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**Brief Comments Regarding Special Education**

**Question from a parent of a child struggling to learn to read:** What programs work?

**Response:**

*For remediation to be effective it needs to be “informed” on three level* (I3):

1. ***Method****: Scientific evidence-based, field tested, track record of success.*
2. ***Instructor****: Sufficient training, experience, and knowledge to deliver the chosen program of instruction as intended by the author; with fidelity to design.*
3. ***Dosage****: Those elements necessary to ensure a reasonable rate of progress, such as intensity and duration of instruction. In intervention studies “the key to meaningful effect size was intensity.” (Hollis Scarborough 10-4-13)*

*The formula of Informed times three (*I3*) is a no brainer.*

*The Science of Reading and underlying research for the last 30 years has identified the components necessary for the delivery of effective intervention.*

* *Direct and explicit,*
* *structured,*
* *sequential,*
* *cumulative, and*
* *phonic based.*

*Some programs are scripted and require only program specific training to deliver the program as intended (e.g., Project Read, Wilson, Sonday, PAF). Other approaches require deep knowledge that allows the professional interventionist to diagnose need and prescribe customized and targeted intervention (e.g., Orton-Gillingham, Alphabetic Phonics, Slingerland).*

*Assuming the method of instruction has a scientific evidence base, and the instructor is properly trained and motivated, the intensity of instruction should be determined by the growth intended and the time available to achieve such growth. For instance:*

|  |  |  |  |
| --- | --- | --- | --- |
| Child identified  | Goal | Timeline | Factors  |
| Beginning of 1st Grade | Reading at cognitive potential at **beginning of 4th grade** | **Three** years of instruction:* Indiv./homogeneous Small group (≤ 4)
* 60-minute class
* 3 X per week
 | Three years to achieve the goal requires intense focus on decoding, word identification, and fluency. In 4th grade, emphasis shifts to a focus on comprehension, “from learning to read to reading to Learn.” J. Chall |
| Beginning of 2nd Grade | Reading at cognitive potential at **beginning of 4th grade** | **Two** years of instruction* Indiv./homogeneous small group (≤ 4)
* 60-minute class
* 4 X per week
 | Two years to achieve the goal requires intense focus on decoding, word identification, and fluency.  |
| During 3rd grade | Reading at cognitive potential at **beginning of 6th grade** | **Two** years of instruction* Individual (preferred); or homogeneous small group (≤ 4)
* 60-minute class
* 4 to 5 X per week
 | Two years to achieve the goal requires intense instruction in decoding, word identification, fluency, vocabulary, syntax, and comprehension. |
| After 5th grade | Reading at cognitive potential at **beginning of 9th grade** | **Three** years of instruction* Individual (preferred); or homogeneous small group (≤ 4)
* 60-minute class
* 4 to 5 X per week
 | Three years to achieve the goal requires intense and frequent instruction in decoding, word identification, and fluency; with heavy emphasis on morphology, as well as vocabulary, and syntax to address issues related to written expression. |

*This analysis is just common sense. The intensity of instruction would be determined by the time available to achieve mastery (i.e., one, two, or three years). It makes no sense, under any circumstance, for the intensity of intervention to be less than three 60-minute sessions per week and sessions missed due to school holidays and the like should be made up, if possible. Of course, if the child achieves reading at potential prior to the transition period identified (i.e., Fourth, Sixth, or Ninth Grade), all the better.*

*Progress should be monitored every two weeks with data being reviewed every eight to nine weeks. The method or intensity of instruction must be adjusted if the growth trajectory is below that which is necessary to achieve the goal established.*

**Question from a third-grade teacher:** Is there a "handout" or "template" for talking to parents about their child being at risk for reading difficulties, including dyslexia, that we can use after screening is completed?

