



Published in final edited form as:

Child Dev Perspect. 2009 March 23; 3(1): 41–43. doi:10.1111/j.1750-8606.2008.00074.x.

On the Importance of a Unified Model of Responsiveness-To-Intervention

Lynn S. Fuchs and Douglas Fuchs
Vanderbilt University

Abstract

In this commentary, we take issue with only one idea in Fletcher and Vaughn’s overall balanced description of the potential advantages and disadvantages of RTI: the assertion that RTI models are best conceptualized as a set of processes, not as a single model of service delivery. We argue that RTI’s major goal, to prevent long-term and debilitating academic failure, is better served by a unified model that encourages shared understanding among all school-based practitioners about intervention intensity, roles and responsibilities, and constructive and effective relationships between general and special education. We briefly describe a unified model, explain how it eases some of the challenges associated with RTI implementation, and consider implications for learning disabilities.

Fletcher and Vaughn (this issue) present a balanced description of the potential advantages and challenges associated with responsiveness-to-intervention (RTI) for preventing academic failure and identifying learning disability. In this brief commentary, we take issue with them on only one idea. They write, “RTI models are best considered as a set of processes and *not a single model*” (p. X, emphasis added). As they note, RTI practice varies dramatically from site to site, especially in the number of intervention “tiers” and how special education fits. We propose that RTI’s major goal, to prevent long-term and debilitating academic failure, is better served by a single, unified model that helps practitioners understand procedural variations under the same umbrella. A unified model will permit shared understanding of intervention intensity, shared notions of appropriate roles for various personnel, and a shared conceptualization of the relationship between general and special education. We briefly describe such a unified model, explain how it eases some of the challenges associated with RTI implementation, and consider implications for learning disabilities.

A Unified RTI Model

To illustrate RTI, Fletcher and Vaughn describe one “common implementation” (p. X) among a great variety of RTI models; the major distinction between our model and theirs is that we propose this as a unified model, not as one of many models.¹ Our unified model incorporates three levels of intensity: primary prevention, secondary prevention, and tertiary prevention.

Primary prevention is restricted to the instructional practices general education teachers should be able to conduct independently and with competence. That is, classroom teachers should be responsible for implementing the core program, which is integrated with classroom routines that provide opportunities for instructional differentiation and with

Inquiries should be sent to Lynn S. Fuchs, 228 Peabody, Vanderbilt University, Nashville, TN 37203.

¹Because we elaborate on this model, our description may not represent Fletcher and Vaughn’s perspective.

accommodations that permit access to the primary prevention program for all students. Most core programs are designed using instructional principles derived from research, but few are empirically validated because of the challenges associated with conducting controlled studies of complex, multicomponent programs.

By contrast, *secondary prevention* involves a time-limited run of small-group instruction that relies on a validated tutoring protocol. The validated protocol specifies instructional procedures and dictates its duration (typically 10 to 15 weeks of 20- to 40-minute sessions) and frequency (three or four times per week). Secondary prevention is distinguishable from primary prevention in three ways. First, secondary prevention is empirically validated, whereas primary prevention is research-principled. Second, an adult delivers secondary prevention in a standard manner to small groups of students. Instead, primary prevention relies on whole-class instruction with or without differentiated activities. The differentiated activities are typically restricted to peer-mediation or independent learning centers. Third, because secondary prevention relies on an explicit standard protocol, it does not require as much professional judgment as does primary prevention. The standardization of the protocol permits paraprofessionals to implement secondary prevention, thereby making RTI more feasible. Hence, secondary prevention is not the responsibility of the general education teacher but rather may be overseen by professional support staff (such as reading and math coaches), with paraprofessionals as tutors.

