

# Following All the Children: Early Intervention and Montessori

*By Jacqueline Cossentino*

**A**s the number of students with learning difficulties rises, educators, including Montessorians, are confronted with the challenge of serving all children with intelligence, practical expertise, and compassion.

A growing array of early intervention models aimed toward addressing diverse learning needs and developmental challenges prior to Special Education Identification are gaining prominence in educational policy and practice. Such models are grounded in principles central to Montessori pedagogy, including mixed-age grouping, differentiation, and ongoing child study. In addition to honoring Montessori's legacy of personalized, inclusive education, early intervention models offer promising approaches to building both institutional and individual instructional capacity, enabling Montessori educators to more effectively follow not just the theoretical child, but all children.

## **Every Child Is Exceptional**

Educators of all persuasions—including Montessorians—are witnessing significant increases in the number of students with learning difficulties. In recent years, both researchers and practitioners have noted a rise in attentional issues, autism spectrum disorders, and sensory integration difficulties. Blame it on television, environmental toxins, aging parents, or

more systematic identification, the rise in incidence crosses ethnic, racial, and economic lines (though children in poverty continue to be more likely than their more affluent peers to be placed in special education). No matter how you slice it, children with diverse learning needs constitute a growing segment of the nation's classrooms, and they are changing the face of schooling.

Most public schools report a special education population of between 11% and 15% (NCES). While reliable figures on similar populations in independent Montessori schools are more difficult to track, anecdotal reports suggest that the incidence may be closer to 22% (NCES; Pickering, 2003). Because it is regarded by many as friendly to learning differences, parents often seek Montessori (and other independent) schools when their children demonstrate difficulty in "regular" school. That such students are served in Montessori schools, many without benefit of formally mandated individualized education plans (or the bureaucratic procedures that accompany them), would seem to lend cre-

dence to the oft-cited claim that Maria Montessori was herself a special educator and that her method constitutes the world's first inclusion model of support services.

To be sure, it is difficult to argue the historical resonance of this claim. Montessori launched her career working with special needs students under the influence of the writings of French psychologist Edouard Séguin, one of the patriarchs of special education. Likewise, her emphasis on hands-on, differentiated, self-paced learning guided by intensive and ongoing child study provides a template for best practice in both general and exceptional classrooms (Gresham, 2002; Lillard, 2005). Moreover, that Montessori environments provide opportunities for free movement, choice, and extended periods of deep concentration help explain what appears to be a lower-than-average incidence of attention-related difficulties, as these pillars of Montessori pedagogy also happen to be treatment strategies for ADHD (Pickering, 2003; Rief, 2008). Perhaps most importantly, Montessorians are trained to perceive every child as



*Continuity of materials in Montessori classrooms*



Frída Azari Photography

exceptional and, in response, to hold flexible, individualized instruction in the highest regard (Cossentino, 2009).

In a foundational way, then, Montessorians are, at the very least, close cousins of special educators. In the course of daily practice, however, theoretical and dispositional affinity can only go so far. When learning differences become learning disabilities, even the most sensitive and resourceful of teachers can be pushed beyond their limits. Too often, the frustration that comes with an inadequate skill set prompts teachers and schools to conclude that the special needs child does not “fit” in a regular school environment. “We don’t want to set the child up for failure” or “We don’t have the resources to adequately serve your child” are explanations offered to the parent whose child has been screened out of an independent school. In public schools, where such screening is illegal and where the stakes for poor academic performance are high, the situation is different. As educators in the public sector confront the challenge of guiding all students toward academic success, policies and practices associated with prevention, early screening, and identification of learning needs have moved to the center of the enterprise of schooling. This article is about the lessons that accompany that challenge, and their particular

applicability to Montessori educators.

In fact, the trajectories of Montessori education and special education, particularly early intervention, intersect in important ways. Historically, Montessori theory and practice have influenced the development of special education pedagogy. In some cases, as in Ireland, Montessori training and special education training have been explicitly combined. In other cases, Montessori practices, such as child study, the use of manipulative materials, and a focus on choice and individualization, have made their way into special education pedagogy through subtle cross-fertilization among practitioners. More recently, however, developments in special education policy have begun to influence Montessori practice.