**Response:**

*It is important to value the parents’ concerns, whether spoken or not. Parents are often overwhelmed and have difficulty expressing their feelings. Their hopes for the future are being threatened and their role as their child’s protector is unclear. Behind their thoughts and actions is the existential need to ensure that they have no reason to look back from an uncertain future and think or feel that “I wish I had.” The educator can help by offering the parent a share in the ownership of the efforts to meet the needs of their child. Parents need to be given a role; they need to feel empowered. Without a participatory role, their sole job is to monitor and critique the efforts of others. Often, one can encourage a meaningful exchange by simply imagining what the parent must be feeling.*

1. ***Value*** *the parents’ concerns,*
2. ***Educate*** *parents as to what is wrong and what needs to be done, and*
3. ***Engage*** *parents by involving the parents.*

**Question from an elementary school principal:** Could we address parent involvement in a district in which there is high poverty, food scarcity, children being raised by grandparents, or parents working more than one job? How is student success affected with little parent involvement?

**Response:**

*I remember one time being asked to speak to parents about dyslexia in a very large inner city elementary school. A thousand children and only three parents showed up. The exits to the school were supervised, the children were treated as if they needed to be herded, their curiosity was considered rudeness, and the responsibility of the educators appeared to begin when the bell rang in the morning and end when the bell rang in the evening. Equity in education is a national challenge. The children were not getting the education to which they were entitled. The educators felt stymied by the lack of participation of parents and felt that there was little that they could do but keep the children safe while in school. Poverty is not a mental illness or a developmental disability. If a very poor family resides in a “well off” school district that child gets a “well off” education. So, where does the fault lie? A poor school district has the added responsibility to make resources available not only between bells but before and after the bells ring. Equity in education requires more. An outreach program is needed to help parents help their child. Liaise and work with social service programs to connect with parents and keep abreast as to what is happening in the community. Every home needs access to internet and materials that encourage the development of vocabulary, background knowledge, self-awareness, and encourages a sense of empowerment. It is the responsibility of us all to ensure that we have the will and the means to help up those whose situation holds them down. There are books written on this subject. One model is referred to as Full-service Community Schools (FSCS) which “are characterized by four pillars of practice: integrated service provision, extended learning opportunities, family and community partnerships, and collaborative leadership and decision making.”*

*(*[*https://www.childtrends.org/blog/full-service-community-schools-are-critical-investments-for-children-and-families-in-poverty*](https://www.childtrends.org/blog/full-service-community-schools-are-critical-investments-for-children-and-families-in-poverty)*)*

*I point this out to indicate simply that this is not an issue that has gone unnoticed. See also US Department of Education Office of Elementary and Secondary Education FSCS.*

**The ability to authoritatively explain issues that are of significance to parents reduces conflict, promotes collaboration, and improves outcomes for children.**

The goal of this paper is not to explain the issues addressed to teachers and administrators, but to help teachers and administrators explain the issues to parents who do not have sufficient background knowledge to feel comfortable with what they are being told.

We all understand that a parent would die for their child. When a parent believes that the happiness and general welfare of their child is in jeopardy they need knowledge, understanding, and faith that their child is in good hands. Having understandable and candid answers to parents’ concerns at the educator’s fingertips establishes a foundation for the faith the educator would wish the parents to have in the educator’s ability to meet the needs of the child. The following addresses some issues related to establishing an educator/parent collaboration built on mutual trust.

**Trust:**

**The best way to be trusted is to trust in return.**

1. Value your relationship (we can’t do this without you),
2. Show that you understand and care,
3. Communicate honestly,
4. Inform and educate,
5. Admit your weaknesses,
6. Do what you promise, and
7. Do what you believe to be right,

**Forging positive relationships:**

Common understandings regarding a free and appropriate education (FAPE):

* + - 1. The child is entitled to it,
			2. The parent wants to get it, and
			3. The educator wants to give it.

Effective and efficient learning requires that all members of the educational triumvirate do their part. It is the educator’s responsibility to encourage a team approach.

* + - 1. Educator provides *informed* intervention,
			2. Parents provide positive *reinforcement,* and
			3. The student contributes *buy-in* to the educator’s efforts and goals.

School districts logically focus initially on the parameters of the district’s share of the responsibility to meet the needs of the student. The district’s responsibility is also to engage parents in the process. Parents who are not engaged and do not feel a sense of ownership in the education of their child develop into critics looking for problems and failures rather than collaborators looking for solutions and successes.

