The Addiction Frame Triggers the Disability Obligation:

Section 504, the Reversibility Paradox, and the Legal Incoherence of 2026 School Phone Policy

Travis Gilly
ORCID: 0009-0007-2954-6313
Real Safety AI Foundation
Illinois, United States

Working paper, June 2026 (v2)

ABSTRACT

In 2026, school districts, state legislatures, and advocacy organizations across the United States have justified restrictive phone and screen time policies targeting minors by invoking the clinical frame of addiction. This paper argues that the rhetorical invocation of addiction, when made by an entity receiving federal financial assistance, constitutes a statutory trigger for the protections of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. Addiction is a recognized disability under federal disability rights law. A child whose compulsive engagement with a device or platform has been characterized as addictive by the regulating institution is, by that institution's own framing, an individual with a disability within the meaning of federal law. The institution owes that child a Section 504 evaluation, a written accommodation plan, procedural protections, and a clinically supervised pathway to any reduction in access. The institution does not owe that child a Yondr pouch and a confiscation protocol. This paper establishes the statutory chain linking the addiction frame to Section 504 obligations, introduces the Reversibility Paradox as a governing principle for withdrawal protocols under conditions of attachment formation, distinguishes addiction frame policies from pedagogically framed phone policies, and proposes two substantive implementation paths available to districts that wish to address the condition the addiction frame describes without creating federal civil rights liability.

Keywords: Section 504, Americans with Disabilities Act, Title II, school phone policy, cell phone ban, behavioral addiction, gaming disorder, adolescent mental health, child find, reasonable accommodation, withdrawal syndrome, Reversibility Paradox, disability rights, educational technology policy, Office for Civil Rights

I. INTRODUCTION

By early 2026 a substantial majority of U.S. states had enacted statutes or regulations restricting student access to phones during school hours, and the count has continued to move.[1] The rhetorical justification for these policies, across advocacy literature, legislative findings, and federal executive pronouncements, consistently relies on a specific clinical frame: that the patterns of engagement between children and algorithmically mediated platforms constitute addiction. This paper takes no position on the empirical accuracy of that characterization. Its claim is narrower and concerns a

[1] Counts published during this period vary by whether they include full-day bans, bell-to-bell restrictions, district-discretion mandates, and pilot programs, and they were revised repeatedly across the 2025 and 2026 legislative sessions. The argument advanced here does not turn on the precise figure, only on the scale of adoption and the uniformity of the justifying rationale.

consequence that has received insufficient attention in the policy literature.

The argument is as follows. When an entity receiving federal financial assistance characterizes a condition using the clinical frame of addiction, and that entity is simultaneously implementing restrictive interventions against the population it has so characterized, the entity has triggered affirmative duties under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131 et seq. Those duties include evaluation upon suspicion of disability, development of an accommodation plan, provision of a free appropriate public education, manifestation determination prior to significant changes in placement, and a suite of procedural protections. These duties are incompatible with the confiscation based interventions the invoking institutions are simultaneously proposing. The paradox is structural rather than rhetorical. Its resolution requires either that the institution build the accommodation infrastructure the clinical frame commits it to, or that it displace the intervention from the student to the engineering decisions that produced the compulsive engagement pattern, or both.

Section 2 establishes the statutory chain. Section 3 examines the descriptive claim about the object of the addiction and its relation to the policy mechanism. Section 4 introduces the Reversibility Paradox and examines its transfer to the pediatric context. Section 5 addresses the clinical phenomenon of screen driven attention symptomatology and its policy implications. Section 6 considers the absence of engagement with Section 504 obligations in the advocacy literature that has shaped the policy wave. Section 7 presents two substantive implementation paths available to districts, together with a rhetorical option whose sustainability is constrained. Section 8 concludes.

II. The Statutory Chain

The chain proceeds in five steps. Each rests on settled authority.

A. Addiction as a Covered Impairment

The Americans with Disabilities Act defines disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such impairment. 42 U.S.C. § 12102(1). The U.S. Department of Health and Human Services Office for Civil Rights has consistently interpreted addiction, including substance use disorders and behaviors meeting the clinical criteria for addictive disorder, as a covered impairment under Section 504 and the ADA. The 2024 final rule on Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance codifies this interpretation in its regulatory updates to 45 C.F.R. Part 84 (U.S. Department of Health and Human Services, Office for Civil Rights, 2024).[2] Guidance specifically addressing opioid use disorder, issued in 2018 and reaffirmed thereafter, confirms that drug addiction is a disability under Section 504, the ADA, and Section 1557 of the Affordable Care Act when it substantially limits a major life activity (U.S. Department of Health and Human Services, Office for Civil Rights, 2018).