When a validated tutoring protocol is implemented accurately for secondary prevention, the large majority of students should benefit. In this way, *validation* provides a basis for two critical, interrelated assumptions. First, a student's unresponsiveness to a validated protocol is not due to poor instruction but rather to characteristics that reside within the student (i.e., a possible disability). Second, students who do not benefit from secondary prevention demonstrate a need for *nonstandard* instruction. As written in federal law, students who have a disability and display a need for nonstandard instruction are entitled to special education. Hence, a comprehensive evaluation follows to confirm the presence of a disability, making *tertiary prevention* synonymous with special education.

Tertiary prevention differs from secondary prevention in two important ways. First, in tertiary prevention, teachers establish clear, individual, and ambitious year-end goals in instructional material that matches the student's needs. This material may or may not be grade-appropriate, i.e., it may address foundational skills necessary for successful performance in grade-appropriate material and, in this way, represent appropriate content standards. Second, because the student has demonstrated insufficient response to standard forms of instruction at primary prevention and secondary prevention, tertiary instruction is individualized. The teacher begins with a more intensive version of the standard protocol (such as longer sessions or smaller group size) but does not presume that the standard protocol will meet the student's needs. Rather, frequent progress monitoring quantifies the effects of the protocol using rate of improvement (slope). When slope forecasts that goal attainment is unlikely, the teacher experiments by modifying components of the protocol while monitoring the effects of those modifications. In this way, the teacher inductively and recursively designs an effective, individualized instructional program.

This *curriculum-based measurement* (CBM) progress-monitoring technology, which is clearly distinguishable from and more intensive than secondary prevention's standard and validated protocol, has an impressive track record of randomized control trials showing improved learning outcomes for special education students (Fuchs & Fuchs, 1998). However, such use of CBM in tertiary prevention requires teachers with special training and special focus. We argue that tertiary prevention should be fueled with the resources and professional expertise available in special education (Fuchs, Stecker, & Fuchs, 2008).

How A Unified Model May Strengthen RTI Implementation

This unified model eases RTI implementation by articulating distinctions among the intensity of the three levels of the prevention system. This articulation provides a basis for reliably classifying practices as primary, secondary, or tertiary. These distinctions should help building-level administrators and teachers determine how to deploy staff in a sensible and efficient manner.

It is important to note that a unified RTI model does not necessarily mean rigid RTI implementation. Schools remain free to select different practices for the three levels of the prevention system. They also have the option of incorporating multiple interventions within any given level. So schools vary their *RTI implementations* even as they conceptualize those implementations within a *unified model*. By contrast, practitioners presently classify their RTI models in terms of tiers; models have between two and seven. *Tiers* refer to the sequence of interventions that constitute a school's prevention system. Unfortunately, the term *tiers* communicates no meaning about intensity. (In fact, as we write, instructional research does not provide the basis for reliably distinguishing among more than three levels of prevention.) The intensity of School A's Tier 3 (the third intervention students receive in School A's prevention system) may be identical to School B's Tier 5 (the fifth intervention students receive in School B's prevention system). This creates confusion as practitioners seek to understand the practices they might incorporate within their RTI system. How many tiers are enough? Which tier should precede another? When is special education an appropriate resource? By contrast, the unified model permits schools to classify practices according to a shared understanding of primary, secondary, and tertiary prevention levels of intensity. School A's Tier 3 and School B's Tier 5 might both be deemed tertiary prevention, with School B incorporating a sequence of three validated standard tutoring protocols, all at secondary prevention, before a student advances to tertiary prevention. This helps practitioners understand procedural variations under the same conceptual umbrella and promotes coherence among RTI practices within and between districts. Within a school building, it clarifies the RTI mission and provides an organizational framework for RTI design.