Meeting parents’ needs does not increase or expand the responsibility of the school district. Meeting parents’ needs:

1. improves the parent-school relationship,
2. decreases the cost of conflict,
3. promotes the morale of district personnel, and
4. improves the outcome for the child.

The return on investment benefits the district and the child.

**Communicating with parents**

Good intentions are not enough. Consider the following dialogue taking place at the conclusion of an initial classification conference:

*“Now that we have completed comprehensive testing, we have found some issues that need to be addressed. But do not worry, we have professional staff that are experienced and able to provide the needed services. We propose to develop an IEP that will:*

* *Identify reasonable goals,*
* *Describe appropriate interventions,*
* *Monitor progress, and*
* *We will let you know how we feel about the success of our efforts every few months.*

*We are the experts in this field, we know what we are doing, trust us.”*

Although this does not sound inappropriate and may be heartfelt, if this was a conversation with an oncologist, the patient may want to know more - “trust us” would not be enough. For instance, you might want to know:

* What are you going to do?
* Who is going to do it?
* Has he done it before?

The parent is often expected by educators to sit back and let them do their job without further inquiry. The result is a parent that is uninformed and anxious.

Alternatively,

* Value the parents’ concerns,
* Educate the parents as to what is wrong and what needs to be done, and
* Engage parents by involving them (parents need to feel that they are a part of the process of meeting the needs of their child).

**Sample dialogue:**

*“Testing has revealed a concern that, unless properly treated in a timely manner, could have consequences regarding Jimmy’s future potential and happiness.* (**Valuing parents’ concerns.**) *We found that Jimmy has relative weaknesses in processing the phonological component of language, commonly referred to as ‘dyslexia.’ Dyslexia is not a disability in the usual sense, but a natural variation in brain function not unlike variations in other abilities like artistic or athletic talent. However, it can affect the development of literacy skills, which at this time and in this culture are very important skills.* (**Educating the parent as to what is wrong.**)

*For intervention to be successful it needs to be informed by science and evidence-based on three levels:* (**Educating the parent as to what needs to be done.**)

* + *The method should reflect the science of reading and have a track record of success. In this case we are going to use a structured, sequential approach known as (name the program being used).*
	+ *The instructor should have sufficient knowledge, experience, and training to deliver the chosen method as intended. Ms. Smith is certified by (name the organization) and has had specific training in (name the program being used).*
	+ *Such intervention needs to be delivered with sufficient intensity to evidence meaningful progress. We suggest that three times per week for forty-five minutes per session should be sufficient. However, we will:*

**Assure parents that progress will be monitored and meaningful.**

*We will:*

* + 1. *Monitor progress every two weeks,*
		2. *Track progress over a six-to-nine-week period to ascertain whether we are on a path to achieve the intended goal,*
		3. *Inform you of our findings, and*
		4. *Adjust intensity as necessary.*

**Engage parents as a team member and partner in the education of their child.**

*Our efforts will not be as successful as we would hope without your collaboration and partnership. This is how you can help:*

* *If possible, read with Jimmy for 20 minutes every day in a book suggested by Ms. Smith. You read one paragraph and let Jimmy read the next paragraph.*
* *Also, read to Jimmy, before bedtime, a book of interest to him that is at his thinking level to expose him to advanced vocabulary and background knowledge that is contained in books above his current reading level.*
* *Let Jimmy see you reading newspapers or books on your own and discussing with others what you have read.*
* *Keep abreast of that on which Ms. Smith is focusing so you can reinforce when the opportunities present.*
* *Keep us informed if there is any change in Jimmy’s attitude toward school and learning (for better or worse).*

There is nothing contained in this alternate approach that wasn’t inferred in the previous conversation and left unsaid. Of course, the actual content will change depending on the resources available in each case but, if the educator feels that an appropriate education is possible, the program being offered should be described in a manner that allows the parent to understand. For instance, the interventionist may not actually be “trained,” but is “in a training program and is being supervised by someone who is not only trained but a trainer”! If the educator believes that an appropriate program is possible, there should be no reason why it cannot be described in detail. *“We do not simply hope something will work; we have reason to believe that what we are proposing will work, and this is why.”*

**Triage need and prioritize intervention**

Everything cannot be done all at once. We treat a heart attack before a broken finger. Educational Triage is the process of determining the priority of interventions based on relative importance.

