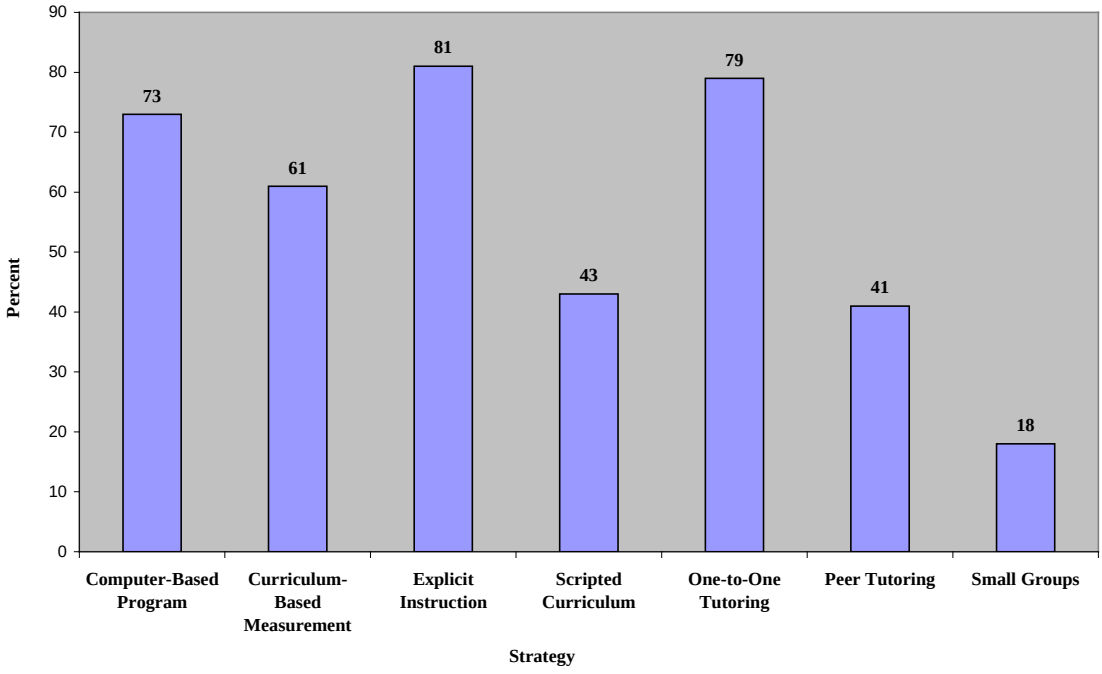
Note. The columns do not total 100% because multiple responses were permitted.

Figure 4: Universal Screener Performance Targeted for Tier Intervention (*n* = 97)



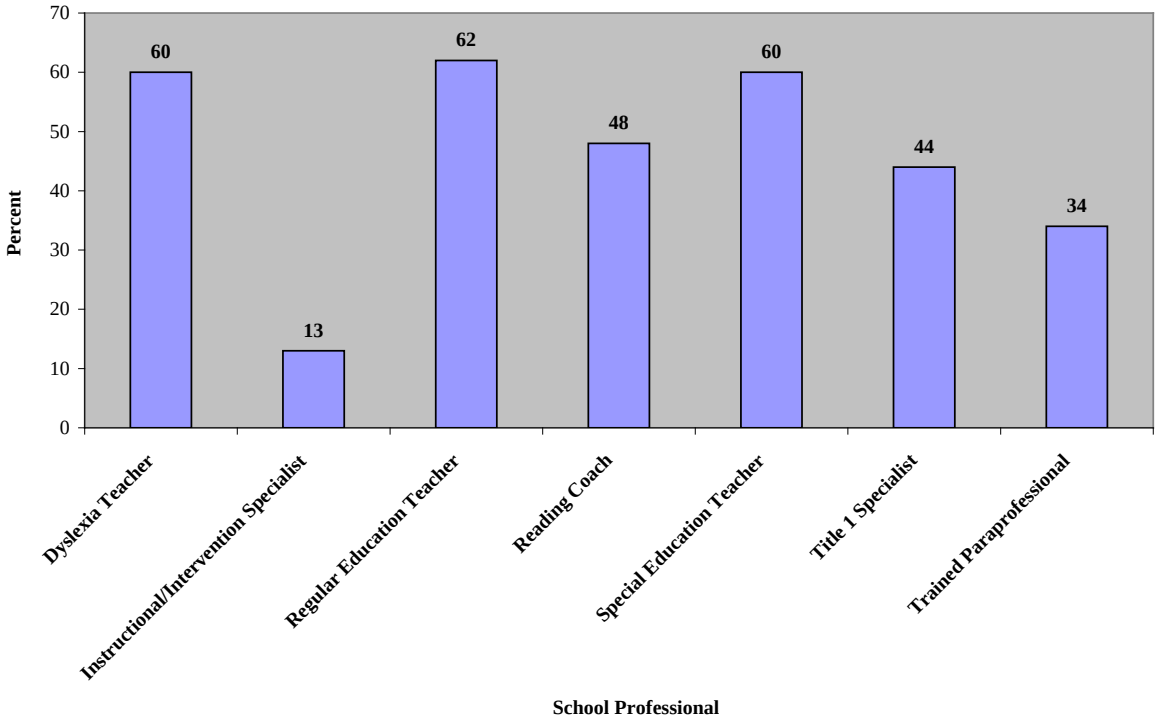
Note. The columns do not total 100% because multiple responses were permitted.

Figure 5: Tier II and III Intervention Strategies (n = 93)



Note. The columns do not total 100% because multiple responses were permitted.

Figure 6: Professional Providing Intensive Intervention (*n* = 98)



Note. The columns do not total 100% because multiple responses were permitted.