B. The Scope of the Current Use Exclusion

The ADA contains an exclusion at 42 U.S.C. § 12210(a) addressing individuals who are currently engaging in the illegal use of drugs. This exclusion applies to substances scheduled under the Controlled Substances Act, 21 U.S.C. § 812.

[2]The 2024 final rule is published at 89 Fed. Reg. 40066 (May 9, 2024) (codified at 45 C.F.R. pt. 84), with most provisions effective July 8, 2024. The rule restructured and renumbered Part 84; provisions that appear in pre-2024 sources under former section numbers now appear at redesignated numbers (for example, the former methods-of-administration provision at 45 C.F.R. § 84.4(b)(4) was redesignated to § 84.68(b)(3), and the former "recipient" definition at § 84.3(f) was redesignated to § 84.10, both by 89 Fed. Reg. 40180 (May 9, 2024)). The Department of Education's parallel Section 504 regulation governing public schools, 34 C.F.R. Part 104, was not amended by the HHS rulemaking and retains its original numbering.

Congress separately enumerated specific behavioral conditions excluded from coverage. Under the Rehabilitation Act the enumeration appears at 29 U.S.C. § 705(20)(F), which provides that for the purposes of sections 791, 793, and 794 the term individual with a disability does not include an individual on the basis of, among other conditions, compulsive gambling, kleptomania, or pyromania, or psychoactive substance use disorders resulting from current illegal use of drugs. The ADA carries a parallel enumeration at 42 U.S.C. § 12211(b)(2). Precision matters here because section 794 is Section 504 itself, so the exclusion reaches the statute this paper invokes rather than sitting harmlessly in an employment provision.

Two features of that enumeration bear on the present question. The first is its form. It is a closed list of named conditions rather than a category. Congress did not exclude behavioral addiction; it excluded three specified disorders and one narrow substance category, and under the ordinary canon the enumeration of particular exclusions supports the inference that unenumerated conditions remain covered. The ADA Amendments Act reinforces the direction of construction, instructing that the definition of disability be construed in favor of broad coverage to the maximum extent permitted by the terms of the Act. 42 U.S.C. § 12102(4)(A).

The second is the objection the form invites, which is addressed at Section 7 below rather than assumed away: compulsive gambling is the paradigm behavioral addiction, and a court could read the exclusion as expressing a congressional judgment about behavioral addictions generally, extending it by analogy to compulsive engagement with technology.

C. Diagnostic Recognition of Technology Related Addictive Disorders

The World Health Organization's Eleventh Revision of the International Classification of Diseases includes Gaming Disorder (6C51) within the diagnostic category of Disorders due to addictive behaviours. The category was adopted at the Seventy-Second World Health Assembly in May 2019 and entered into effect on 1 January 2022 (World Health Organization, 2022). The American Psychiatric Association included Internet Gaming Disorder in Section III of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders as a condition for further study (American Psychiatric Association, 2013). Legal analysis has further considered whether digital addiction qualifies as a disability under the ADA when it substantially limits one or more major life activities. Watkins (2019) concluded that digital addiction arguably qualifies as an ADA disability if it substantially limits a major life activity such as sleeping, eating, or working. The ADA Amendments Act of 2008 enumerates learning, concentrating, thinking, communicating, and working among major life activities. 42 U.S.C. § 12102(2)(A).

D. Schools as Covered Entities

Title II of the ADA applies to public entities, which includes public school districts. 42 U.S.C. § 12131(1). Section 504 of the Rehabilitation Act applies to any program or activity receiving federal financial assistance. 29 U.S.C. § 794(a). Section 504 imposes affirmative obligations on covered entities, including evaluation of any student reasonably suspected to have a disability, development of an accommodation plan, provision of a free appropriate public education, manifestation determination before significant changes in placement, and procedural due process protections.[3] 34 C.F.R. Part 104.

[3]The Department of Education's Section 504 regulation governs public schools. The affirmative obligations summarized here are codified principally at 34 C.F.R. § 104.33 (free appropriate public education), § 104.35 (evaluation and placement), and § 104.36 (procedural safeguards). These provisions were not affected by the 2024 HHS rulemaking, which amended only 45 C.F.R. Part 84.

E. Why the Duty Runs Through Evaluation Rather Than Through the Regarded-As Prong

The obvious route from institutional characterization to statutory duty runs through the regarded-as prong. An individual meets the definition of disability if subjected to a prohibited action because of an actual or perceived impairment, whether or not the impairment limits or is perceived to limit a major life activity. 42 U.S.C. § 12102(1)(C), (3)(A). Institutional characterization of a population as addicted is perception of impairment in the ordinary sense of the term.