1. Avoid providing what is not needed; time is a limited resource.
2. Do no teaching that is not meaningful. Teaching a foreign language to a 15-year-old child who can’t make change for a dollar or read above the third-grade level is like giving eyeglasses to the blind or radios to the deaf.
3. Differentiate intervention. A child with difficulty learning how to read needs the attention of someone who is trained to address the needs of children who have “difficulty learning how to read,” not someone who is successful at teaching reading to the other 80% of the student population.

IEPs that don’t triage need and prioritize targeted interventions are of little value. Our approach should be to find it and fix it, not to wait and see.

**Controversial therapies:**

There have been many therapies that have garnered significant, if not long lasting, attention over the years. Eye exercises, colored lenses, practicing walking on a balance beam, juggling, spinning in a barber’s chair, lifting weights, taking sea sickness pills, and blaming yeast in the gut are just a few theories that have been promoted for children with dyslexia. The reason for their initial success is rather simple. Parents sacrifice money and time with the expectation of success. Being human, many see what they are hoping to see (i.e., confirmation bias), the child is encouraged by parents’ aspirations and the child’s motivation and confidence improves (e.g., Hawthorne effect, placebo effect); the child might even begin to read more often. Has the ability to read improved because of the intervention? The science says, “no.”

To be **controversial,** a therapy must have something about it that attracts supporters. I have tried over the years to identify those ingredients that permit some ideas to have a significant number of believers despite limited research-based evidence of being meaningful and effective.

1. **Intuitively appealing**. Humans are attracted by simple answers to complex questions. Using a colored overlay is a lot easier than facing two years of intensive intervention. You need eyes to read, the problem must be visual. Truth is often counterintuitive, “The reading gaps of the deaf as compared to the blind seem almost a contradiction. The blind are the better readers. This happens because reading is closer to hearing than to seeing.” (Jeanne S. Chall)

2. **Anecdotal record of success**. Success is anecdotal (personal success stories) and not scientifically evidence based. There are many influences that must be recognized before you can attribute a particular outcome to a specific cause. For instance, parents and the child become vested in being rewarded for their effort or expenditure, a confirmation bias (i.e., you expect to get what you pay for). I call one variation of this phenomenon “private school syndrome.” The private school may even offer inferior services as compared to the public school, however, since the parent had to pay or fight for it, it is assumed to be better. This “ownership” promotes the perception of value and effectiveness. The “placebo effect” of sugar pills, and the “Hawthorne effect” (the tendency to work harder when experiencing a sense of participation in something new or special) are common examples of variables that influence outcomes unrelated to the therapy that seeks to take the credit.

 3. **Guru factor**. The proponent of the therapy sounds authoritative, is charismatic, and appears to know your child. He or she offers to assume the parents’ burden, clear up the parents’ confusion, and assure the parents that they will never have to look back and experience guilt for what could have been.

 4. **No unexplained failures**. The failure of the therapy to achieve expected outcomes is explained in terms of:

1. The parent misunderstanding the goal of the therapy,
2. The therapy provides the groundwork for future (not immediate) growth,
3. The parent not believing or following through sufficiently for the program to be successful, or
4. The **child** being lazy and unmotivated.

In other words, failure is attributed to influences external to the therapy itself.

 5. **The lack of evidence-based support is due to professional jealousy**. The therapy is said to be so good it threatens a profession, entrenched theories, and challenges the life’s work of leaders in the field. The proponents of the therapy claim to “think out of the box” and since they “challenge the status quo” they are rejected by a mainstream that is shackled by old ideas and rigid paradigms. Anyone who stands alone claiming to be better than the group should have a Surgeon General’s warning taped to their back.