What follows is an examination of why and how that influence has evolved as it has. More important, I probe the potential of recent developments in special education policy to enhance Montessori practice. What are the natural affinities between special education and Montessori practice? What specific pedagogical moves lie at the core of following the child? How might Montessorians more effectively leverage the unique properties of the prepared environment and the prepared adult to better serve all children? The answers to these questions illuminate how progressive, data-centered

approaches to identifying and responding to students with learning differences can make the process of following the child more transparent, more equitable, and more successful.

### **The Case of Serena**

Consider the following case, a composite drawn from several Early Childhood classrooms in Montessori schools<sup>1</sup>: Serena is a 3-year-old girl in her first year at school. While she was born in the U.S., English is not her first language; Spanish is the primary language spoken at home. Upon entering the school, Serena spoke little English or Spanish. She was unable to maintain focus on any work for more than a few minutes, and then only with the assistance of an adult. When not supervised closely, she tended to crawl on the floor, hide under tables, and disturb other students as they worked. After observing this behavior for the first 2 weeks of school, Serena’s teacher, Helen, concluded that both she and Serena needed help.

By mid-September, Serena was on the agenda of the Early Childhood instructional team’s weekly early inter-

<sup>1</sup> Cases quite similar to Serena’s exist in a variety of schools, both public and private. Public schools, however, are more likely to feature the full spectrum of support services, and constructing the case around such a program allows description and analysis of an ideal case.

vention meeting. After presenting her case to a team composed of fellow early childhood teachers, the school social worker, and assistant principal, Helen was asked to identify a goal for Serena—one that could be observed, measured, and evaluated within the next 4 to 6 weeks. Helen identified the goal of Serena independently choosing and completing one piece of work each morning. The next step was for Helen to come up with strategies she might employ to help Serena meet that goal. For this she turned to her colleagues.

For the next 5 minutes, the room was silent as each team member (save for Helen) wrote as many ideas as possible that could be incorporated into a Montessori work period. Once completed, upwards of 30 ideas had been recorded on sticky notes, which were displayed in clusters for Helen to survey and assess. Suggestions ranged from “limit her choices to two or three” to “have her work with an older student” to “provide positive encouragement.”

From the bank of strategies, Helen chose two. The first was a visual technique that had been used successfully by another teacher with a similar student. Since Serena struggled with spoken language, the team considered that the ritual of asking for a lesson or being verbally directed to work might be causing stress. What if the stress were removed through the use of pictures of work choices, which Serena could select by browsing through a (preselected) notebook of work? Since a colleague had already created such a notebook for a 5-year-old, Helen wouldn't have to start from scratch, but rather modify it with work choices drawn primarily from the Sensorial and Practical Life areas.

The second strategy selected called for close partnering with the classroom assistant. Since Serena clearly needed ongoing adult support, Helen and her assistant would work together to see that at least one adult eye was always on the child. They would take

turns maintaining proximity and be available to intervene as needed. The hope was that as Serena's work repertoire expanded and her concentration span increased, she would begin to transfer the satisfaction that came from disturbing others into the more ordered work of self-construction. But this would take time, and during that time, Serena needed ongoing modeling, attention, and patience from both adults in the room.

As the discussion of the strategy selection concluded, Helen collected all 30 suggestions and placed them in an envelope. She agreed to evaluate the success of the chosen strategies through daily documentation of work choices and concentration spans. The team set a progress check for 6 weeks hence. If the goal had been met, the team would set a new goal. If not, they would consider more intensive support.

### **Intervention and Montessori: Practical and Historical Links**

The process described above constituted the first step in a three-layered process known variously as early intervention, Response to Intervention<sup>®</sup>, and tiered instruction (Cummings, et al., 2008; Tilly, 2008). Six weeks after this initial session, Helen reported on Serena's progress. Using a simple tally, Helen tracked both the amount of work Serena was able to complete for each of the 30 days of the strategy and the length of time she was able to sustain concentration during a given work period. After 6 weeks, the progress was uneven, but the data revealed a trend: Serena was able to meet her goal 75% of the time. Following a brief celebration, the team considered a new, more challenging goal. Throughout the year, Serena remained on the team's radar. Her action plan was updated two more times, and records of progress were maintained in Serena's cumulative file.

By the time Serena arrived at her second year, she had developed strategies for interacting appropriately with

peers and had increased her concentration spans significantly. She no longer hid beneath tables. She chose work from all areas of the room—though she continued to prefer Sensorial and Practical Life to language and math—and she greeted adults with a smile and a cheerful “hello” each morning.

