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Impact of States' Adoption of Response to Interventions (RTI) on Disability Identifications

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Executive Summary

Special education identification has risen steadily for decades, reaching nearly eight million students in 2025 (CRPE Unlocking Potential Dataset, 1975–2025). While national discussions frequently attribute this increase to improved diagnostic awareness or changing disability prevalence, our work across rural communities in the Black Belt South reveals another powerful and largely overlooked driver: schools are using special education as their primary response to unaddressed trauma.

In classrooms, trauma and ADHD can look indistinguishable because both can involve impulsivity, distractibility, and restlessness, yet physiologically they reflect opposite nervous-system states. When chronic stress is misread as a neurological disorder, students are routed toward ADHD labels, stimulant treatments, and eventually special education referrals. Each misidentification becomes one more case in rising IDEA counts.

Our analysis draws on CRPE's 50-year national dataset combined with extensive local, community-generated evidence: ROI's systems maps co-created with more than 500 rural residents; hundreds of one-on-one interviews; human-centered design sessions; focus groups; and large community workshops across multiple rural counties. Taken together, these sources reveal a self-reinforcing system in which trauma, misinterpretation, inadequate training, and funding incentives interact to inflate special education identification.

The result is a national paradox: special education has become America's de facto trauma-response system. Unless states redesign general education to recognize

and respond to distress upstream, identification rates will continue to rise while root causes remain untreated.

Introduction: A National Trend With Local Roots

Over the last 50 years, special education identification has risen from roughly 8 percent of U.S. students to nearly 14 percent, even as the population of school-aged children remained relatively flat (CRPE Unlocking Potential Dataset). Yet national trends alone cannot explain why identification continues to climb or why some regions, particularly rural, high-poverty, majority-Black counties, are seeing the fastest growth.

ROI's work across the rural Black Belt South offers a crucial lens. In these communities, educators, parents, and providers repeatedly describe a pattern that does not appear on standard disability dashboards: chronic stress and trauma showing up as classroom behavior, misread as ADHD, and managed through the special education process. This research is grounded in five years of participatory, community-based inquiry:

- 500+ community members engaged through systems-mapping workshops
- Hundreds of one-on-one interviews with teachers, parents, clinicians, students
- Focus groups with caregivers, school teams, and youth
- Human-centered design sessions to unpack local experiences of stress and school response

These lived-experience mechanisms help explain what the national dataset only hints at: a system overwhelmed by trauma is using disability identification as a workaround. The patterns visible in CRPE's 50-year dataset align directly with the causal

mechanisms surfaced in our systems maps: rising identification occurs where trauma exposure is high, trauma-trained providers are scarce, and behavior becomes the proxy for distress.

When Trauma Looks Like ADHD, but Points to Something Else

To educators, the behavioral overlap is striking. Students experiencing trauma often appear unable to sit still, distracted or "zoned out," quick to anger, and/or restless and impulsive. These outward behaviors are identical to the symptoms listed on ADHD screening checklists. But physiologically, the two states are opposite:

- **ADHD = under-arousal.** The nervous system runs "cold." Stimulants (e.g., methylphenidate) raise baseline activation, making it easier to regulate attention and executive function.
- **Trauma = chronic over-arousal.** The stress-response system is stuck in fight-or-flight. Heart rate, cortisol, and hypervigilance are already elevated. Stimulants increase distress and reactivity.

As repeated in multiple caregiver interviews captured in our systems maps:

> "The school is always calling me, telling me my kid is acting up. My child isn't hyper. He's scared."
>
> "I took my 5-year-old to the doctor, and before we even made it back to the office, the doctor took one look at my child in the waiting room and said, 'Yep, that kid has ADHD. Let's get him a prescription.'"

From a physiological standpoint, ADHD medication can help under-arousal but worsen overarousal. When trauma is mistaken for ADHD, students often worsen rather than improve, and schools escalate to a special education referral. That referral triggers interventions designed for a neurological disorder rather than a stress response, so the root cause remains unaddressed and the student cycles through supports that never fit their needs. These individual errors compound into structural patterns.

The Rural Black Belt South: Where the Feedback Loop Is Strongest

While misdiagnosis occurs nationwide, rural counties in the Black Belt South experience a perfect storm of conditions that magnify the problem.

High prevalence of chronic adversity. Through systems-mapping workshops, parents and educators describe daily stressors that increase baseline dysregulation: family instability, substance-use epidemics, housing insecurity, community violence, food insecurity, and disruption across caregiving networks. In these contexts, children arrive at school already in hyperarousal, and because it resembles ADHD, they are often treated as if they have it.

Severe provider shortages. Many rural counties have far fewer than one child psychologist per 4,000 students. As a result, school teams without clinical training shoulder diagnostic responsibility, relying on behavioral checklists rather than trauma-informed assessments.

Minimal trauma training for general educators. Across dozens of focus groups, teachers describe feeling unprepared:

> "No one taught us how stress shows up in the body."
>
> "We just see the behavior and think kids are choosing to act badly. After I learned the science of trauma, I understand there's a deeper reason why a student is acting that way. There is energy trapped in their nervous system (trauma) and they got to get it out."

Without frameworks for understanding stress physiology, behavior becomes the proxy.

Funding incentives tied to classification. In many rural districts, the only path to additional staffing or counseling support is IDEA eligibility.
Classification functions as a gateway to resources, and that structure unintentionally creates incentives that increase over-identification.

Historical inequities and rural exclusion. Majority-Black rural counties face deeper structural disadvantages: fewer providers, fewer alternative supports, greater exposure to adversity, and fewer trained clinicians. This compounds longstanding racial inequities in discipline and identification. In the words of one rural mother during a systems-mapping session: "If your child is struggling here, the school has two tools: suspension or special ed."

Data Sources and Methodology: Multiple Lenses on a Single Pattern

Our findings emerge from synthesizing four complementary datasets:

- **CRPE Unlocking Potential Dataset (1975–2025).** Reveals five decades of rising identification nationally, with substantial state-by-state variation.

