

## Chapter 2

# Problem Solving and Response to Intervention

The practice of school consultation today is quite different from that of the 1990s. Why is that the case? How has school consultation changed? It is the goal of this chapter to explore these complex questions.

Our explorations lead us to consider problem solving, response to intervention (RTI), and school consultation. However, our coverage of each in this chapter is intentionally unequal. Problem solving, for example, is introduced here and covered in more depth in Chaps. 5, 6, and 9. Likewise, school consultation is the focus of this entire book and its treatment in this chapter is minimal, as it instead provides a backdrop for the other two topics. That leaves RTI.

If you have not visited schools recently, or do not visit them regularly, you may be unaware of the ubiquitous presence of RTI. A brief definition of RTI is “the systematic use of assessment data to most efficiently allocate resources in order to improve learning for all students” (Burns & Gibbons, 2008, p. 1). In RTI, “students are exposed to multi-tiered interventions in general education settings to determine which students need what services delivered, with how much intensity, and for how long” (Gresham, 2009, p. 206). In a short time, RTI has greatly affected the way services are delivered to students, and certainly the practice of school consultation has been changed as a result.

It is important to realize that the RTI literature is already voluminous and continues to expand rapidly. Thus, we cannot comprehensively present RTI as much as introduce it along with related topics and offer a context for how together they mesh with the contemporary practice of school consultation. We proceed by describing (1) contextual influences on RTI and the contemporary practice of school consultation; (2) aspects of problem solving; (3) fundamental characteristics of RTI; and (4) relationships between and among problem solving, RTI, and school consultation.

## **Establishing a Context for RTI and the Modern Practice of School Consultation**

To explore the intertwined nature of RTI and school consultation, we build on background information presented in Chap. 1 using the framework of philosophical, legislative, and empirical influences advanced by Erchul and Sheridan (2008b).

### ***Prevention as a Philosophical Influence***

From its earliest beginnings, consultation in the human services has been concerned with preventing mental illness and educational failure (Zins & Erchul, 2002). *Primary prevention*, for instance, refers to lowering the rate of new cases of a disorder in a population over a period of time by counteracting harmful effects before they have an opportunity to produce the disorder (Caplan, 1964). School consultation has been shown to operate at the primary prevention level by demonstrating reductions in the number of referrals for special education services in a particular school following consultation with regular education teachers (e.g., Ponti, Zins, & Graden, 1988). Although the terms primary, secondary, and tertiary prevention basically have been replaced with the terms universal, selective, and indicated prevention, respectively (see Chap. 5), the recurring message is that consultants often work with consultees on existing problems to prevent future problems from occurring. Prevention, then, has always been a significant undercurrent in the consultation literature (Erchul & Sheridan, 2008b).

Certain elements of RTI also reflect the importance of prevention. First, the special education category of *specific learning disability* (SLD) historically has relied on documenting the presence of an IQ-achievement discrepancy. This conceptualization is acknowledged as psychometrically flawed and embodies a reactive “wait-to-fail” approach by withholding interventions until a child’s achievement drops significantly below his or her IQ (Gresham, 2009). The Individuals with Disabilities Education Improvement Act of 2004 (IDEIA 2004) offers an alternate way to conceptualize SLD using RTI. Specifically, within RTI, a child suspected of SLD is presented with evidence-based interventions implemented with integrity. If the child responds favorably, then the learning difficulty is thought to have been treated successfully before a full-blown learning disability could develop. If the child responds poorly to these interventions, however, he or she is deemed eligible for further evaluation and assistance (including special education). The proactive, front-loading of intervention resources found in RTI thus is very consistent with a prevention/early intervention philosophy that utilizes an at-risk rather than deficit orientation (Gresham).

Another aspect of RTI that reflects a preventive orientation is the multitier system of intervention, specifically in its foundational tier (i.e., tier 1). Although we describe the system of tiers in greater detail later on, at this point it is sufficient to grasp that

*universal screening* occurs in tier 1. With the universal screening of academics, for instance, all students receive brief measures of academic and/or behavioral competency that are evaluated at the level of the classroom or school building to answer these questions: (1) How many students are responding to the instruction provided?; (2) Is the instruction effective?; (3) How many students are at risk for failure?; and (4) Who are the students needing further assessment and possibly greater supports? (Ikeda, Neessen, & Witt, 2008). The described screening procedure represents a clear example of a primary/universal prevention activity within RTI.