While the behavioral progress she had made was evident, Serena still demonstrated difficulties with language. In response, the team focused its attention on isolating the source of the difficulties, which would guide instructional supports written into Serena's action plan. Because her case called for additional clinical expertise and more intensive support, she moved into the second stage of the early intervention process. Following a preliminary consultation with the school's speech language therapist, the team developed new goals aimed toward helping Serena develop phonemic awareness and increase her vocabulary.

Strategies matched to these goals included daily one-on-one practice with sandpaper letters, eye spy games, and the mystery bag. In addition, both Helen and her assistant made a point of inviting Serena to interact verbally with peers and recording the nature of those interactions as part of daily record keeping. Finally, the team invited the speech language therapist, who maintained a part-time caseload 3 days a week at the school, to observe Serena twice before the next review of the case, which would take place 4 weeks from the completion of the new action plan.

It is likely that Serena will remain on the team's radar throughout her years in Early Childhood, and probably into Elementary. At age 4, it is still too early to determine whether Serena's language difficulties are severe enough to qualify her for special education services or accommodations. However, the team understands that early attention to difficulties in oral language can, in many cases, resolve issues sufficient to

enable the child with delays to become a proficient reader and writer, and that the most effective time for addressing language issues is prior to the age of 5. Likewise, had the challenges Serena displayed at age 3 gone unaddressed, her behavioral issues would have likely masked the obstacles affecting her language development.

That sort of “miss” is all too common, even in Montessori classrooms, where ongoing observation, record keeping, and adjustment are, ideally, hallmarks of instruction. The consequences of inadequate diagnosis and progress monitoring can be grave. For a child like Serena, those consequences could range from significant reading delays, to accumulated losses in other areas, to misdiagnosed social/behavioral disorders, to inappropriately targeted special education services.

Moreover, prior to the ascendancy of tiered intervention systems, students like Serena, who inevitably would be found deficient in behavioral as well as academic performance, would almost certainly be identified as learning disabled. And once such identifications were made, much of Serena’s education would be in the hands of adults other than her classroom teacher. If students like Serena were enrolled in independent schools without the benefit of mandated student services, such as speech, occupational, and physical therapists, they, more often than not, would be screened out of the general program and into programs equipped to serve students with special needs.

Increasingly, however, progressive, data-centered approaches to supporting students are enabling teachers and schools to interrupt that cycle and redirect children like Serena toward a path of holistic and responsive support, in which needs and instruction are carefully matched.

The idea of “match,” as psychologist J. M. Hunt (1961) put it, has been central to Montessori practice from the

beginning. It’s also what prompted reform-minded educators and policy makers in the 1960s to advocate for significant investments in early intervention as a means of enhancing the life chances of children placed at risk. Head Start, one of the key programs to emerge from Lyndon Johnson’s Great Society, was built on the premise that boosting early learning would constitute a comprehensive and consequential intervention in the lives of poor children. Among other benefits, Head Start was expected to boost IQ,

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improve parenting skills, and provide access to basic health and welfare services through community-based, federally funded support (Rose, 2010).

At precisely the time that the Office of Economic Opportunity, under the direction of Sargent Shriver, was devising plans for Head Start, Montessori education was experiencing a rebirth in the United States and news of the method was spreading among psychologists like Hunt, educators, and well-to-do parents. Indeed, Shriver’s in-laws, the Skakels, were instrumental in the founding of Whitby School, one of the nation’s first Montessori schools (Whitescarver & Cossentino, 2008). Other Montessorians experimented with Montessori classrooms in impoverished communities in initiatives that foreshadowed Head Start programming (Gitter, 1965). Not surprisingly, Montessori was identified as one of several models for Head Start. While not linked to official special education policy—that would come a decade later with the passage of the Education for All Handicapped Children Act of 1975 (EHA)—the rise of Head Start, with its implicit focus on early intervention, added one more connector in the chain linking Montessori and special education.

EHA was later renamed the Individuals with Disabilities Education Act (IDEA), which both identified rights for students with disabilities and mandated differentiated instruction based on individual children’s needs. While the core tenet of IDEA—that all children are entitled to individualized instruction—bears a striking similarity to Montessori’s mandate to “follow the child,” gaps between theory and practice were pronounced from the law’s inception. After nearly three decades of criticism, prompted by

advocates for children with disabilities, Congress embarked on a substantial overhaul of the act.