- **North Carolina's county-level IDEA and ADHD classifications (2010–2024).** Several rural counties have seen ADHD-related IDEA placements double, now representing one in five new special education entries.
- **ROI Community-Generated Systems Maps.** Co-created with 2,000+ rural residents, mapping lived relationships between stress, school climate, discipline, and mental-health access. These maps surface nuanced causal loops such as:
    - "Hypervigilance → perceived defiance → discipline → dysregulation → referral"
    - "Stimulant mismatch → escalation at home → teacher concern → evaluation request"
    - "Behavioral framing → stigma → avoidance → worsening symptoms → placement"
- **Human-centered design fieldwork.** Interviews and workshops reveal mechanisms that the quantitative data cannot detect, including why parents avoid reporting trauma, how teachers interpret behavior, why stimulant reactions get coded as "worsening ADHD," and why certain labels unlock help while others do not.

Together, these datasets allow us to make a causal, not just correlative, argument. Systems maps were especially valuable because they reveal macro feedback loops that are invisible in quantitative datasets but central to how schools actually respond to student distress.

The Misdiagnosis Map: A Self-Reinforcing Loop

Across counties, we observe a predictable cycle:

1. **Chronic stress exposure.** Poverty, instability, violence, adverse childhood experiences (ACEs), and community adversity.
2. **Stress shows up as behavior.** Inattention, hyperactivity, impulsivity (identical to ADHD checklists).
3. **Behavior interpreted without trauma training.** Teachers and teams lean toward ADHD, not stress physiology.
4. **Trial of stimulant medication.** In trauma-exposed students, stimulants heighten arousal.
5. **Escalation when symptoms worsen.** Parents report “my child is worse”; teachers report they are “still not focusing.”
6. **Referral to special education.** The only structured system available with perceived support.
7. **More students classified more resources.** Incentivizing continued reliance on special education as a support system.
8. **Underlying trauma remains untreated.** The cycle continues with the next child.
9. This is not a failure of any single educator, clinician, or parent. It is a systemic adaptation to chronic underinvestment in trauma-responsive general education.

Deepening the Diagnostic Question: Disability Versus Distress

Experts and practitioners inevitably arrive at a valid question: Is it possible, or even necessary, to disentangle innate disability from environmental stressors? Our systems maps, interviews, and fieldwork suggest three key insights:

- **Trauma alters brain development.** Chronic toxic stress can impair attention, working memory, and executive function. As a result, trauma can generate ADHD-like symptoms even when ADHD is not present.
- **Interventions overlap more than they diverge.** Structure, predictable routines, relationship-building, and emotional regulation support BOTH trauma and ADHD. Thus, the question is less “which diagnosis is correct?” and, moreover, does the child have access to the support they need?
- **Rationing services through diagnosis creates inequity.** When supports depend on labels, not needs, trauma-exposed students must be misdiagnosed to receive help. This is the core ethical problem our analysis exposes.

What States Can Do: Resource a Needs-Responsive System

Improving outcomes starts with resourcing trauma-responsive general education, ensuring support is driven by need rather than labels. Several practical steps can redirect students away from misdiagnosis.

- **Unlock Medicaid for trauma-healing services.** Many states (20+) already allow schools to bill for EMDR, TF-CBT, somatic therapies, and school-based

counseling; few districts use these pathways. Clear guidance and training immediately expand access.

- **Provide low-cost nervous-system regulation tools.** Biofeedback and HRV devices, breathing tools, and sensory supports help students—and teachers—recognize trauma-driven dysregulation versus ADHD-like behavior.
- **Implement universal trauma screeners.** ACEs and stress screeners ensure trauma history is part of evaluation, not an afterthought.
- **Invest in relational buffering.** Consistent, supportive adult relationships—mentors, near-peers, looping teachers—are among the most effective trauma interventions.
- **Require multidisciplinary assessment teams.** Include trauma-trained clinicians in ADHD evaluations, especially in high-adversity counties.
- **Fund needs-based supports untethered to IDEA.** Flexible dollars for counseling, social workers, and regulation spaces prevent classification from becoming the only gateway to help.

Conclusion: Rethinking What Special Education Is Being Asked to Do

The rise in special education identification is not simply a story about disability prevalence. It is a story about how systems respond to distress when general education is under-resourced and trauma is widespread. When support flows only through diagnosis, misdiagnosis becomes a structural inevitability. The path forward is not to tighten gatekeeping or reduce identification pressure. It is to resource general education so that students' physiological, emotional, and behavioral needs can be met

without requiring a disability label.

If we can distinguish between disability and distress, not as a way to restrict access but to provide the right support, we can begin to build a system that meets students where they are. The question is not whether students qualify for a label, but whether systems are equipped to meet their needs. Trauma and ADHD may look alike in a classroom, but they are opposite states of the nervous system: one too high a motor, one too low.

When trauma is misread as ADHD, we don't just risk a paperwork error; we send a frightened, dysregulated child into a treatment designed to rev them up further. The result is predictable: symptoms intensify, behavior escalates, and the path leads to special education rather than healing. A trauma-responsive general-education system breaks this cycle. It directs children with chronic stress toward interventions that calm and restore, and children with ADHD toward supports that build regulation and executive function. When states make this shift, special education can serve its true purpose, and thousands of children each year can receive the right support the first time.

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Appendix 1

An Expanded Guide to Building Trauma-Responsive Schools & Preventing Misdiagnosis: Practical Strategies Schools Can Use to Distinguish Trauma From ADHD

This document from the Rural Opportunity Institute synthesizes the most actionable, physiologically grounded approaches schools can use to address distress upstream and reduce misidentification, while offering 20 concrete strategies educators and policymakers can apply immediately to distinguish trauma from ADHD, support students' nervous-system needs, and build the systems conditions that prevent unnecessary referrals.