That route is available for the antidiscrimination claim and unavailable for the accommodation claim, and the distinction is dispositive enough that an argument which misses it will fail on a motion. Congress provided that a public entity under subchapter II need not provide a reasonable accommodation or a reasonable modification to policies, practices, or procedures to an individual who meets the definition of disability solely under the regarded-as prong. 42 U.S.C. § 12201(h). A student who is only regarded as addicted therefore cannot compel an accommodation plan on that basis alone. The regarded-as prong is also subject to a transitory and minor exception for impairments with an actual or expected duration of six months or less. 42 U.S.C. § 12102(3)(B).

The duty this paper identifies therefore runs through a different provision, and it is stronger for it. The Department of Education's Section 504 regulation requires a recipient operating a public elementary or secondary program to conduct an evaluation of any person who, because of handicap, needs or is believed to need special education or related services, before taking any action with respect to initial placement and before any subsequent significant change in placement. 34 C.F.R. § 104.35(a). The trigger is belief of need, not established disability. Nothing in § 12201(h) touches it, because an evaluation is not an accommodation. It is the procedural step by which the entity determines whether an accommodation is owed.

The chain therefore reads as follows. Institutional invocation of the addiction frame supplies the belief that the affected students need special education or related services. That belief triggers the evaluation duty under § 104.35(a). Evaluation determines whether the student has an actual impairment substantially limiting a major life activity. Where it does, the full apparatus follows: free appropriate public education, an accommodation plan, procedural safeguards, and manifestation determination before a significant change in placement. Where it does not, the entity has discharged its obligation and may proceed. What the entity may not do is invoke the frame, impose the intervention, and skip the evaluation between them.

F. Institutional Invocation as Diagnostic Act

The operative step in the chain is this. When a school district, a state legislature, or a federal agency relies on the addiction frame as a load bearing justification for a restrictive policy, the invocation is an institutional characterization of the condition of the affected population. Counsel for an invoking institution may argue that the characterization was rhetorical rather than clinical. Such an argument faces significant obstacles. The existence of diagnostic categories corresponding to the invoked frame under the ICD-11 and DSM-5 classifications, the concurrent reliance of state attorneys general on the clinical addiction theory in ongoing litigation against platform companies, and the pattern of the invoking institution treating the frame as the substantive rationale for its intervention together undermine any retreat to metaphor. The frame, once invoked in the regulatory record, functions as diagnosis.

The principle extends beyond the specific institution whose written policy contains the operative language. A local education agency implementing a state statute that rests on legislative findings of adolescent behavioral addiction has imported the state's characterization of the affected population into its own implementation context. The federal executive pronouncements, the state statutory findings, the advocacy literature incorporated by reference in model policy language, and the district level policy text operate as a connected regulatory record. The Section 504 evaluation duty, which attaches when an entity knows or reasonably should know that a student has a disability, does not require

the implementing entity to have originated the diagnostic frame. Constructive knowledge of disability status can be imputed from the chain of authority on which the entity's own policy rests. An institution cannot implement inside a policy frame that characterizes the affected population as addicted and simultaneously disclaim the diagnostic import of that frame when its own accommodation duties are at issue.

A structural paradox results. The state attorneys general pursuing litigation against platform companies on the theory that the platforms cause clinical addiction in minors are, in many cases, officers of the same state governments that have simultaneously enacted confiscation protocols for the population those plaintiffs characterize as addicted. If the litigation theory is correct, the affected population is disabled within the meaning of federal law. The interventions imposed on that population have proceeded without the procedural infrastructure that Section 504 and Title II would require.

III. The Object of the Addiction

The policy wave examined in this paper rests on a descriptive claim that requires examination before its legal consequences can be adjudicated. The claim that children are addicted to their phones is the shorthand that appears in advocacy literature, legislative findings, and executive pronouncements. The shorthand is imprecise in a way that matters for both the clinical argument and the policy response.

The physical device is not plausibly the addictive object. If it were, the remediation behavior observed among concerned parents would not cluster around the substitution of feature limited devices for smartphones. A flip phone is a physical device with a screen that permits voice communication and short messaging. It does not, in ordinary use, produce the sustained compulsive engagement that motivates the policy wave. The willingness of parents to substitute one physical device for another as a remediation strategy indicates that the variable of concern is the category of platform access the device mediates, not the device itself.

The addictive object is the engineered content delivered through platform applications whose retention mechanics are documented in the litigation record. Variable reward scheduling, infinite feed architectures, autoplay defaults, and recommendation systems optimized for prolonged session duration are the design choices for which state attorneys general are currently pursuing liability against platform providers. The clinical characterization of the affected population's condition, if it is correct, is a characterization of their relationship with these content and design systems. It is not a characterization of their relationship with a handheld radio frequency device. This distinction has two consequences.