The most significant outcome of the 2004 reauthorization of IDEA was a provision for employing early intervention (“early intervening services”) as a means of determining eligibility for special education services. In the past, students who were suspected of having significant learning disabilities were identified through a series of tests designed to measure the difference between the student’s intelligence and his or her scholastic achievement. In instances where the discrepancy was significant, a student qualified. Criticisms of procedures associated with the discrepancy model included claims that too many students were inappropriately placed in separate settings, students did not receive appropriate services when served in regular classrooms, students were denied access to related services such as speech or physical therapy and psychological counseling, and disproportionate numbers of minority students were identified (NCD, 2002).

By contrast, tiered instructional models aim to create a filter designed both to target specific learning difficulties and distinguish developmental

from instructional issues. Tiered instruction locates substantial responsibility with classroom teachers, and when implemented effectively, reduces the number of students identified for special services and increases the likelihood that support will be appropriately targeted, monitored, and demonstrably effective (Cummings, et al., 2008; Fuchs & Fuchs, 2006).

As the demand for evidence of tiered instruction as a gateway to special education eligibility has risen, school systems have responded in creative ways. Early Intervention systems now exist in 34 states, and districts continue to make substantial invest-

ments in structural, procedural, and instructional capacity in order to comply with the stipulations of IDEA. As schools mobilize around the concept of early intervention, teachers are redefining their systems for record keeping, assessment, and the instructional decisions that follow. School schedules must include time for team meetings, and administrators must hone their skills as participants in as well as leaders of rigorous and ongoing data-based deliberation.

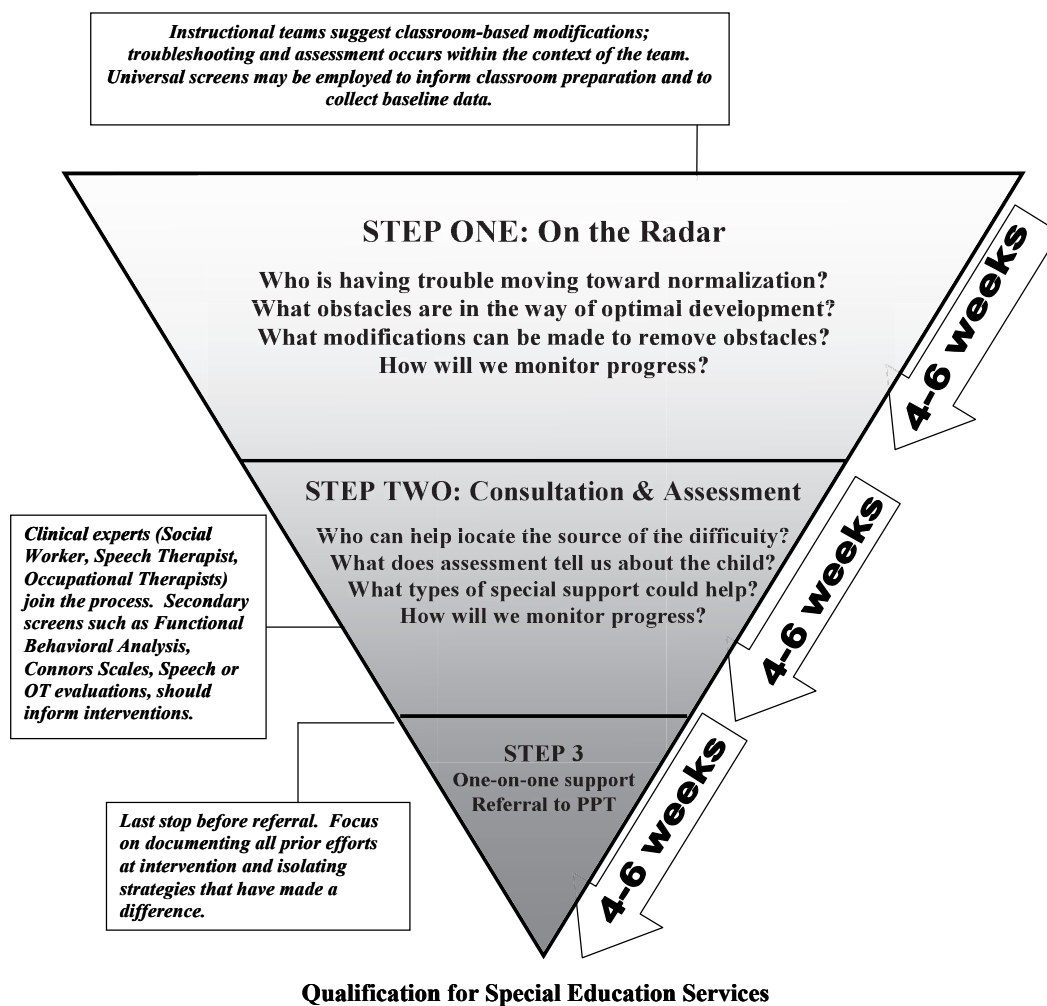
While data collection and analysis are critical to the success of these systems, the true center of early intervention remains the concept of “match.”