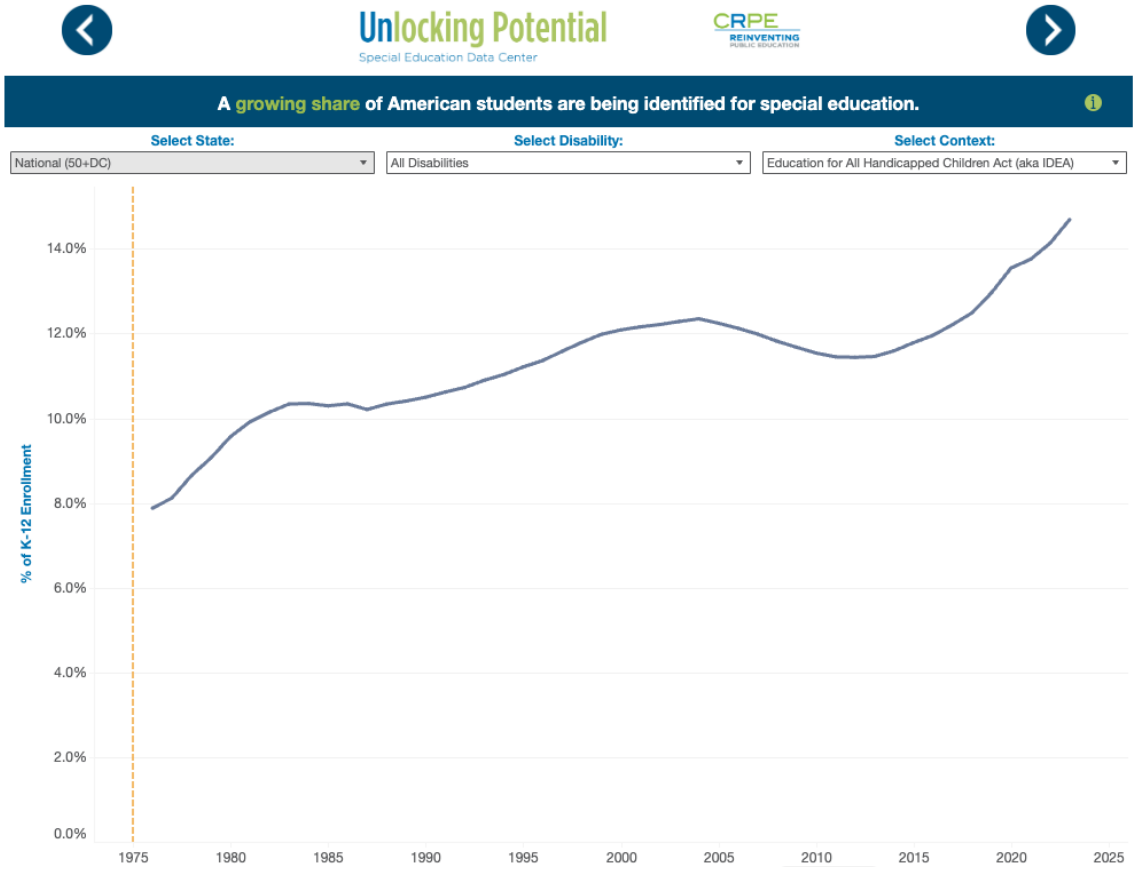
Appendix 2

CRPE Unlocking Potential Dataset (1975–2025)

The figures below draw on the Unlocking Potential Dataset, a 50-year national dataset developed by the Center on Reinventing Public Education (CRPE). It is the most comprehensive longitudinal source on how special education identification has changed over time. The data tracks state-by-state patterns in eligibility, disability categories, and student outcomes. Taken together, these visuals illustrate how rising identification is not an isolated local phenomenon; it is a decades-long national pattern with dramatic variation across states. These visuals highlight several core trends relevant to this paper: Special education identification has grown steadily for five decades, ADHD-related classifications have increased significantly in many states, and rural, high-poverty regions show disproportionately rapid growth.

The dataset helps situate our rural fieldwork within a national context, showing what communities experience on the ground: trauma misread as disability, rising behavioral referrals, and escalating IDEA counts. This mirrors broader systemic patterns seen across the country that provide essential national context: the growth rural communities are experiencing locally mirrors broader systemic shifts in how schools interpret and respond to student distress.

Figure 1. National Trend in Special Education Identification (1975–2025)