First, confiscation of the device as the operative policy intervention is not correctly aligned with the characterized object of the addiction. A student whose compulsive engagement with algorithmically curated content has been classified as addiction does not cease to be exposed to that content when the device is confiscated during school hours. Alternative devices, including school issued devices and household devices, continue to deliver the content outside the policy's reach. The device confiscation intervention reduces access to the content within the policy window and leaves the addictive content delivery infrastructure entirely operative elsewhere in the student's environment.

Second, the disjunction between the object of the addiction (engineered content) and the object of the intervention (physical device) does not dissolve the statutory consequences of the institutional characterization. Section 504 and the ADA attach to the characterization of the population, not to the accuracy of the policy mechanism adopted to address the condition. An institution that characterizes a population as addicted has triggered accommodation duties toward that population regardless of whether the institution's chosen remediation mechanism is correctly aligned with the clinical phenomenon it purports to address. A policy that misidentifies the addictive object does not escape the disability rights obligations the characterization generates. It merely guarantees that the intervention will be simultaneously legally

exposed and clinically ineffective.

IV. The Reversibility Paradox

The emerging clinical and legal literature on AI-induced psychosis has produced a structural principle with direct relevance to the school phone policy context. The principle originates in the analysis of a 2025 case in which a 48 year old man's death followed two attempts to disengage from a conversational AI system that had become the primary relational object in his daily life. The account is drawn from the complaint in *Fox v. OpenAI*, No. 25STCV32379 (Cal. Super. Ct., L.A. County, filed Nov. 6, 2025), coordinated into JCCP No. 5431, and from contemporaneous reporting (Bansal, 2026). The allegations have not been tested by a factfinder and are described here as pleaded. The first attempt at withdrawal was undertaken cold turkey. The complaint describes several days of somatic and affective symptoms, naming chills, memory disturbance, and uncontrollable crying, followed on the third day by a psychotic break, a finding of imminent likelihood of serious harm to self, and involuntary commitment for over a week. Following return to the system, a second attempt preceded death. The three day latency is the feature that matters for the pediatric transfer analyzed below, because it locates the window of greatest risk after the behavior the intervention targets has already stopped. The case is now a central reference point in product liability proceedings brought against platform providers.

The Reversibility Paradox, stated here as the premise on which this section proceeds, holds that reversibility of an induced pathological state is not equivalent to the safety of its reversal. A condition may be genuinely reversible, in the sense that removing the environmental stimulus resolves the underlying pathology, while simultaneously presenting acute risk when the reversal is undertaken without clinical supervision. The mechanism by which the pathology resolves is the mechanism by which withdrawal produces crisis. Attachment formation that underlies the induced state is the same attachment formation whose abrupt severance destabilizes the affected individual.

The principle has three operational corollaries. First, an instruction to discontinue engagement does not itself constitute clinical intervention. Where the discontinuation is enforced without accompanying clinical support, the instruction functions as a trigger for the crisis the support would have managed. Second, unsupervised withdrawal is contraindicated in any case exhibiting attachment formation to the engagement mechanism. In the pediatric context, this pattern corresponds to the subset of students whose compulsive engagement functions as a primary regulatory mechanism for underlying anxiety, depressive symptoms, ADHD, or unmetabolized trauma. Third, an institution that invokes the clinical frame of addiction has implicitly selected a category of disorder for which withdrawal protocols are established in the clinical literature. Departure from those protocols, when implemented against the population the institution has characterized, provides the foundation for a negligence claim and a Section 504 violation.

A. The Pediatric Severity Profile

The motivating case involved an adult and a conversational AI system under conditions of exclusive attachment. Children experiencing unsupervised withdrawal from compulsive engagement with social platforms do not present the same acute mortality profile. They present a different profile with different but consequential endpoints. The premise that abstinence from a compulsively used digital product produces a measurable syndrome at all is the load bearing one, and it now has direct empirical support. Yen, Lin, Wu, and Ko (2022), comparing 69 individuals with internet gaming disorder against 69 regular gamers under prospective abstinence, found withdrawal related symptoms in 85.5 percent of the disorder group, including affective disturbance, anhedonia, and urge, together with elevated heart rate relative to controls. The autonomic finding matters because it supplies a physiological correlate rather than a purely self reported one. The broader clinical literature on behavioral addiction supplies the conceptual mapping (Alavi et al., 2012) and the treatment models developed for compulsive internet use (Young, 2011). Observed and predicted endpoints include

elevated anxiety, situational depression, academic performance decline, escalation to alternative compulsive behaviors, and the surfacing of previously masked underlying conditions.

The same study contains a finding that cuts against a simple transfer, and it should be stated rather than omitted. Gaming withdrawal symptoms attenuated within a single day. That result is a reason to distinguish rather than to abandon. What abstinence removes in the gaming case is an activity. What a phone policy removes for a subset of students is a social environment and, for some, the primary means of contact with a peer community that does not exist locally. The removal of a social environment is the case in which the attachment and bereavement literatures rather than the gaming abstinence literature supply the prediction, and it is the case in which the severity ceiling is higher.