## ***NCLB and IDEIA 2004 as Legislative Influences***

Several specific federal laws enacted since the early 2000s have led to notable educational reforms such as RTI that in turn have affected school consultation. The two laws considered here are the 2001 reauthorization of the Elementary and Secondary Education Act (better known as No Child Left Behind or NCLB) and IDEIA 2004. When compared to their immediate predecessors, these laws shifted the focus of schools' documentation from *how* their programs deliver educational services to the *results* they produce (Reschly & Bergstrom, 2009).

### **NCLB (2001)**

The major contribution of NCLB is that it has made the US educational system accountable for learning by setting academic performance goals for all students and establishing rewards and sanctions for educational professionals to meet these goals. A driving assumption behind NCLB is that all students can learn, and all schools must be proficient in teaching basic reading and mathematics skills by the 2013–2014 academic year. Science-based practice in the classroom is the means by which this change is to occur. Some positive indicators of the impact of NCLB thus far include: (1) school personnel taking outcomes of student learning very seriously, (2) schools frequently conducting large-scale assessments and collecting a considerable amount of student data, and (3) school personnel using these data in decision making at both individual and system levels (Tilly, 2008). The high-stakes aspects of NCLB bode well for greater use of school consultation services and fostered the introduction of RTI later on in IDEIA 2004.

Along these lines, Burns and Gibbons (2008) made the salient point that “although RTI was born in special education law, it was conceived in the No Child Left Behind Act” (p. 4). Some NCLB provisions that are regarded as having facilitated the development of RTI are: (1) frequent collection and review of data; (2) accountability for results, such as through tracking a school's adequate yearly progress; (3) use of science-based instructional and intervention strategies; (4) reading instruction targeted toward five empirically based component areas; (5) emphasis on prevention and early identification/treatment of academic problems; and (6) public reports of student achievement by individual school, breaking these data

down by categories such as student race/ethnicity, English language proficiency, and disability category (Reschly & Bergstrom, 2009).

### **IDEIA (2004)**

A special education law, IDEIA 2004 is the current reauthorization of the Education for All Handicapped Children Act of 1975 (P.L. 94-142). The regulations for IDEIA 2004 Part B, released in August 2006 for implementation during the 2006–2007 academic year, present several implications for school consultation. The first of these, of course, is that RTI was introduced as an acceptable substitute for the time-honored IQ/achievement discrepancy eligibility determination for SLD. Although IDEIA 2004 links RTI exclusively to SLD identification, Reschly (2008) argued incisively that because the law specifies that RTI can be used *prior to* or as a part of the referral process, one cannot know ahead of time if a child has an SLD, and therefore RTI rightfully applies to all high-incidence disability categories. High-incidence disabilities include SLD, speech/language impairment, mental retardation, and other health impairment; these categories account for about 70% of all disabilities in the population within the age group of 3–21 (National Center for Educational Statistics, 2009). This line of thought has been instrumental in advancing an expanded role for school psychologists that involves them in more consultation, problem solving, and RTI activities.

Second, IDEIA 2004, like its predecessor, IDEA 1997, promotes *positive behavior support* (PBS). Positive behavior support is “an application of a behaviorally based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occur” (Office of Special Education Programs, n. d.). The objective of PBS is to establish and sustain primary/universal (i.e., school-wide), secondary/targeted (i.e., small group), and tertiary/indicated (i.e., individual) support systems that improve lifestyle results for all children and thereby produce meaningful educational and behavioral change (Simonsen & Sugai, 2009). Evaluations of school-wide PBS programs have shown that 84% of students annually receive one or fewer office referrals for major rule violations when primary/universal support is in effect (Horner, 2007, cited by Simonsen & Sugai). We highlight PBS because it illustrates both (1) how a multitiered system of intervention found in RTI can apply to behavioral as well as academic problems and (2) that consultation constitutes a viable means by which this type of service can be delivered (e.g., Knoff, 2008).

### ***Empirical Influences***

From provisions of the federal laws just reviewed, it is evident that we live in a time that heralds scientifically based professional practice. Other terms used to denote this orientation include “evidence-based intervention,” “empirically supported treatment,” “empirically validated therapy,” and “evidence-based practice” (Erchul

& Sheridan, 2008b). Most importantly, this viewpoint dictates that a professional's actions should be informed by the best available research, and it is a view that is integral to the fields of mental health (Norcross, Beutler, & Levant, 2006), professional psychology (APA Presidential Task Force on Evidence-based Practice, 2006), and school psychology (Kratochwill et al., 2009). As scientist-practitioners, we hope that everyone undertaking RTI and school consultation will embrace this orientation.