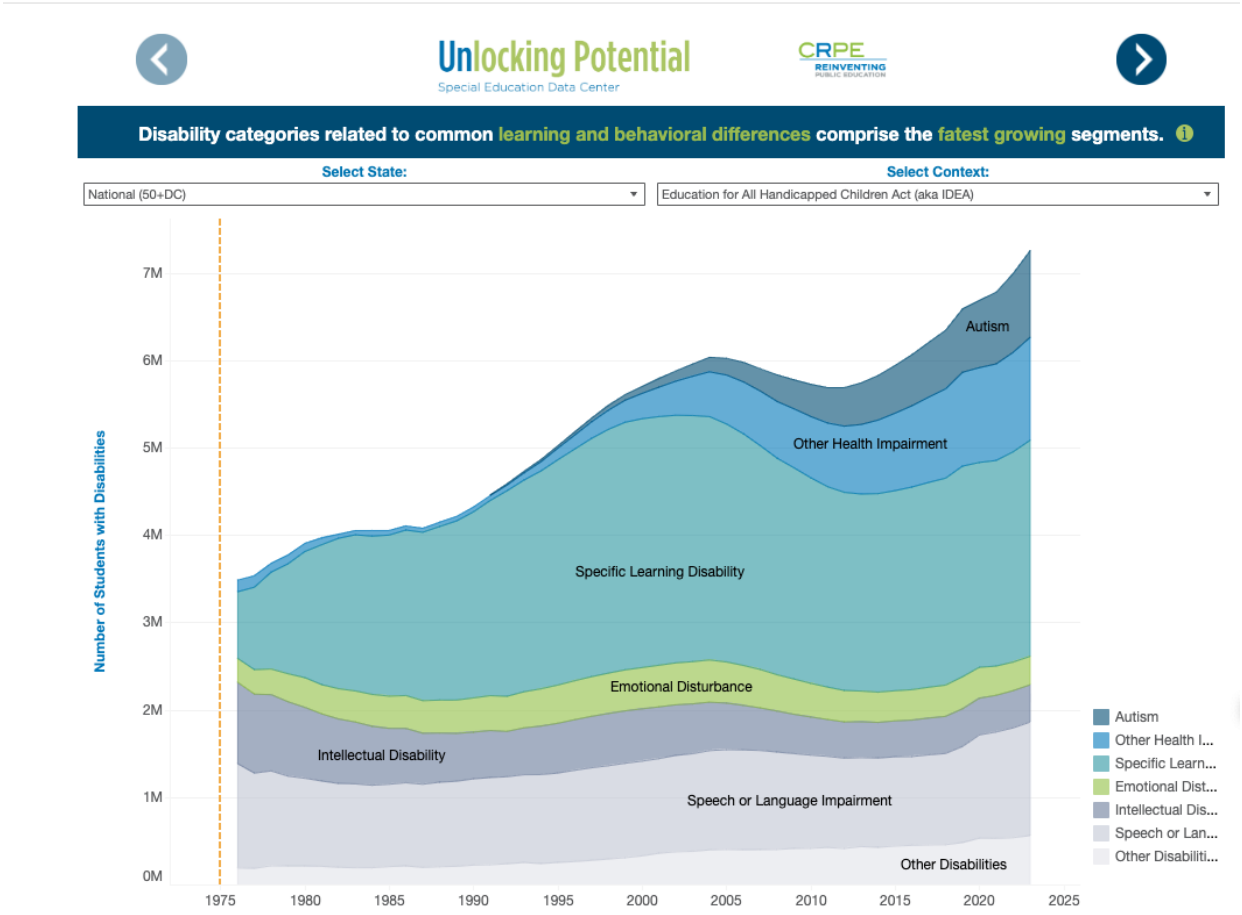


This figure shows a steady long-term rise in the share of U.S. students receiving special education services, increasing from about 8% in the 1970s to nearly 15% today.

Figure 2. State-by-State Variation in Special Education Identification Rates (2023)

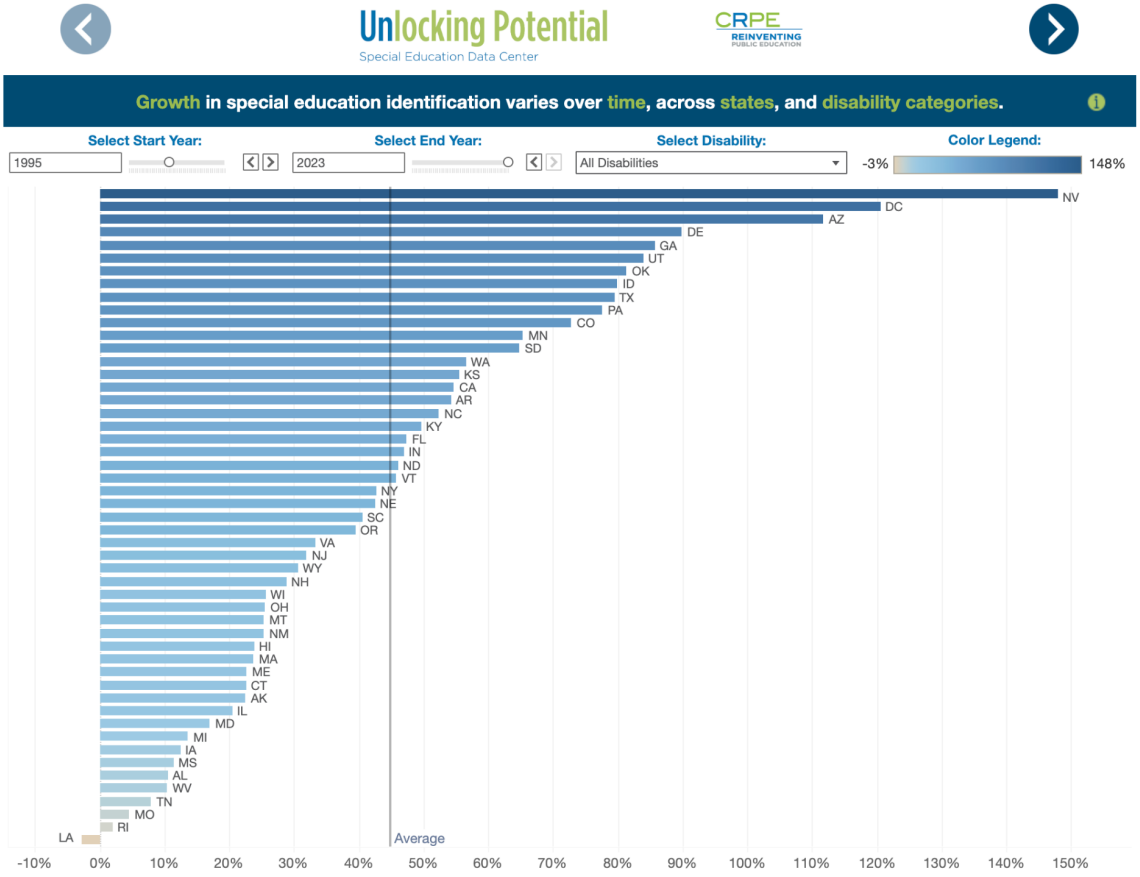
This map shows that identification rates differ widely across states, ranging from roughly 10% to over 20%, highlighting how state systems and local conditions shape classification patterns.

Figure 3. National Growth in IDEA Disability Categories (1975–2025)



This stacked area chart illustrates that the fastest growth in special education comes from categories related to learning and behavioral differences—especially Autism and Other Health Impairment—driving the overall rise in IDEA identification.

Figure 4. Percent Change in Overall Special Education Identification by State (1995–2023)



This figure shows that overall special education identification has increased in nearly every state over the past three decades, with wide variation in growth rates. Some states are rising by more than 100%, while a few remain flat or decline. The data highlights how state systems, practices, and local conditions shape classification patterns.