That subset is identifiable in advance and is disproportionately composed of students the policy debate rarely names. Students who are isolated in their physical environment by disability, by geography, by family circumstance, or by an identity not safely expressible at home use platform mediated contact as their functioning social world. Social isolation and loneliness carry measured risk of a magnitude comparable to established medical risk factors, with meta-analytic odds ratios of 1.29 for social isolation and 1.26 for loneliness (Holt-Lunstad and colleagues, 2015). For these students a uniform restriction is not the withdrawal of a compulsion. It is the withdrawal of a support, and the aggregate outcome measures a district is likely to collect will not distinguish the two.

At population scale, the clinical literature supports more serious predictions. Unsupervised withdrawal from a compulsive engagement pattern, imposed simultaneously on a pediatric population in which attachment formation is prevalent, is predicted by the behavioral addiction withdrawal literature to produce increased incidence of clinical depression, anxiety disorder presentation, and, in vulnerable subpopulations, suicidality. The combined position of the clinical literature is that abrupt cessation without scaffolding, applied to a population characterized as addicted, carries foreseeable risk of mortality at the margin even where the individual case mortality profile is less acute than in adult parallel cases. The policy wave's failure to engage with this prediction is a failure of foreseeability at the scale at which the policy is being implemented.

The most epistemically consequential endpoint concerns attribution. A student presenting with new onset depressive or anxiety symptoms several weeks after a district phone policy takes effect is a student whose symptomatic trajectory will ordinarily be attributed to causes other than the policy. The withdrawal profile predicted by the clinical literature is indistinguishable, at the level of symptomatic presentation, from a number of unrelated adolescent mental health trajectories. In the absence of a monitoring protocol built into the policy, the causal link between institutional intervention and individual symptom onset is not recovered.

V. Screen Driven Attention Symptomatology and Its Policy Implications

A distinct but related clinical phenomenon bears on the question of implementation. Problematic engagement with mobile devices has been associated with attention symptoms that overlap the presentation of attention-deficit/hyperactivity disorder (Panagiotidi & Overton, 2022). The association has been demonstrated across multiple study populations and has been replicated with respect to internet use, gaming, and smartphone specific patterns of engagement. Inattention symptoms, in particular, correlate with indices of problematic mobile phone use.

The empirical literature does not support the claim that screen engagement causes ADHD. It supports the narrower claim that compulsive engagement patterns can produce attention symptoms indistinguishable, on standard clinical screening instruments, from those associated with ADHD. This distinction has two policy relevant consequences.

First, where a student's attention symptoms are driven by engagement patterns, the removal of the engagement mechanism produces a rapidly changing clinical picture. The standard school year diagnostic process assumes relative stability of presentation across the diagnostic window. A phone policy that alters the primary driver of the presentation

invalidates the diagnostic baseline. A district implementing such a policy without provision for diagnostic reevaluation or communication with treating clinicians will miss the window in which medication regimens targeting the presentation might be reconsidered.

Second, the withdrawal process itself produces a transient symptomatic presentation that overlaps worsening ADHD. Increased restlessness, impaired sustained attention, emotional dysregulation, and reduced task initiation are predicted responses to behavioral addiction withdrawal and are also among the core presentations of ADHD. Districts without infrastructure for clinical supervision of the transition will have no principled basis for distinguishing withdrawal from underlying pathology during the relevant window.

VI. The Advocacy Literature and the Accommodation Question

The advocacy literature that has shaped the 2026 policy wave has engaged substantively with the empirical and clinical arguments for restriction but has not, in the works reviewed for this paper, engaged with the statutory consequences of the clinical framing on which its arguments rely. Haidt (2024), in a work that has significantly influenced the policy environment, relies on the language of addiction as a central descriptor of adolescent engagement with social platforms and advocates for restrictive interventions at the school and state levels. Twenge (2017), whose earlier empirical work underlies much of the subsequent synthesis, similarly employs the clinical frame. It should be recorded that the empirical basis of that synthesis is contested, most directly by Orben and Przybylski (2019), and that the contest is relevant here in a specific way: the weaker the empirical warrant for the addiction frame, the harder it is to justify a district's decision to adopt the frame and the obligations that follow from it while declining the obligations themselves. Neither work, nor the subsequent public facing writing by either author, addresses the Section 504 and ADA obligations that the clinical framing generates when adopted by institutions subject to federal disability rights law.