Data are only useful when they help match a student’s needs with appropriate assistance. And that depends entirely on the capacity of teachers to make sense of the observations, tallies, and scores they compile. In other words, early intervention calls teachers to activate the analytic and experimental side of their practice, which is, as Maria Montessori herself put it, central to her vision of “scientific pedagogy.”

### Early Intervention as a School-Wide Priority: Implementing a Viable Process

Montessori schools that organize themselves around early intervention

Figure 1. Early Intervention as a Process of Gradual Filtering and Intensification



commit to two key goals. The first is to focus intensively on children in the first plane of development. The second is to establish and follow a structured process for responding to all children's needs in a rational and individualized manner. Both commitments maximize the natural strengths of Montessori pedagogy. Both commitments also push teachers to stretch their analytic and diagnostic skills to build bridges between the prepared environment and the wider educational community.

A well-functioning early intervention process works like a funnel, with the largest number of student issues addressed through Step 1 modifications, leading progressively through more intensive interventions toward the final step of referral for special education services.

As a practical matter, early intervention means catching difficulties before they turn into insurmountable obstacles. Infant, Toddler, and Early Childhood teachers serve as the child's first prepared adult. In order to follow every child, these adults must mobilize their skills at observation, environment design, and flexible lesson presentation so that atypical behaviors are noted early, followed meticulously, and addressed within the first 6 months. In a well-functioning system, first-plane teachers will have the largest and most fluid caseload, and most of those cases will involve children between the ages of 3 and 5.

Accounting for the full range of developmental issues, schools can expect between 25% and 30% of their early childhood students to make it to the first step of the process. Schools with higher numbers of bilingual students or English Language Learners can expect that percentage to rise. Issues will range from speech delays to sensory integration and autism spectrum concerns, most of which will present during the child's first months at the school, to executive function, working memory, and reading diffi-

culties, which will become more evident between the ages of 4 and 5. In all cases, the central questions for early childhood children in the first step of intervention revolve around normalization: Who is moving toward normalization and who is having difficulty? What obstacles are impeding optimal development? What modifications can be made to remove obstacles?

In addition to naturalistic observation, Step 1 supports can be well served by basic diagnostic screening instruments. In order to gather baseline data on oral language facility, many schools institute screens such as the Peabody Picture Vocabulary Test to all entering students. The June Shelton School and Evaluation Center has devised a series of diagnostic tools aimed specifically for Montessori students (Pickering, 2001).

While many issues, particularly those related to speech and early reading, can be resolved during the early childhood years, students who have not exited the system by the time they turn 5 are likely to be candidates for more intensive intervention and possibly special education referral, regardless of whether the child is enrolled in a public or independent school. In these cases, documentation of the relative success or failure of strategies employed is essential for effective intervention and/or special education placement.

Regardless of when a child enters early intervention, the process is designed to expedite problem solving by adhering to specific procedures and time limits. For instance, a student on a Step 1 action plan who does not demonstrate progress within a 4- to 6-week time frame will move on to Step 2. At this secondary level, clinical professionals are brought into the deliberative process as the team shifts its focus toward a more intensive diagnostic approach to intervention. Tutoring, speech therapy, counseling, and other related services may be recommended for the child at Step 2. For

schools that employ clinicians (either full-time or consulting), the process calls for strategic scheduling so that consultants can attend meetings, collect and share data, and generally participate in the work of the team. Schools that do not employ such professionals should at the very least develop relationships with local speech and occupational therapists that allow for occasional consultation and referral. As closer monitoring of the needs of a school's population reveals the nature and frequency of challenges, budgets should be adjusted to meet those challenges.