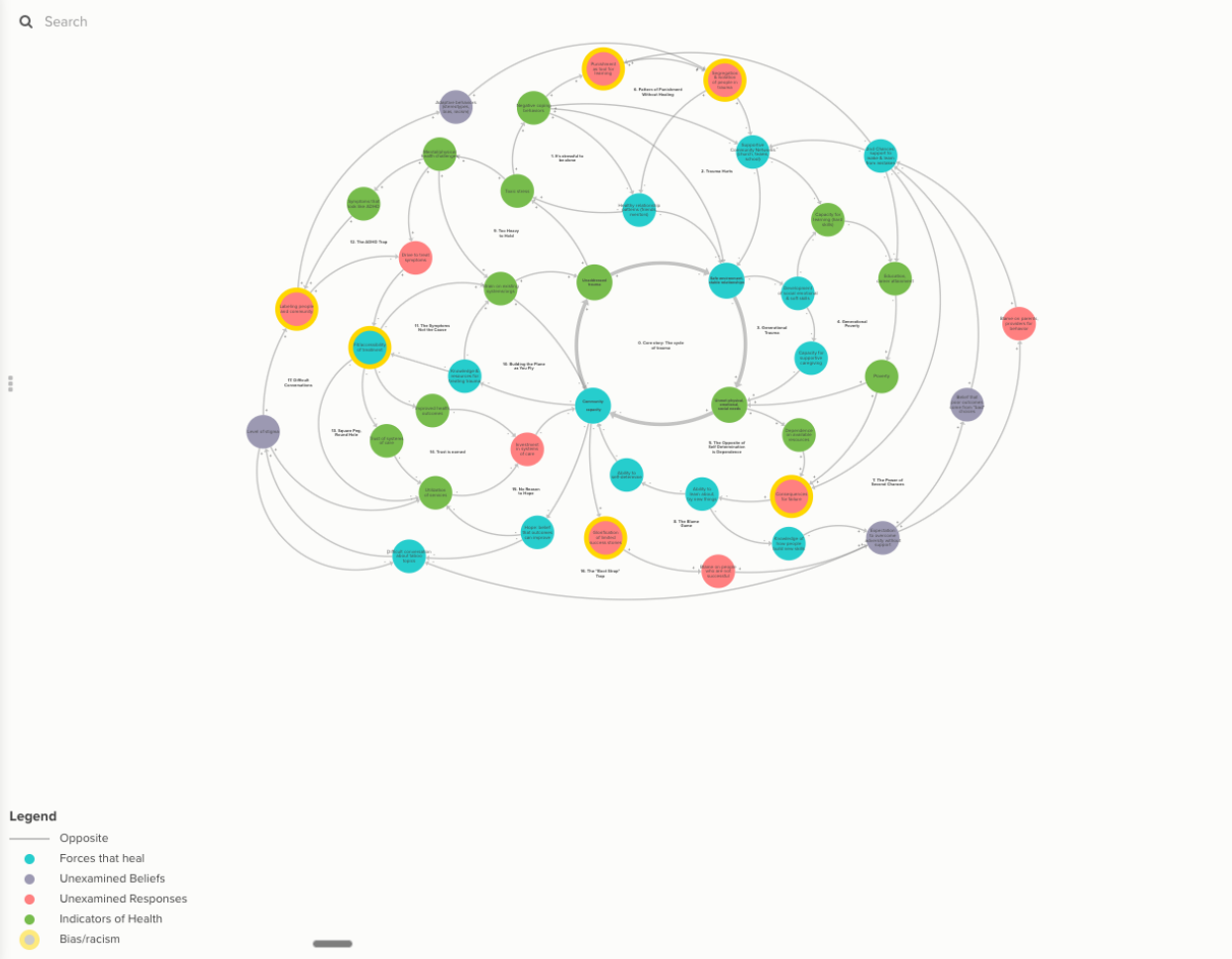
Appendix 3

Community-Generated System Map: A Systems Map of Generational Trauma in the Rural South

The following diagrams come from Rural Opportunity Institute's community-generated systems map, created through multi-year participatory work with more than 2,000 rural residents. Teachers, parents, youth, clinicians, law enforcement, and community leaders collectively mapped how trauma moves through families, schools, and systems—and how those systems respond. The loops shown here illustrate the core mechanisms surfaced by the community: How chronic stress and hyperarousal show up as classroom behavior, how behavior is interpreted in the absence of trauma training, how stimulant mismatch and school discipline escalate distress, and how these dynamics feed into special education referral and misdiagnoses.

These feedback loops provide a community-authored causal explanation for why trauma can masquerade as ADHD in rural schools. They also reveal where small interventions—regulation supports, relational buffering, accurate evaluation, or needs-based services—can break the cycle.

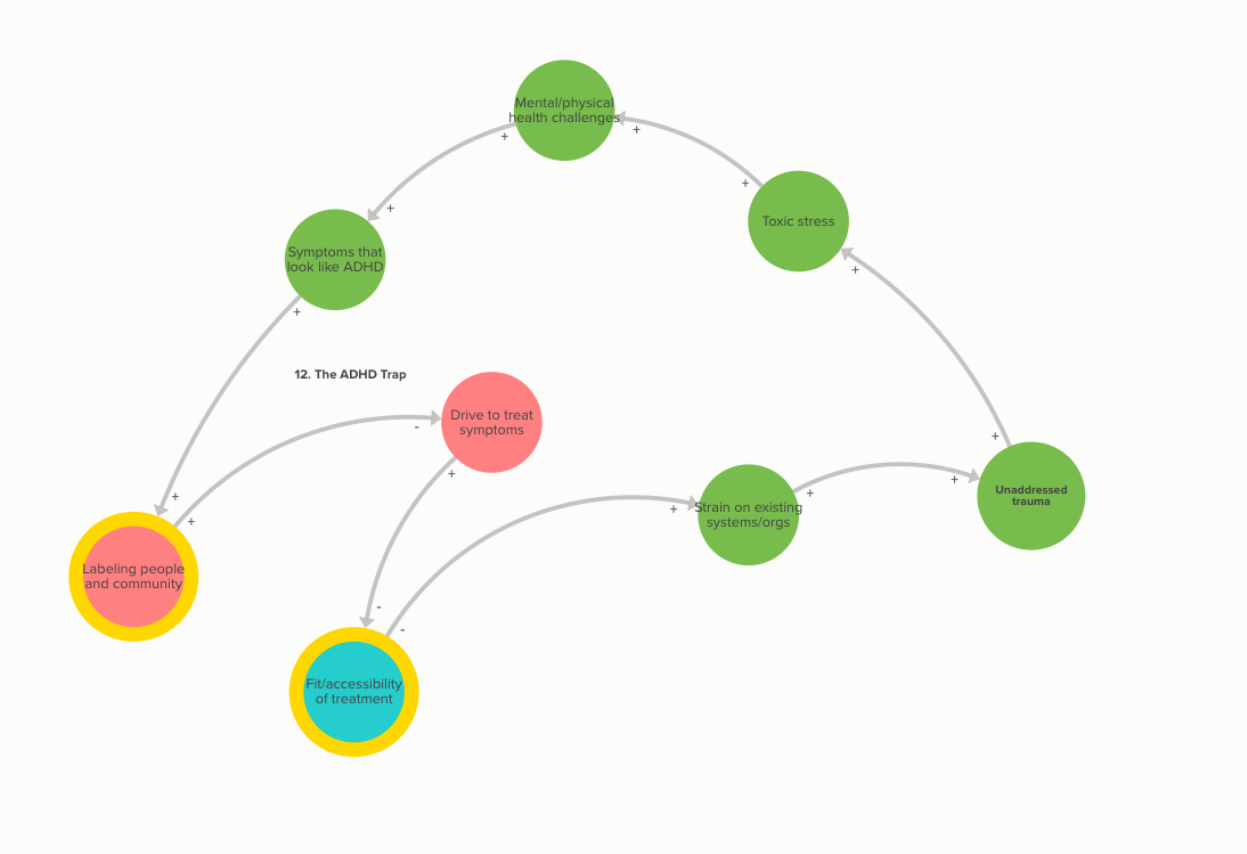
Figure 5. Community Systems Map of Trauma, Misinterpretation, and School Response