Apart from this general commitment to science guiding practice, however, what are some specific empirical influences on RTI and school consultation? Reschly and Bergstrom (2009) presented eight such influences:

1. Applied behavior analysis;
2. Behavior assessment, curriculum-based measurement (CBM), and formative evaluation;
3. Principles of learning and instruction;
4. Meta-analysis findings;
5. Direct instruction;
6. Reading instruction;
7. Learning strategies; and
8. Consultation methods for problem solving.

Each listed area is a domain onto itself and to which many graduate degree programs dedicate an entire course! We shall not elaborate further on these empirical influences here, but do address each content area elsewhere in this book. It is evident that these research foundations influenced policy developments in the late 1990s to early 2000s, which then influenced federal law in the early- to mid-2000s (Reschly & Bergstrom, 2009).

The activity of problem solving is fundamental to both school consultation (Brown, Pryzwansky, & Schulte, 2006) and RTI (Burns, Deno, & Jimerson, 2007). Next, we introduce problem solving by presenting a definition and key aspects as well as elements of problem solving carried out in a team-based format.

## Problem Solving

### *What is Problem Solving?*

In general, *problem solving* is a systematic process, wherein an issue of concern is identified, clarified, and analyzed to the point an appropriate strategy is selected or devised and then implemented to address the problem. Following implementation of the strategy, its impact on the problem is evaluated.

In psychology and education, problem solving may be usefully depicted through a series of questions, such as:

1. Is there a problem and what is it?
2. Why is the problem happening?

3. What can be done about the problem?
4. Did the intervention work? (Tilly, 2008, p. 18)

These questions correspond to four stages: problem identification, problem analysis, plan implementation, and problem evaluation (Bergan, 1977; Bergan & Kratochwill, 1990). It should come as no surprise that these problem-solving stages constitute essential features of RTI and school-based problem-solving (i.e., behavioral) consultation (Erchul & Schulte, 2009; Kratochwill, Clements, & Kalymon, 2007). Problem solving and the four stages are addressed in detail within the context of the integrated model of school consultation in Chaps. 5 and 6.

### ***Problem-Solving Teams***

Formal team-based problem solving in schools has been evident at least since the mid-1970s' enactment of P.L. 94-142, which required multidisciplinary teams to decide on student eligibility for and placement in special education (Gravois, Groff, & Rosenfield, 2009). Beginning in the 1980s, this group decision-making format evolved to also include prereferral intervention teams (PITs), which were intended to support teachers, decrease inappropriate referrals to special education, and help difficult-to-teach students in the regular classroom (e.g., Graden, Casey, & Christenson, 1985). Although group composition can vary, a PIT often includes the referring teacher, regular education teachers, special education teachers, school psychologist, other specialists, and a school administrator. Following a PIT's problem-solving discussion, it is assumed the classroom teacher will deliver an intervention to the student. Interestingly, a survey of state departments of education indicated that 86% of states now either require or recommend PITs, but most do not offer any guidance about how to implement them (Truscott, Cohen, Sams, Sanborn, & Franks, 2005). We present other information about PITs in Chap. 9.

Burns, Wiley, and Viglietta (2008) further distinguished PITs from problem-solving teams (PSTs). They noted that PSTs are more closely aligned with behavioral consultation (Bergan & Kratochwill, 1990) and its systematic problem analysis component in particular, and are more concerned with identifying interventions that produce positive results for children. In contrast, Burns et al. view the role of PITs as much more focused on special education referral issues.

Despite these apparent and important fundamental differences, PITs and PSTs have much in common, and it is clear that the extant research literature on PITs has implications for the practice of RTI, most specifically that a paradigm shift is required as teams move from a special education eligibility framework to one of identifying interventions that work. A sampling of this literature reveals that: (1) PITs can vary considerably in terms of member composition, overall goals, and interventions developed (Truscott et al., 2005); (2) PITs have demonstrated success in producing outcomes such as improving student academic achievement and lowering referral rates for special education (Burns & Symington, 2002); (3) PIT

members perceive their own teams as functioning well and PITs in general as constituting an effective service delivery model (Bahr, Whitten, Dieker, Kocarek, & Manson, 1999); (4) teachers feel their opinions are often devalued by other team members; (5) teachers believe PIT-developed interventions are frequently unclear, redundant, or not tailored to the individual student; and (6) teachers experience frustration that PITs do not always take responsibility for intervention implementation and/or outcomes (Slonski-Fowler & Truscott, 2004). This mixture of accomplishments and challenges leads to many opportunities as PITs “become” PSTs in the RTI era.

