New Special Education Law from Both Sides of the Fence

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Effective September 01, 2010, federally mandated change will significantly alter how elementary school children are identified as educationally disabled and entitled to special education services in Rhode Island. Change for Secondary education students will follow suit on September 01, 2011. This is a brief overview of these changes and in no way comprehensive. It is presented for psychologists who have occasional transactions with school districts regarding the determination of eligibility for a child with a learning disability. Official materials can be obtained from the Rhode Island Department of Education. Theoretically, this latest Special Education law and procedures ensures any poorly performing student's access to nearly all supportive services with little to no delay. The federal agenda driving these changes is a goal to reduce the proportion of students identified as disabled until the State's proportion reflects the national base rate. These innovations rest on the idea that with sufficient and aggressive early intervention, most poorly performing children will improve rapidly and need no long-term specialized support. Thus, the very process of identifying children with a specific learning disability (SLD) will take on a new character. Key principles adapted to this purpose come from well established psychological principles, emphasizing early intervention and progress monitoring. Formerly, the process was heavily weighted toward "assessment and prescription" of remedial actions. Unfortunately these actions often took on a life of their own, delayed the implementation of treatment, and failed to provide quality assurance. Underlying concepts for providing early intervention, quality assurance, and identifying disabled children should be familiar to practicing clinicians. The new process has parallels with the community mental health model of primary, secondary and tertiary intervention for acute, intermediate and chronic psychopathology. Interventions may have different labels such as Tier I, Tier II and Tier III but the concept is the same. Changed, however, is how all children will be evaluated for disabilities. The most radical change involves special education and related services eligibility for students with an SLD. Previously, school based or privately generated reports were utilized to generate scores. Discrepancies in standard or standardized scores among a battery of tests were considered. If the discrepancy was 'significant', the child was identified as disabled. Base rate statistics among measures and other issues were overlooked. We now know that applying this discrepancy standard to a population of average students would erroneously identify about one in four non-handicapped students as disabled. The previous model then, did not serve to specify and discriminate well the students who were in need. Further, the protracted nature of its referral process impaired timely deployment of remediation. Rapid allocation of resources often averts further deterioration of a struggling student's classroom performance. Other criticism of the standardized test "Discrepancy Model" is its failure to evaluate the child's response to intervention, failure to place the child in context of other children (locally, regionally, nationally), and failure to assess the student in context of the child's unique history.

The new model views an underperforming student's response to a valid series of interventions, via repeatable outcome measures, generally abbreviated as "response to intervention", or simply RTI. School districts will be obliged to review how the child is progressing based on a convergence of measures over time. An instrument targeting the specific deficit and capable of being used for repeated administrations would be employed, very much like a dependent variable in a repeated measures research design. As the school year begins, all children would be screened with this type of instrument. Children whose scores fall below an established cut-off would begin to receive additional intervention known to be effective for the child's specific deficit(s). After a period of intervention the measure would be re-administered. Children falling below criterion would receive an additional or modified intervention along with the previous remediation and the regular curriculum. Universal screening and intervention is new to the process. However, the initial screening and treatment is not a special education procedure. The early intervention, RTI model identifies struggling students and gives them access to specialists and resources quickly. As children attain mastery, they would drop-out of the more intensive services, but progress monitoring would continue. Historically, reading abilities were the first category of skills targeted for this type of immediate support, as it is the most fundamental

educational skill. As of September 01, 2010, an individualized plan can be up and running with greater expedience than the initial referral process under the old rules. Even with these measures, a small proportion of children might require special education services. Such consideration might follow two periods of intensive intervention. Prior to consideration of a child with an SLD, evidence that each intervention was administered with fidelity, as well as the child's English proficiency would need to be established. Then, consideration of a child for categorization as having an SLD would review results of progress monitoring in context of each progressive intervention, along with other factors. Standardized, curriculum based nationally normed and criterion referenced grade level expectation measures, available State assessments and local district assessments would be reviewed along with the child's RTI. The target child's rate of progress and proficiency would be compared to grade level peers in this way. The key question would be improvement of the initial "gap" between the student and the child's peers. If a child's level of ability is not significantly below average, that child would not qualify. None of these considerations include a clinical diagnosis or formal assessment. In fact, a formal diagnosis such as a reading disorder would not be incorporated in the eligibility deliberations for SLD; only the child's response to intervention and individual factors would be considered. Other factors excluding eligibility for SLD include a lack of appropriate instruction, visual, motor, or hearing disability, mental retardation, emotional disturbance, cultural, environmental, or economic factors, and (as indicated above) limited English proficiency. By eschewing the classic standardized instruments characteristic of psychological assessment, it might seem that the present concept is substituting less standardized measures for ones with known reliability and validity. This however, is not the case. By utilizing repeatable measures, as well as measures of differing types and with differing standardizations, the present concept may be thought of as utilizing attributes of aggregated data while also incorporating multiple traits in a matrix of multiple assessments and treatments. Future identification of children with an SLD, then, has better discrimination and specificity than ever before. Rather than being less scientific, the new model is empirically based, less susceptible to bias, and facilitates early intervention. The four dimensions of academic achievement gap, educational progress, individual context and demonstrated need for special education services will determine eligibility for SLD.

However, this does not mean that all psychological or psycho-educational reports are obviated. A description of a child's individual factors, submitted (with proper release) during the process of any evaluation of eligibility might prove indispensable. In the greater scheme of eligibility for special education services, children remain eligible under categories other than SLD. Rhode Island requires assigning every identified child to a specific category of disability. While SLD may be an area of contention during this period of transition, there are 12 other categories of disability enabling allocation of special services, and access to half of them can be facilitated by a comprehensive psychological evaluation. Licensed psychologists remain in a unique position to provide formal assessments for the special education categorization process in areas of disability including autistic spectrum disorders, emotional disturbance, mental retardation, developmental delay (for children aged 4 - 8), other health impaired, and traumatic brain injury. For the remaining six categories (multiple disability, visual impairment, deaf-blindness, hearing impairment, orthopedic impairment, speech/language) a psychological assessment may be essential to provide an appraisal of the unique factors impacting the child as a result of the primary disability. There is another side of this coin: psychological assessment can be influential to terminate or disprove the need for labeling a child as disabled, should that be the family's wishes. A report based on standardized tests remains a, so called, "*n* of one study" to demonstrate that the child is not disabled; children who are disabled have a persistent "gap" in ability relative to the norm.

Starting September 01, 2010, a new process of early intervention which engages children in need with evidenced-based remediation should benefit the children we all serve. These changes in the law and rules governing special education should refocus resources from discrepancy determination testing to valid, child-based remediation. While the helpfulness of a psychological assessment remains, the manner in which psychologists collaborate with school districts may change as the new Special Education law and rules take effect.