This figure shows the broader community-generated systems map created through ROI's participatory workshops. It visualizes how stress, trauma, school environments, beliefs, and system constraints interact to shape children's experiences. The map highlights reinforcing loops, including unmet basic needs, dysregulation, punitive responses, and labeling, as well as balancing forces like relational support and healing practices. Together, these dynamics show how structural conditions lead trauma to be

mistaken for ADHD and where schools and communities can intervene to break the cycle.

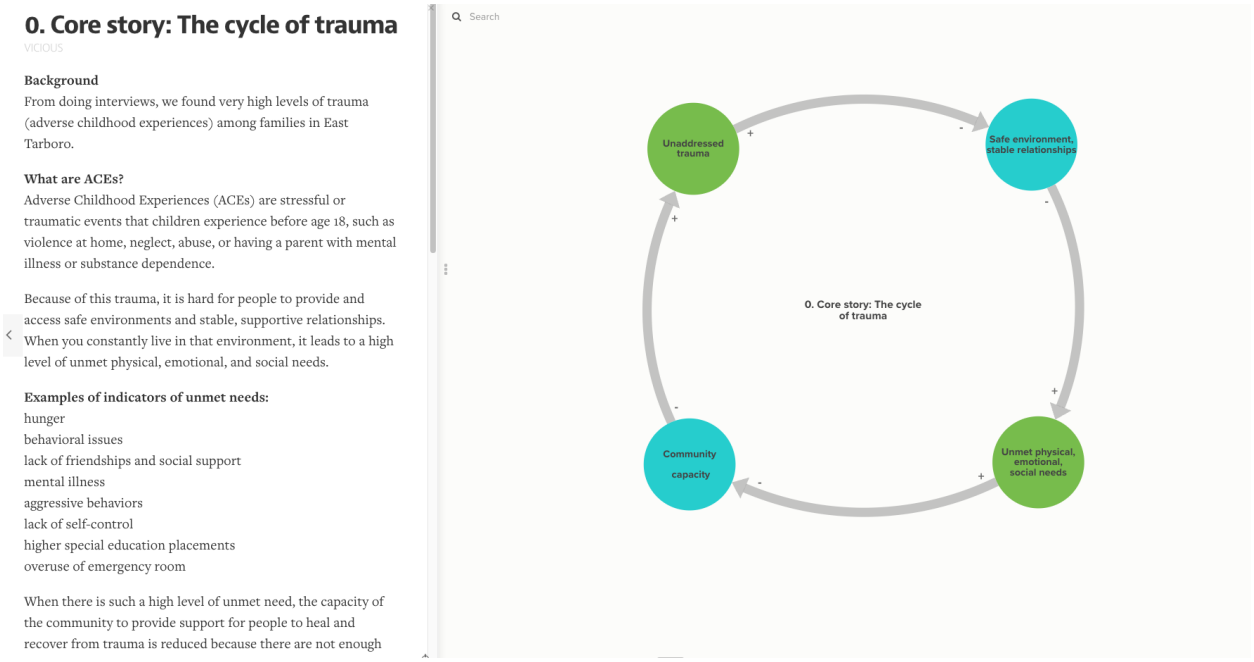
Figure 6. The ADHD Trap Feedback Loop



This loop illustrates how toxic stress in children can produce behaviors that look identical to ADHD, which creates a strong drive to treat symptoms rather than underlying causes. When trauma-driven hyperarousal is misinterpreted as a neurological disorder, stimulant medication can worsen dysregulation and lead to escalating symptoms, growing strain on families and schools, and increasing pressure to pursue additional treatment. As these ineffective interventions fail to resolve the problem, the system reinforces ADHD labeling and directs more children into special