If Step 2 interventions are unsuccessful, the child may likely be headed toward qualifying for special education services. Again, this juncture is critical regardless of whether the child is enrolled in a public or independent school. Step 3 supports are the last stop before identification and, as such, they often mirror the type of services provided by special education teachers: one-on-one programmed instruction, intensive therapy, and, in some cases, accommodations similar to those the student may expect once he or she is deemed eligible for services. Progress monitoring at this stage matches the intensity of the interventions. Because all students, regardless of where they attend school, are entitled to necessary special education services, parents of children in independent schools must be informed of their rights with regard to eligibility. The quality of progress monitoring, combined with sensitive communication with parents, can make the difference between success and failure for a child (and his or her family) confronting learning challenges. Even if a child turns out to have challenges that cannot be met by the school's existing resources, the transition to a new program can be made much more constructive by a carefully monitored intervention process.

While the child is always the cen-

tral focus of the work of early intervention, that work is made possible by collective deliberation. Known variously as “instructional teams,” “program level teams,” or “data teams,” these groups of between four and eight professionals are the engine of the process. In order to make the most of Montessori expertise, teams should be organized by planes of development. Depending on the school’s enrollment, team meetings should be scheduled to address two to three cases in a 60-minute session, with time for follow-up on each case within 4 to 6 weeks. Weekly meetings are optimal, and all meetings should follow a standard format, including protocols for preparation, discussion, and time-keeping.

For most teachers, including Montessorians, the deliberative process requires both practice and support. For this reason, meetings should be convened by a designated facilitator, whose role consists of maintaining case dockets, creating and announcing agendas, and ensuring that meetings proceed according to agreed-upon norms. Working well as a team takes time and trust. Once the structure and norms of the meeting are established,

team meetings become a venue for serving students as well as fostering teacher development.

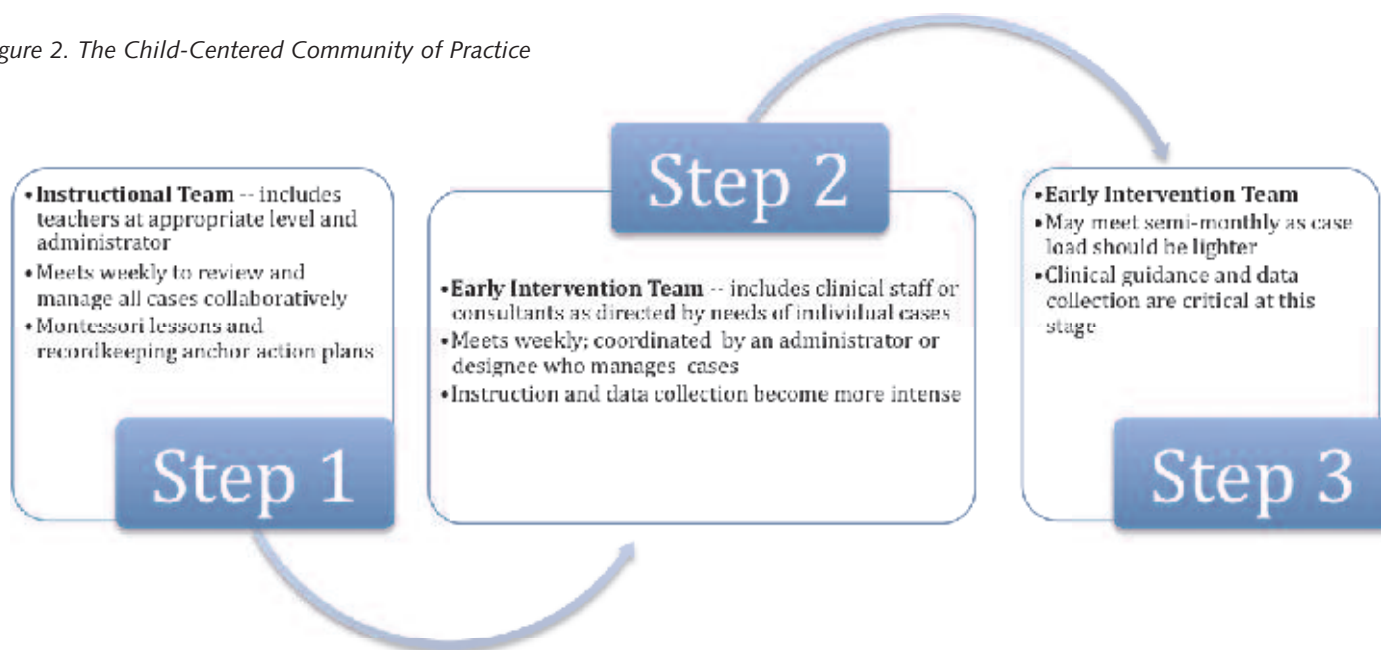
### From Data to Knowledge to Service: The Child-Centered Community of Practice