Speaking of PSTs, two recent studies documented the importance of feedback provision as a way to increase procedural integrity and enhance RTI outcomes in a team-based format. First, using a multiple baseline design across three schools, Burns, Peters, and Noell (2008) sought to increase the implementation integrity of a problem-solving process by giving performance feedback. Feedback was provided to PSTs in the form of graphs of the percentage of behaviors specified on a 20-item procedural checklist that had been observed in the previous meeting. Improved procedural integrity resulted immediately from the introduction of performance feedback, with the PSTs showing an average increase in implementation of 78% of the checklist behaviors. However, feedback on procedural integrity did not greatly increase team behaviors related to student progress monitoring, intervention effectiveness evaluation, or treatment integrity assessment.

In a related PST study, Duhon, Mesmer, Gregerson, and Witt (2009) used a multiple baseline design across eight cases to assess the effect of performance feedback on establishing teacher treatment integrity and reestablishing it after it had dropped to an unacceptable level. Feedback on intervention implementation was delivered publicly to individual teachers during weekly PST meetings. Results showed that performance feedback was successful in improving or maintaining high levels of treatment integrity in all cases. Perhaps most significantly, these levels of teacher treatment integrity were associated with enhanced student academic performance on targeted skills as measured by researcher ratings. Duhon et al. concluded that the group setting for feedback provision established a context (and the social support/pressure) for teachers to carry out interventions with a high degree of integrity.

There is much more to learn about team-based problem solving in the present era of high-stakes accountability prompted by NCLB and IDEIA 2004. Given the emerging empirical foundation regarding PSTs, in current practice it would appear important to (1) train team members so that they can contribute meaningfully to the problem-solving process, (2) clarify for members the specific purpose/function of the PST, (3) follow scripts or manuals to consistently guide the process and offer feedback regarding procedural integrity, (4) select and faithfully implement intervention plans that are conceptually relevant and evidence based, (5) monitor treatment plan integrity and provide feedback when needed to improve implementation, and (6) directly assess student outcomes to measure RTI (Burns et al., 2008; Gravois et al., 2009; Martens & DiGennaro, 2008).

## RTI

It has taken a considerable portion of this chapter to build a foundation for understanding RTI and the modern practice of school consultation. In this section, we discuss RTI itself, focusing on central components, basic approaches, tiers of service delivery, and typical assessment and intervention methods.

### *What is RTI?*

RTI is “the practice of (1) providing high-quality instruction and intervention that match students’ needs and (2) using students’ learning rate over time and level of performance to make important educational decisions” (Buffum, Mattos, & Weber, 2009, p. 14). These decisions may include offering more intense interventions in the regular education classroom and determining whether a student should enter special education.

According to Reschly and Bergstrom (2009), the critical components of RTI are:

1. Provision of interventions to students via multiple tiers that reflect varying levels of intervention intensity and measurement precision;
2. Specification of goals and objectives for treatment that stem from a mixture of federal, state, and local standards;
3. Universal screening of all students to evaluate both current educational practices and the risk status of individual students;
4. Identification of student academic, behavioral, and/or emotional regulation needs as indicated by a discrepancy between expected and actual performance;
5. Selection and faithful implementation of evidence-based interventions that target student academic, behavioral, and/or emotional regulation needs;
6. Utilization of frequent progress monitoring with appropriate measures in order to assess the movement toward goals and changing either goals or interventions depending on the progress noted;
7. Recognition of some variability across specific RTI models relative to their comprehensiveness in contributing to educational decision making; and
8. Expectation that RTI data will be used to evaluate individuals, classrooms, and schools to make important educational decisions.

### *RTI Systems of Implementation*

Once universal screening has determined a student needs additional support, there are two primary ways to deliver interventions in RTI: the problem-solving system and standard protocol system (Buffum et al., 2009). Understandably, more relevant to the purpose of this book is the *problem-solving system*, in which the

problem-solving method is followed – as in behavioral consultation – to analyze and operationally define a student problem, select/design and implement a treatment plan with integrity, and assess the effectiveness of the plan (Gresham, 2009). As carried out within a team context, the problem-solving approach tends to require greater training of school personnel, but the resulting interventions tend to reflect their greater input and potential commitment as well Buffum et al., (2009).