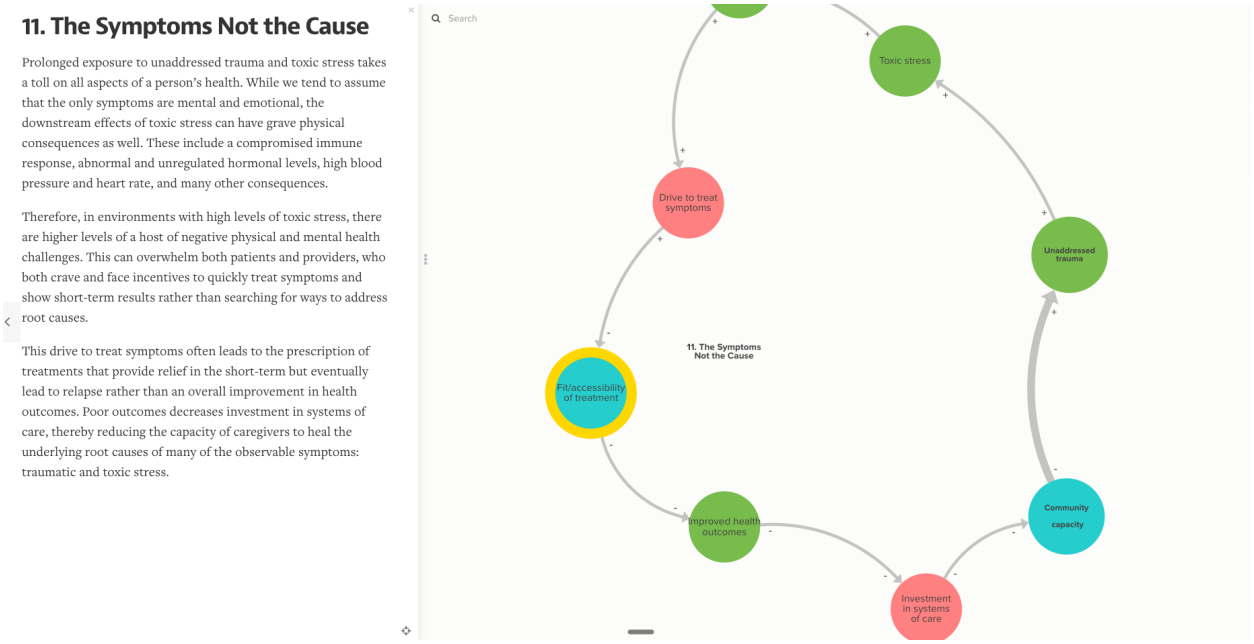
education pathways. This deepens the challenges schools face, leaves the original trauma unaddressed, and strengthens a cycle in which limited resources are spent on treatments that do not fit the actual source of distress.

Figure 7. Core Loop: The Cycle of Trauma



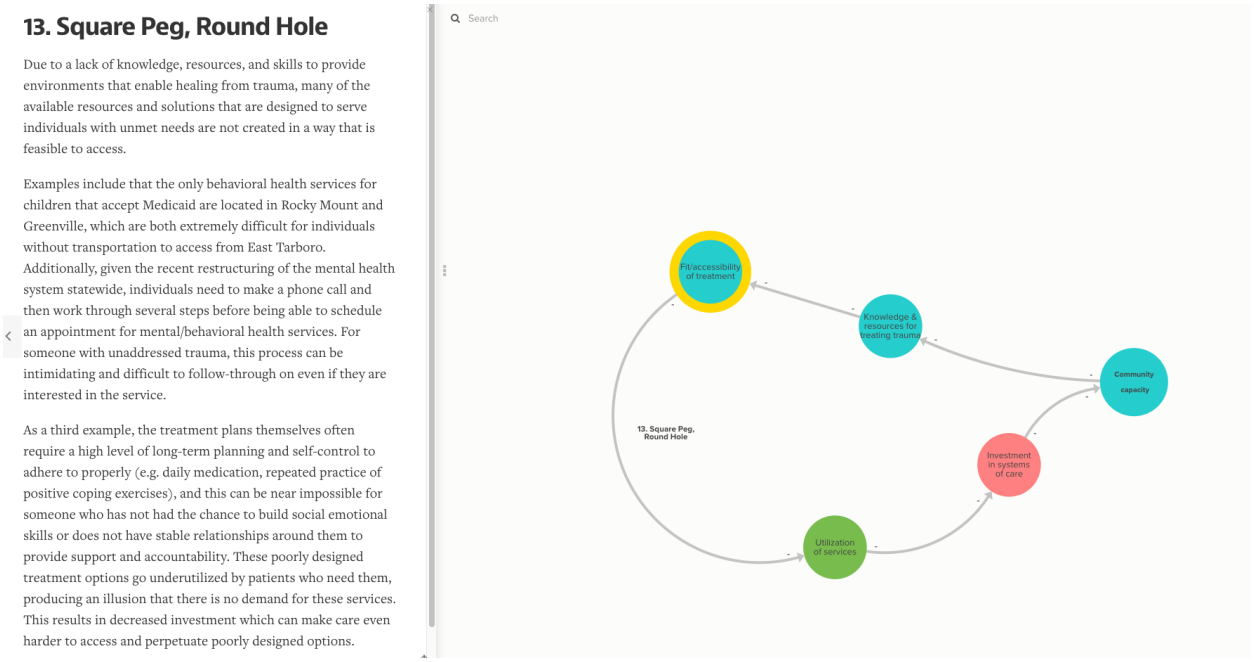
This loop shows how unaddressed trauma increases unmet physical, emotional, and social needs, which then weaken the community's ability to provide safe environments and stable relationships. Lower community capacity makes it harder to reduce trauma exposure, which keeps the cycle moving. This root dynamic helps explain why students arrive at school already dysregulated and why trauma often gets mistaken for ADHD in classrooms that are not equipped to meet these underlying needs.

Figure 8. The Symptoms, Not the Cause



This loop illustrates how toxic stress harms physical and mental health and creates conditions where providers and caregivers feel pressure to treat visible symptoms rather than the underlying trauma. Symptom-focused treatments may offer short-term relief but do not lead to real healing, which lowers health outcomes and reduces investment in systems of care. This dynamic mirrors what schools experience when trauma-driven behaviors are treated as ADHD symptoms rather than signs of distress.