The holistic, integrated nature of Montessori pedagogy can, for some Montessorians, feel at odds with the clinical, rationalized systems of early intervention. Language like “data,” “action plans,” and “intervention” can be off-putting to educators who are more accustomed to talking about “sensitive periods,” “language explosions,” and “cosmic education.” But a closer look (and listen) reveals that early intervention, particularly when implemented by thoughtful Montessori teachers, gets to the heart of Montessori pedagogy. Early intervention’s emphasis on precise progress monitoring and documentation coupled with the social, deliberative requirement of teamwork can illuminate what, for many, is a mysterious and evanescent undertaking. Early intervention gives us a process and a language for talking about what teachers actually do when they follow the child.

Early intervention is, above all, a collaborative process that exemplifies the power of collective deliberation in transforming data points into usable knowledge. Teachers who engage in early intervention report immense satisfaction with the process for three key reasons. First, collaborative deliberation about particular students places children at the center of the enterprise. Second, structured discussion about instructional strategies both values the collective expertise of the team and makes practice visible by unpacking the discrete moves that compose a teacher’s pedagogy. Third, the systematic and precise chronicle of progress is more likely to produce successful results than the solitary trial and error that characterizes the professional life

Practitioners who share common language, practice, and goals, and who work together to create and use knowledge, are known as “communities of practice” (Brown & Duguid, 1991; Wenger, 1998). Communities of practice share some similarities with “professional learning communities” (DuFour, 2004), particularly when they exist in schools. However, a key distinction revolves around the intersec-

Figure 2. The Child-Centered Community of Practice



tion of identity and practice. Where professional learning communities are working groups dedicated to the enterprise of improving learning, communities of practice exist in many settings. Orchestras, athletic teams, scholars of particular disciplines, chefs, carpenters, and other artisans often belong to communities of practice. Unlike professional learning communities, which direct their energies primarily toward the achievement of outcomes, communities of practice exist to serve needs internal as well as external to the community.

The community that comprises an orchestra, for instance, devotes its collective effort to expanding, refining, and sharing musical knowledge, partly for the sake of improving the orchestra's performance and partly for the sake of deepening the community's shared understanding of its practice. Practice functions as the embodiment of the community's purpose, which is primarily to fuel practice. The relatively closed system of the community of practice, characterized by mutual engagement, joint enterprise, and shared repertoire, also characterizes the professional culture of Montessori educators (Cossentino, 2005, 2009).

When applied to Montessori schooling, a well-implemented early intervention process strengthens the community of practice by providing structure and transparency to the work of following the child. Grounded in principles of Montessori pedagogy, team meetings provide a venue for colleagues to develop as well as share expertise. Because the team's practice entails the creation and management of knowledge, clinical language is part of the process. And because that practice centers on serving the child according to the Montessori principles, the bulk of deliberation revolves around understanding and removing obstacles to development, refining a particular Montessori presentation, or developing more sensitive approaches to pro-

viding support without impeding independence. In this way, the collective work of early intervention serves as both a manifestation and a fulfillment of Montessori pedagogy.

Put another way, if early learning, child study, and differentiation are what Montessori is all about, then Montessori is all about early intervention. Schools that make early intervention an institutional priority (shared by teachers at all levels, as well as parents) can maximize the power of Montessori pedagogy—making practice visible to all members of the community and increasing the odds that all students will be served.

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JACQUELINE COSENTINO is a researcher who studies Montessori culture and practice. She has served as principal of two Montessori schools and currently co-directs grantify, a consulting firm specializing in research and evaluation. Contact her at [jcossentino@grantify.org](mailto:jcossentino@grantify.org).