 6. All forward progress is related to the therapy. **Maturation**, exposure to other educational opportunities, the suggestive impact of a placebo and Hawthorne effects are all variables that often result in progress unrelated to the therapy.

It is important to become an educated consumer of information that appears logical and charismatic. Just because someone recognizes your child, it doesn’t mean that they know your child; or because they know the question that they necessarily know the answer. Sometimes what appears logical and intuitive is in fact wrong.

**Language is powerful.**

Parent: “My son can’t read. He is smart but he is unmotivated and depressed.”

Educator: “**Up until now** your son couldn’t read **and,** with a little more confidence his motivation and mood will improve. This is how we are going to work on improving his self-confidence and motivation.”

Use “up until now” with “and,” instead of “but,” to turn dejection into hope.

**Engaging the reluctant student.**

**Teacher**: “I am aware of your reading issues and know that you can do well in my class. If you sit in the front, I promise never to call on you unless you raise your hand. Also, please feel free to contact me after school to answer any questions you may have.”

**The failure to address learning issues in a timely fashion results in predictable emotional consequences.**

The learning disability exists before the **disability** manifests. A “learning disability,” before it manifests, is neither a “disability,” “disorder,” nor “dysfunction.” Do we feel abnormal or “disordered” if we cannot golf like Tiger, sing like Pavarotti, or act like DeNiro? Of course not. Yet we feel diminished if we do not read as well as the child sitting next to us or memorize the times tables like our baby sister. The one thing that all human beings have in common is that we are all different from each other. Two hundred years ago in the “wild west” the skills that were considered of cultural value would have been sense of direction and hand-eye coordination; whereas the ability to read and write was rare. It is the culture that determines what is to be considered of value, context matters (e.g., a one-eyed man is king in the land of the blind). In years past our heroes were Hercules and Superman; now every TV show features a computer nerd.

A **natural variation in brain function** characterizes the learning disability involved (e.g., processing the phonological component of language, employing executive skills). Should such neurobiological issues fail to be addressed in a timely or effective manner, a predictable cascade of behavioral and psychological consequences ensues. The failure of the child at Stage 2 triggers a defensive response to the pain of cognitive dissonance resulting in the diminished effort and motivation of Stage 3. When motivation and effort decreases, a belief in personal empowerment is diminished and an external locus of control is promoted, the child becomes hypervigilant resulting in anxiety and eventually depression.

At the core of this cascade of emotional and behavioral decline is a psychological response to the pain of cognitive dissonance. “*My parents, teacher, and grandmother say that I am smart, but my experience and friends indicate that I am not smart.*” When the struggle to accommodate such dissonant beliefs becomes psychologically burdensome, the child behaves in a manner to resolve the conflict. At this point the child avoids challenges to keep from exposing weakness. As a friend once said, such a child “would rather be seen as unwilling than being thought of as unable.” If he did not study for the test, he didn’t fail because he wasn’t smart; he failed because he didn’t study and those for whom he cares will continue to consider him smart despite his failure to perform. Such psychological defense mechanisms are subconscious and not an act of will or conscious decision making.

 

The psychological issues (e.g., external locus of control, anxiety, depression) are consequential and not intrinsic; therefore, not the primary diagnosis. But these “consequential” issues must be understood and addressed before the core issue can be properly assessed and treated.

The ability, willingness, and even desire to face one’s fears appears to significantly mediate the potential influence of cognitive dissonance and an external locus of control. A sense of empowerment is the key to overcoming adversity. ***Children who feel empowered wear their*** ***self-confidence like a suit of armor that attracts others because of its beauty and shields from harm because of its strength.***

**MTSS and RTI in a nutshell**

RTI and other Multi-Tiered Systems of Supports (MTSS) are not a way to deny the opportunity of special education to children in need, but, when done properly, an opportunity to make general education meaningful to all children. The effort to understand MTSS has occupied many thousands of man hours and hundreds of position and policy statements, white papers, consensus documents, and research articles. MTSS is a process intended to shift educational resources toward the delivery and evaluation of instruction, and away from classification of disabilities. MTSS is not a particular method or instructional approach. The success of MTSS depends on the timely delivery of evidence-based instruction by highly qualified instructors.