Advocacy organizations that have circulated model legislation language and produced research reports in support of the policy wave have, in the works reviewed for this paper, similarly declined to publish guidance on the compliance infrastructure the clinical framing requires of implementing districts. The 2023 advisory on social media and youth mental health from the U.S. Surgeon General characterizes the patterns of concern as "excessive and problematic use" and "compulsive" engagement rather than deploying the clinical frame of addiction explicitly (Murthy, 2023). The distinction matters for the argument advanced here. Institutions that reach for the clinical frame of addiction in their own policy justifications do so without the hedge that federal executive pronouncements have thus far preserved, and in doing so assume the statutory consequences that the hedge was constructed to avoid.

The absence of engagement is consequential because the implementation gap between the invoked frame and the required accommodation infrastructure is not one that districts can close without budgetary, clinical, and procedural action they have not, in most cases, been given notice or resources to undertake. Advocacy that pushes the clinical frame without addressing the accommodation obligation transfers the statutory liability to the implementing institution.

VII. Objections

Five objections are available. Each is stated in its strongest form.

A. The compulsive gambling analogy

The strongest doctrinal objection is that 29 U.S.C. § 705(20)(F)(ii) and 42 U.S.C. § 12211(b)(2) express a congressional judgment about behavioral addictions as a class, and that a court should read compulsive engagement with a platform as the nearest available analogue to compulsive gambling and exclude it on the same reasoning.

The answer is a reading rather than a certainty. The enumeration is a closed list of three named disorders plus a narrow drug category. Congress excluded gambling in 1990, when gambling disorder was the only behavioral addiction with a recognized diagnostic identity, and could not have addressed a category of disorder that did not then exist. The diagnostic systems themselves now treat the two as distinct entities rather than as instances of a single class: the ICD-11 assigns gambling disorder and gaming disorder separate codes at 6C50 and 6C51, and the DSM-5 places gambling disorder among recognized disorders while treating internet gaming disorder as a condition warranting further study. An exclusion drafted against one diagnosis does not carry to a diagnosis the drafters had no occasion to consider, particularly against the ADA Amendments Act instruction that the definition be construed in favor of broad coverage. 42 U.S.C. § 12102(4)(A).

A district defending against a complaint will nonetheless raise this argument, and the honest assessment is that the question is open. It is a reason to build the accommodation infrastructure on the evaluation duty analyzed at Section 2.5, which does not depend on how the exclusion is read, rather than on the covered-impairment question alone.

B. The regarded-as limitation

The second objection is that the argument proves less than it claims because a student who is merely regarded as addicted cannot compel an accommodation. That objection is correct on its own terms and is why the chain in this paper runs through 34 C.F.R. § 104.35(a) rather than through 42 U.S.C. § 12102(1)(C). The evaluation duty triggers on belief of need. Section 12201(h) limits accommodation, not evaluation. An entity that invokes the frame owes the evaluation; what it owes after the evaluation depends on what the evaluation finds.

C. The effect size objection

The third objection targets the empirical foundation of the policy wave this paper analyzes, and it cuts against the advocacy literature discussed at Section 6 as much as against anything argued here. Orben and Przybylski (2019), applying specification curve analysis across three datasets totaling 355,358 respondents, found the association between adolescent digital technology use and well-being to be negative but very small, explaining at most 0.4 percent of variance, and concluded that effects of that size do not warrant policy change.

Two responses. First, the finding is about quantity of use, and the clinical claim at issue concerns pattern. Xiao and colleagues (2025) found that total screen time at baseline was not associated with their outcomes, replicating Orben and Przybylski, while addictive use trajectories were associated with substantially elevated risk of suicidal behaviors, with risk ratios of 2.14 and 2.39. Dose explains little; pattern explains more. Second, and more important for this paper, the objection is a problem for the districts rather than for the argument. This paper takes no position on whether the addiction frame is empirically warranted. It argues that an institution which adopts the frame incurs the obligations the frame carries. A district persuaded by Orben and Przybylski has a clean exit available, which is to stop invoking addiction. A district that keeps the frame while citing the weakness of the evidence has taken the liability and abandoned the justification.

D. The metaphor defense

The fourth objection is that policy rhetoric is not diagnosis, and that no court will convert a communications document into a clinical finding. The response is that the evaluation duty does not require a diagnosis from the district. It requires belief of need, and a district that has premised a restrictive policy on the proposition that its students are addicted has documented the belief in its own record. The defense is also unstable in operation, since it requires that every board member, administrator, communications officer, and outside consultant refrain from the clinical idiom in perpetuity,

which is a discipline the policy record of the current wave does not display.

E. The remedy objection

The fifth objection is that identifying a duty is not the same as identifying a remedy. Section 504 is enforceable through administrative complaint to the Department of Education Office for Civil Rights and through a private right of action, and the procedural violations described here are of a kind OCR has historically resolved through corrective action agreements rather than through damages. The practical exposure is therefore reputational, administrative, and injunctive rather than primarily monetary. That is a real limit on the argument and it does not reduce the obligation, which exists whether or not any particular family pursues it.