Figure 9: Square Peg, Round Hole

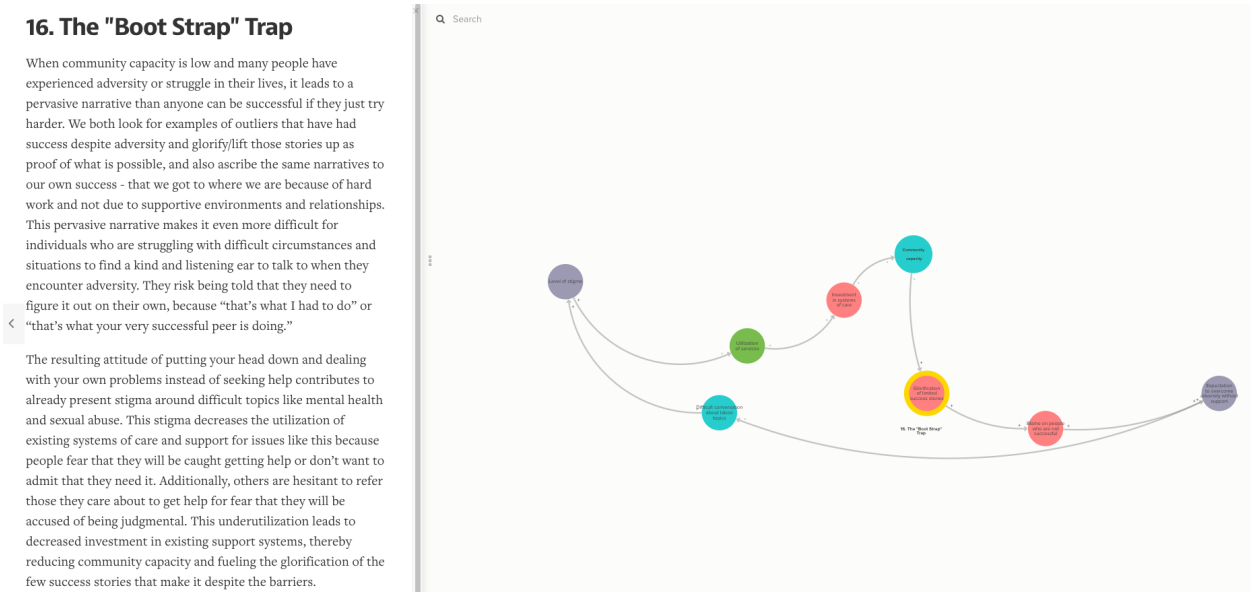


This loop demonstrates how the design of many treatment systems makes it difficult for people with unmet needs to access care. Poor fit and limited accessibility lead to low utilization of services, which creates the impression that demand is low. As investment declines, community capacity weakens, and treatment options become even less responsive. This dynamic parallels what schools face when trauma-informed supports are scarce, and the system defaults toward special education labeling.

Figure 10: No Reason to Hope

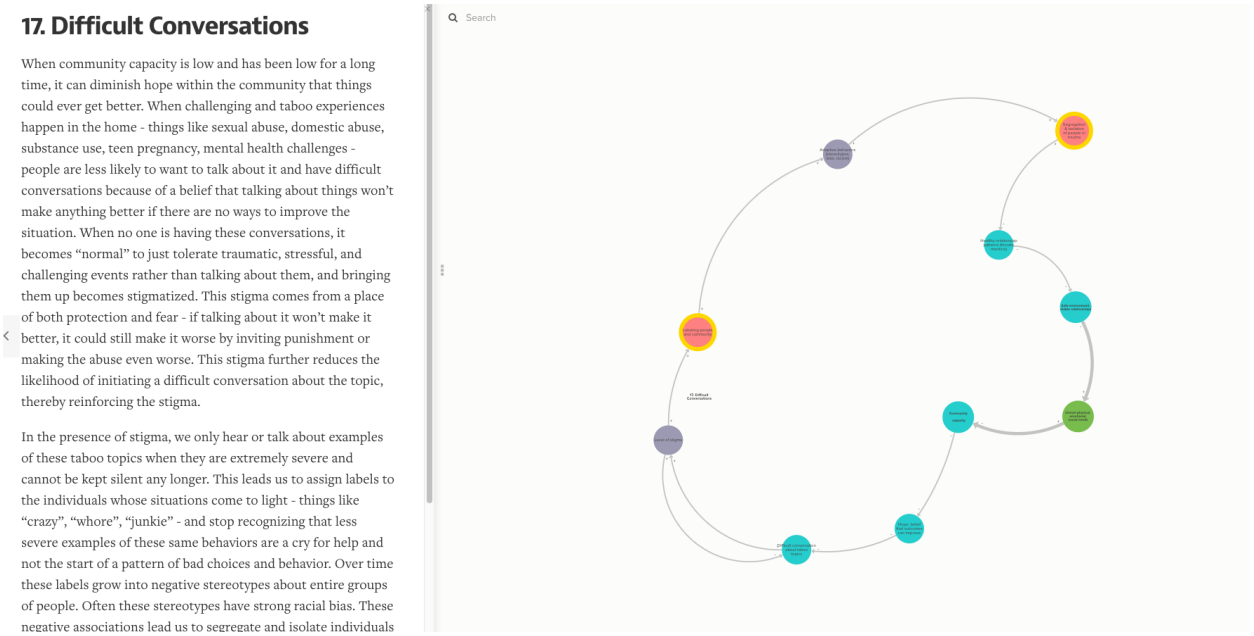
This loop shows how chronically low community capacity reduces hope that services will help, which leads to low utilization of the supports that do exist. Low utilization then drives down investment in systems of care, further shrinking community capacity and deepening hopelessness. When this dynamic appears in schools, families may avoid seeking help or distrust school interventions, increasing the likelihood that children's stress will be interpreted as ADHD rather than as a need for healing.

Figure 11: The “Boot Strap” Trap



This loop shows how a community narrative that emphasizes individual grit over supportive relationships makes it harder for people to seek help when they face adversity. When individuals feel pressure to “figure it out on their own,” the use of available services declines, which reinforces stigma around help-seeking and reduces referrals to needed supports. Low utilization then drives down investment in systems of care and further weakens community capacity. In schools, this dynamic contributes to trauma remaining hidden and unaddressed, which increases the likelihood that trauma-driven behaviors will be misinterpreted as ADHD rather than understood as signs of distress.

Figure 12. Difficult Conversations



This loop illustrates how stigma around discussing trauma and difficult experiences reduces the likelihood that people will talk openly about what they are facing. This lack of conversation normalizes suffering, reinforces stigma, and limits help-seeking. As stigma rises, fewer people feel safe naming their needs, which weakens community capacity and intensifies unmet needs. In schools, this silence makes trauma harder to detect and increases the likelihood that observable behaviors are labeled as ADHD instead.