A second major way to implement RTI is through a *standard protocol system*, in which a recognized set of evidence-based instructional approaches is applied to address student academic problems (Jimerson, Burns, & VanDerHeyden, 2007). For example, there are a number of standard protocol approaches shown to be effective in remediating severe reading problems in young readers, and a major advantage of this approach over the problem-solving approach may be its better quality control over instruction (Gresham, 2009). The standard protocol approach also may involve more straightforward staff training and decision making (Buffum et al., 2009).

### ***Tier-Based Service Delivery Within RTI***

RTI assumes that minor student problems can be solved using fewer resources and more serious student problems can be solved using greater resources (Tilly, 2008). To play out this assumption, services delivered to students in RTI are organized by a graduated series of steps or tiers. Although three- and four-tier RTI models have been reported in the literature, there is emerging support for a standardized three-tier model (Burns et al., 2007). Given this conceptualization, tier 1 describes the least intense level of intervention (e.g., regular education curriculum) and tier 3 describes the most intense level (e.g., long-term individual intervention). Besides the intensity of student needs and resulting intervention, the major differences between tiers are the proportions of students participating and the precision of measurement of student progress at each tier (Reschly & Bergstrom, 2009).

There is no shortage of visual representations of the tiers of RTI, variously depicted as a three-dimensional triangle (e.g., Burns & Gibbons, 2008), two-dimensional inverted triangle (e.g., Malecki & Demaray, 2007), cone (e.g., Graden, Stollar, & Poth, 2007), or pyramid (e.g., Buffum et al., 2009). Due to this variability, we shall not reproduce a particular version here in a figure. Rather, we proceed by describing the general characteristics of a three-tier RTI model and then summarizing them in Table 2.1.

#### **Tier 1**

Because all children in general education classrooms are clients in tier 1 (i.e., primary/universal prevention emphasis), the focus here is on the quality of research-based instructional practices in the core curriculum. *Benchmark assessment* and/or

**Table 2.1** Characteristics of a Generic Three-tier RTI Model

Tier	Population	Description	Assessment
1	All students (academic and behavioral needs for 80–90% of students are handled at tier 1)	Primary/universal/core program: provide excellent core instruction through evidence-based curricula and instructional practices, address minor problems using a best practices approach and sharing strategies that work for other teachers	Benchmark assessment done at least 3 times per year; and data are used to plan services at core and consider progress monitoring of selected students
2	5–15% of students	Secondary/targeted/supplemental level: address moderate problems using small-group evidence-based interventions	Progress monitoring done at least monthly
3	1–5% of students	Tertiary/indicated/intensive level: address severe problems using intensive, individualized evidence-based interventions	Progress monitoring done at least weekly, plus informal classroom-based assessments

*Note.* Adapted from Buffum et al. (2009), Burns and Gibbons (2008), and Tilly (2008)

universal screening of students on basic skills should occur at least three times a year, and results of these evaluations are helpful to (1) evaluate the effectiveness of core instruction, (2) identify those students experiencing difficulties in order to address their needs immediately, and (3) establish school-based norms to facilitate the setting of academic performance goals. Individual growth over time is documented through *progress monitoring*, which allows one to see the extent to which instruction has supported a student in meeting goals in the core curriculum and at what rate. In tier 1, a teacher may give extra support and time to an “at-risk” student who is failing to meet established performance goals. It is estimated that 10–20% of students will not respond to tier 1 science-based instructional practices, so they will be moved to services provided at the more intensive tiers. Percentages or proportions are used to help schools refine their instructional practices. Core instruction is effective when it meets 80% or more of the students’ needs. Until core instruction attains this level, schools must not begin to try to address small group and individual needs because the reality is that they lack the resources to do so (Buffum et al., 2009; Burns & Gibbons, 2008; Tilly, 2008).