VIII. Implementation Paths

Districts seeking to reduce student phone use during school hours without creating federal civil rights liability have two substantive paths available. Both are compatible with the clinical accuracy of the addiction frame as applied to algorithmically mediated engagement. Both recognize that the affected population is disabled within the meaning of federal law when the institution's own framing treats them as such. The paths differ in whether the district addresses the condition as an individual clinical matter or as a systemic product design matter.

Both paths are consistent with the standard societal response to addictive products. Regulation of the producer, education of the consumer, graduated exposure for minors, and clinical support for individuals who develop pathological relationships with the product constitute the policy model applied to alcohol, commercial gambling, tobacco, and high risk pharmaceuticals. Confiscation of the delivery vehicle from the consumer, absent clinical support and without regulatory pressure on the producer, is not a recognized policy model for any addictive product in the modern public health canon. The 2026 policy wave, insofar as it operates exclusively through device confiscation, represents a departure from this canon and a reduction of the policy response to a single intervention class whose evidentiary support is thin.

A. Honoring the Clinical Frame by Building the Accommodation Infrastructure

A district that invokes the clinical framing of its policy must build the accommodation infrastructure the framing requires. This infrastructure includes a Section 504 evaluation pathway for any student whose compulsive engagement has been implicitly characterized as addiction by the policy's rationale, partnership with local clinical providers for graduated reduction and withdrawal supervision, training of counseling and nursing staff on behavioral addiction withdrawal protocols, procedural protections before significant changes in placement, and budgetary provision for clinical supervision not currently present in most district operating budgets.

This path is legally coherent and clinically defensible. Its principal cost is financial and organizational. Districts in under resourced jurisdictions face meaningful barriers to full implementation. The path reflects what it means for an institution to take its own diagnosis seriously.

B. An Education and Accountability Path

A second path reframes the intervention rather than the rationale. This approach proposes that district responses to adolescent engagement with algorithmically mediated platforms focus on educating students regarding the design logic of attention capture, the psychology of variable reward engagement, and the recognition of compulsive patterns in their own behavior. The approach is paired with platform accountability pursued through litigation, regulation, and standards

enforcement, on the model of the tort and regulatory responses to manufacturers and distributors after comparable product design harms.

This path recognizes a structural feature of the problem that confiscation based interventions elide: the addictive character of the engagement pattern is a property of platform design choices rather than of the child operating the device. Variable reward schedules, infinite scroll architectures, and recommendation algorithms optimized for retention are engineering outputs of institutions subject to regulation and liability. Displacing the intervention from the student to the builder aligns the remedy with the locus of the harm. The approach develops transferable capability in the affected population that persists beyond the specific device, platform, or academic setting. Its principal cost is in curriculum development and teacher training; its per student compliance cost is minimal. It is structurally analogous to the evidence based substance use prevention curricula that displaced the Drug Abuse Resistance Education (D.A.R.E.) program following the documented failure of that program to produce durable behavioral change (U.S. General Accounting Office, 2003).

C. The Two Paths Are Complementary

The two paths are not mutually exclusive and in most cases should be pursued in parallel. The accommodation infrastructure addresses students already in compulsive engagement patterns who will be affected by any change in access. The education and accountability path addresses the cohorts who have not yet developed those patterns and the platform design choices that produced the crisis in the first place. A well resourced district can and should do both. A lower resourced district may prioritize the education and accountability path while advocating for state and federal investment in the accommodation infrastructure.

A third option exists but is primarily rhetorical. A district may attempt to preserve its restrictive policy while divesting its public communications of the clinical frame, recasting the intervention on purely pedagogical or classroom management grounds. Counsel advising on Section 504 exposure will often recommend this posture. The posture is available, but its sustainability depends on the discipline of board members, administrators, communications staff, and external consultants in refraining from the clinical frame in public materials. Districts whose policy deliberations have already been conducted in the clinical idiom will find their policy documents reinterpreted through the lens of those deliberations in the event of a complaint. This option is a compliance adjustment, not a substantive response to the underlying harm.

IX. CONCLUSION

The 2026 school phone policy wave has produced a structural legal incoherence that is not yet reflected in the compliance literature at the scale at which the policies themselves have been distributed. The invocation of the clinical frame of addiction, by institutions subject to federal disability rights law, triggers statutory obligations that are incompatible with the confiscation based interventions the institutions are simultaneously imposing.

Two substantive remediation paths are available. The first requires the district to honor the clinical framing it has invoked by building the accommodation infrastructure the framing requires. The second displaces the intervention from the student to the engineering decisions that produced the compulsive engagement pattern, pairing student education with platform accountability pursued through regulation and tort. In most cases the paths are complementary and should be pursued in parallel. The political economy of each jurisdiction will determine the emphasis. The epistemic precondition for either response is recognition that the problem is structural rather than rhetorical. Districts cannot neutralize the paradox by characterizing their invocation of the clinical frame as metaphorical.