**The process:**

**Screen:** Valid screening measures predict who, and who is not, at risk for future difficulty. Children considered to be “at risk” are expected to experience difficulty responding (not keeping up) in the core curriculum as traditionally delivered in the regular general education classroom.

**Teach:** Core curriculum in the regular general education class should be evidence-based and field tested. This means, based on evidence from converging research, that the core curriculum contains all the elements found necessary to effectively teach and has a known track record of success. Such curriculum is to be delivered by “highly qualified” teachers sufficiently trained to deliver the selected instruction as intended (i.e., with fidelity to design).

**Intervene:** Provide “at risk” children with enhanced opportunities to learn, possibly including, but not limited to, additional time exposed to the core curriculum in small groups, other supplementary instruction, or special education.

**Probe (progress monitoring):** Progress monitoring includes brief measures of specific skills that are administered to determine if the child receiving intervention is responding as intended. They are given frequently, at least once every two weeks.

**Chart:** Progress is regularly charted to provide a visual record of actual rate of gain in specific skills in relation to a specified goal. The goal of intervention is for the child to improve relative standing and perform at or close to grade level standards and is individualized according to the unique needs of the child.

**Adjust:** Depending on whether the child is achieving a rate of progress determined by his or her individualized goal, the manner and intensity of intervention will be adjusted. The cycle of progress-monitoring and adjustment of intervention will continue (e.g., every six to nine weeks), even if a determination for special education eligibility is made.

**Procedural protections:**

My *personal interpretation* of the spirit and the letter of the law is that a child should not enter Tier 2 interventions without parents being told that the child has been identified as “at risk,” advised as to the instructional strategies being used, and informed of the progress being experienced. The purpose of early parent involvement is to foster a relationship where the parent is engaged and empowered to be an “instructional partner.”

**The problem with IEPs:**

IEPs, as they are currently prepared, are primarily intended to satisfy legal mandates and only secondarily describe the needs of the student. The document itself is intimidating in size yet lacking in detail, is time consuming to produce, and difficult for parents to understand. It is a burden to the professionals responsible for its preparation, incomprehensible to parents, and relatively meaningless to teachers and interventionists. As such, the IEP, as currently operationalized, is an impediment to school/parent relationships. Most IEPs:

1. Do not generally identify methods or approaches of intervention except in the most general and nonspecific ways (e.g., behavior modification, multisensory, eclectic).
2. Do not specify the training necessary to deliver effective intervention.
3. The summaries of evaluations are often incomplete and self-serving.
4. Goals and objectives are “cookie cutter” and often reflect the resources available to the district rather than the needs of the student.
5. From a school administrator’s perspective IEPs are a potential burden on limited resources including space, time, and cost.
6. Teachers rarely use IEPs to guide individual instruction. (Even in a class as small as five students the ability to implement five IEPs in an individualized and differentiated manner is incredibly difficult.)
7. Experienced interventionists evaluate where the student is (i.e., diagnostic) and what they need to work on (i.e., prescriptive) and do their own thing without being guided by the IEP (until it is time to evaluate progress).
8. Student progress is evaluated by the individual responsible for progress (what could go wrong there?).
9. Targeted mastery is often inadequate or inappropriate (e.g., 75% or 80% across the board). Mastery is a function of the skill being taught (e.g., reading mastery should be above 95%, batting averages 30%, learning to cross a road safely 100%).
10. IEPs are often 30 pages long with perhaps a page and a half of relevant information.

It is important to share with parents the concerns that the school district may have regarding the usefulness of the IEP in its current mandated form and **offer a concise summary that triages the needs of the child and specifies prioritized interventions.**

I refer to the elements that make an IEP meaningful as “SMURF.” The perfect IEP should be:

* Short,
* Measurable,
* Understandable,
* Relevant, and
* Functional

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