This unified model also eases implementation by offering special education resources to fuel tertiary prevention. Moreover, by integrating special education's unique and important role within the unified model, RTI provides an opportunity for special education reform, just as RTI has the potential to strengthen general education: by infusing greater accountability for every student's learning with a combination of research-based programs, validated practices, and demonstrably effective CBM technology for individualizing instruction (Fuchs & Fuchs, 1998). In this vein, it is important to remember that RTI's overarching goal is *not* to prevent special education, but rather to prevent life-long difficulties associated with chronic academic failure. Within the unified model, special education resources are brought to bear toward that end, with meaningful linkage between general and special education that creates the potential for flexible entry to and exit from tertiary prevention on an as-needed basis. Such flexibility parallels the prevention system in health care on which RTI is based, where individuals move in and out of tertiary prevention as needed to address their immediate challenges, even as their diagnoses (or disabilities) do not change.

Implications for Learning Disabilities

A unified model increases the likelihood of RTI success by easing challenges to implementation. It also offers important opportunities for reforming the education system, with the goal of boosting student outcomes. But what are the implications for learning disabilities (LDs)?

Research has yet to provide clear answers about the rate of LD identification. Some predict that RTI will decrease LD prevalence (e.g., Hartman & Fay, 1996), although arguably the most convincing data involve (a) math rather than reading (Fuchs et al., 2005) or (b) interventions that resemble the intensity of tertiary prevention, which are more appropriate for students already identified with LDs (e.g., Torgesen et al., 2001). Beyond prevalence, RTI can modify the identification process by systematically eliminating inadequate instruction as a viable explanation for poor achievement. In this way, it operationalizes LD as severe low achievement, with *unexpected learning difficulty* denoted as failure to respond to standard and validated instruction. This departure from the IQ-achievement discrepancy identification is likely to produce two important shifts in the character of LD. First, with RTI, the academic deficits of students with LDs should become more severe, more highly associated with neurobiological bases, and even more challenging to remediate. Second, RTI should shift the population with LDs toward identification of students whose low achievement is commensurate with their IQ and away from students whose achievement, although not necessarily low, is discrepant from their high IQ. Given a fixed amount of resources to serve students with LDs, controversy about LD conceptualizations that affect which end of the achievement continuum will be served is not likely to disappear any time soon.

Finally, RTI's greatest consequence for students with LDs depends on whether policy makers and others choose to incorporate special education in the RTI reform framework. If special education is included as the third level of a unified prevention system and is reformed as data-based individualized instruction, then schools' capacity to mitigate the negative effects of LDs will improve, and RTI's mission to prevent the chronic failure associated with poor life outcomes is more likely to be realized.

Acknowledgments

Work on this article was supported in part by Grant #H324U010004 from the U.S. Department of Education, Office of Special Education Programs, and Core Grant #HD15052 from the National Institute of Child Health and Human Development to Vanderbilt University. Statements do not reflect the position or policy of these agencies, and no official endorsement by them should be inferred.

References

- Fuchs LS, Compton DL, Fuchs D, Paulsen K, Bryant JD, Hamlett CL. The prevention, identification, and cognitive determinants of math difficulty. *Journal of Educational Psychology*. 2005; 97:493–513.
- Fuchs, D.; Stecker, PM.; Fuchs, LS. Tier 3: Why special education must be the most intensive tier in a standards-driven, No Child Left Behind world. In: Fuchs, D.; Fuchs, LS.; Vaughn, S., editors. *Response to intervention: A framework for reading educators*. Newark, DE: International Reading Association; 2008. p. 71-104.
- Fuchs LS, Fuchs D. Treatment validity: A unifying concept for reconceptualizing the identification of learning disabilities. *Learning Disabilities Research and Practice*. 1998; 13:204–219.
- Hartman WT, Fay TA. Cost-effectiveness of instructional support teams in Pennsylvania. *Journal of Educational Finance*. 1996; 21:555–580.
- Torgesen JK, Alexander AW, Wagner RK, Rashotte CA, Voeller K, Conway T, Rose E. Intensive remedial instruction for children with severe learning reading disabilities: Immediate and long-term outcomes from two instructional approaches. *Journal of Learning Disabilities*. 2002; 34:33–58. [PubMed: 15497271]