The first wave of OCR complaints and Section 504 litigation on this question is foreseeable. Initial complaints will

proceed through families with the legal literacy and resources to pursue them. A judgment in favor of a complainant will produce a template replicable across jurisdictions. By that point, the available response will be reactive. The purpose of this paper is to make the proactive response available while the window remains open.

ACKNOWLEDGMENTS

The author discloses the use of speech-to-text software (Wispr Flow) and Anthropic's Claude as assistive technology for a diagnosed neurodevelopmental condition. All legal analysis, case synthesis, theoretical framing, doctrinal arguments, and conclusions are solely the author's own.

Correspondence concerning this article should be addressed to Travis Gilly, Real Safety AI Foundation, Illinois, United States. Email: t.gilly@ai-literacy-labs.org.

REFERENCES

Alavi, S. S., Ferdosi, M., Jannatifard, F., Eslami, M., Alaghemandan, H., & Setare, M. (2012). Behavioral addiction versus substance addiction: Correspondence of psychiatric and psychological views. *International Journal of Preventive Medicine, 3*(4), 290–294.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12213 (2018).

ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553.

Bansal, V. (2026, February 28). Her husband wanted to use ChatGPT to create sustainable housing. Then it took over his life. *The Guardian*.

Fox v. OpenAI, Inc., No. 25STCV32379 (Cal. Super. Ct., County of Los Angeles, filed Nov. 6, 2025), coordinated into *In re ChatGPT Cases*, JCCP No. 5431 (Cal. Super. Ct., County of San Francisco, Feb. 3, 2026).

Haidt, J. (2024). *The anxious generation: How the great rewiring of childhood is causing an epidemic of mental illness*. Penguin Press.

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, 10(2), 227–237. https://doi.org/10.1177/1745691614568352

Murthy, V. H. (2023). *Social media and youth mental health: The U.S. surgeon general's advisory*. U.S. Department of Health and Human Services.

Orben, A., & Przybylski, A. K. (2019). The association between adolescent well-being and digital technology use. *Nature Human Behaviour*, 3(2), 173–182. https://doi.org/10.1038/s41562-018-0506-1

Panagiotidi, M., & Overton, P. (2022). Attention deficit hyperactivity symptoms predict problematic mobile phone use. *Current Psychology, 41*(5), 2765–2771. https://doi.org/10.1007/s12144-020-00785-2

Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (2018).

Twenge, J. M. (2017). *iGen: Why today's super-connected kids are growing up less rebellious, more tolerant, less happy, and completely unprepared for adulthood*. Atria Books.

U.S. Department of Health and Human Services, Office for Civil Rights. (2018). *Drug addiction and nondiscrimination laws: A chat with OCR*. https://www.hhs.gov/sites/default/files/opioid-newsletter-october-201 pdf

U.S. Department of Health and Human Services, Office for Civil Rights. (2024). *Section 504 of the Rehabilitation Act of 1973 final rule: Section by section fact sheet for recipients of financial assistance from HHS*. https://www.

hhs.gov/civil-rights/for-individuals/disability/section504-rehabilitation-act-of-197
ocr-detailed-504-fact-sheet/index.html

U.S. General Accounting Office. (2003). *Youth illicit drug use prevention: DARE long-term evaluations and federal efforts to identify effective programs* (Tech. Rep. No. GAO-03-172R).

Watkins, M. (2019, April). *Gonna have to face it we're addicted to... everything?! Digital addictions in the workplace*. Fisher Phillips. https://www.fisherphillips.com/news-insights/gonna-have-to-face-it-we-re-a
html

World Health Organization. (2022). *International classification of diseases, eleventh revision (ICD-11)*. https://icd.who.int/

Young, K. S. (2011). CBT-IA: The first treatment model for internet addiction. *Journal of Cognitive Psychotherapy, 25*(4), 304–312. https://doi.org/10.1891/0889-8391.25.4.304

Xiao, Y., Meng, Y., Brown, T. T., Keyes, K. M., & Mann, J. J. (2025). Addictive screen use trajectories and suicidal behaviors, suicidal ideation, and mental health in US youths. *JAMA*, 334(3), 219–228. https://doi.org/10.1001/jama.2025.7829

Yen, J. Y., Lin, P. C., Wu, H. C., & Ko, C. H. (2022). The withdrawal-related affective, gaming urge, and anhedonia symptoms of internet gaming disorder during abstinence. *Journal of Behavioral Addictions*, 11(2), 481–491. https://doi.org/10.1556/2006.2022.00008