## Tier 2

Tier 2 serves 5–15% of students and has a secondary/targeted prevention emphasis. This tier incorporates the core curriculum instruction of tier 1 along with supplemental instruction, which often includes small group research-based interventions. When feasible, these groups should be formed around similar student skill deficits, and progress monitoring should occur at least monthly. A student’s response to tier 2 interventions is typically evaluated using a *dual discrepancy approach*, which

means both the (1) level of progress and (2) rate of growth over time relative to predetermined criteria are considered. For example, if a first grade student is below criterion on a measure of oral reading fluency (e.g., reading fewer than 30 words/min) and displays a growth rate slope that is more than one standard deviation below the average rate for other first graders, then the conclusion is that progress is inadequate. If after a reasonable period of adjusting the intervention the selected intervention(s) is not working, the student may be moved to tier 3 or to an entirely different core curriculum. Of course, if the student has responded (i.e., the interventions have produced clear gains), he or she may be returned to the core program of tier 1 (Buffum et al., 2009; Burns & Gibbons, 2008; Tilly, 2008).

### **Tier 3**

The remaining students (approx. 5%) are served in tier 3, which has a tertiary/indicated prevention emphasis. This tier consists of the core curriculum supplemented by intensive instruction/intervention, which is often delivered one-on-one and with no more than three students to one educator. The main differences between tiers 2 and 3 do not relate to the interventions themselves but rather to their intensity, duration, and frequency, with tier 3 interventions typically being more intense, more frequent, and of longer duration. Progress monitoring also takes place more often – it is recommended that specific skills be assessed weekly if not more frequently. A dual discrepancy approach again is usually used to determine student responses to intervention. Those who are successful in tier 3 may be reintegrated into tier 1 or 2, but those who fail to meet criteria following intensive, repeated intervention may remain in tier 3 or be referred for special education evaluation (Buffum et al., 2009; Burns & Gibbons, 2008; Tilly, 2008).

### **Additional Considerations**

There are several other points relevant to a discussion of tiers within RTI. First, because of RTI's origins as an alternative to diagnosing SLD, it is logical but wrong to think of RTI as pertaining only to academics. RTI addresses socio-emotional and behavioral functioning as well and many RTI models clearly make this point (e.g., Graden et al., 2007). Second, how long a student stays at tier 2 or tier 3 is, of course, related to his or her responsiveness to the selected intervention, the amount of time the team estimates the student will need to reach the goal, and whether the student has other circumstances that the team wants to consider. However, some guidelines for the length and modality of treatment at tier 2 is 30-min sessions 3 days/week in groups of 3–6 students for 6–8 weeks, and at tier 3 is 30-min sessions 5 days/week in smaller groups or individually for 6–8 weeks (Buffum et al., 2009). Obviously, these multiweek “doses” of intervention may be repeated as necessary, always keeping in mind that the goal is for the intervention to help the student to catch up to peers.

## ***Assessment and Intervention Methods Within RTI***

The assessment and intervention methods commonly seen in RTI and school consultation are extensive and varied and are the central focus of Chaps. 7 and 8, respectively. In concluding this introduction to RTI, we offer some general thoughts about its assessment and intervention techniques.

Relative to assessment, RTI makes extensive use of CBM in universal screening and progress monitoring. CBM offers a precise, direct way to assess student functioning and progress in basic academic skill areas. CBM probes of 1–3 min each can be administered repeatedly to measure skills such as oral reading fluency, spelling, math computation, and writing. A popular CBM measure within RTI is the Dynamic Indicators of Early Literacy Skills (DIBELS; Good & Kaminski, 2002), which assesses seven areas and can generate graphical displays of data to gauge both individual and school-wide performance. When compared to traditional norm-referenced assessment, advantages of CBM include being more closely related to the curriculum, more sensitive to smaller changes in performance, and shorter in duration (Merrell, Ervin, & Gimpel, 2006). Another advantage of CBM is its greater utility to teachers and parents who generally grasp the missing skills that CBM assesses, and then connect more readily with appropriate interventions for those skills.

Another common evaluation technique in RTI is *functional behavioral assessment* (FBA). FBA is a systematic way to collect information about antecedents (i.e., what happens before a student's behavior), behaviors (i.e., what the student is doing), and consequences (i.e., what happens after the behavior) in order to specify causal reasons for the behavior and then intervene to foster acceptable alternative behavior (Witt, Daly, & Noell, 2000). FBA has its origins in the fields of developmental disabilities and applied behavior analysis, and thanks to provisions of IDEIA 2004 (e.g., PBS), it is commonplace in school-based practice today (Steege & Watson, 2008). Within RTI, FBA appears to be useful in developing interventions in tier 2 (Rathvon, 2008) and tier 3 (Buffum et al., 2009). Although there may be a tendency to think that FBA applies only to the assessment of behavioral problems, its relevance to academic problems is also abundantly clear (e.g., Daly, Witt, Martens, & Dool, 1997). Other techniques related to FBA (e.g., brief experimental analysis of behavior, systematic formative evaluation) are presented in Chap. 7.

Relative to interventions within RTI, there is a plethora of evidence-based interventions available to address academic and behavioral problems of school-aged children (Morris & Mather, 2008). Although we expand on the possibilities in Chap. 8, meta-analytic results have shown effect sizes of 0.70 and higher for a variety of these interventions based on applied behavior analysis; direct, systematic, and explicit instruction; problem solving, and behavior assessment. Effect sizes above 0.50 have been documented for various interventions that target math skills, writing skills, and learning strategies (Reschly & Bergstrom, 2009). This area of knowledge changes rapidly, but fortunately the *What Works Clearinghouse* (<http://ies.ed.gov/ncee/wwc>) and *Intervention Central* (<http://www.interventioncentral.org>)

websites make available useful current information. Finally, we would like to reinforce the message that the effectiveness of any evidence-based intervention hinges on its fidelity of implementation (i.e., treatment integrity) (Martens & McIntyre, 2009). This statement is particularly true when the intervention is delivered through an intermediary (e.g., teacher) rather than a specialist, as is nearly always the case in school consultation and RTI.

## Conclusion

To close this chapter, we summarize our views on the relationships between and among the interrelated constructs of problem solving, RTI, and school consultation. First, *problem solving* underlies both RTI and consultation and, in fact, problem solving is a core task within our integrated model of school consultation. Although RTI and problem solving are used as synonyms in certain contexts (Reschly & Bergstrom, 2009), not all RTI involves a problem-solving process in that a standard protocol approach may be used instead (Gresham, 2007). Also, RTI may be portrayed as a system of tiered interventions that makes use of problem solving at each level, whereas problem solving also can be a stand-alone process that advances through the stages/questions described earlier (Reschly & Bergstrom). Furthermore, early approaches to problem solving (e.g., behavioral consultation) were not devised with today's RTI multitiered system of interventions in mind, although clearly they have been useful in conducting prereferral interventions since the 1980s (Kratochwill et al., 2007).

Second, it is apparent that RTI incorporates problem solving and its effective implementation calls for the same skills as those required in school consultation. Finally, we regard *school consultation* as the overarching construct of the three in that problem solving is one aspect of consultation and, although all RTI activities invoke consultation to some degree, not all school consultation focuses on RTI issues. This position is echoed by Gutkin and Curtis (2009) who stated: "It is apparent that a [problem solving]/RTI model is not only consistent with, but in fact dependent on, the delivery of effective consultation services by school psychologists and other educational specialists for successful implementation" (p. 594).

Although a school consultant needs to be well versed in the many issues surrounding RTI, we do not believe that school consultation will ever become synonymous with RTI. In promoting this view, we intend to introduce some healthy skepticism about the long-term viability of RTI, as have others (e.g., Reynolds & Shaywitz, 2009). On a grander scale, Gene Cash, a past President of the National Association of School Psychologists, has proclaimed, "RTI is a wonderful service delivery model, but it is not the future of school psychology" (2009, p. 2). Problem solving, on the other hand, is more likely to endure as a core characteristic of consultation and an essential means to deliver specialized services to students, and that it is why it is central to the integrated model of school consultation.

Importantly, this chapter has promoted the view that school consultation now takes place in an era of high-stakes, team-based service delivery that demands evidence-based practice. These circumstances are very different from those that originally gave rise to consultation (e.g., Caplan, 1963), and understandably may lead one to question some fundamental assumptions of consultation described in Chap. 1. For example, because within RTI an evidence-based intervention must be used and be implemented faithfully, a teacher is no longer free to reject an intervention from a PST because it is unfamiliar, time consuming, or philosophically unappealing (Martens & DiGennaro, 2008). Likewise, confidentiality of communications within consultation may not be possible because so many school personnel comprise a PST and information and opinions are freely shared (Caplan, Caplan, & Erchul, 1995).

From content presented thus far in this book, it may be surmised that the school consultant's role may be characterized as that of a change agent (Conoley, 1981b). To realize this role fully, the consultant must understand how to accomplish change through the exercise of interpersonal influence, and this is the focus of Chap. 3.



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