REAL SAFETY AI FOUNDATION · WORKING PAPER

SECTION 504 · AMERICANS WITH DISABILITIES ACT · SCHOOL PHONE POLICY · BEHAVIORAL ADDICTION · ADOLESCENT MENTAL HEALTH · REVERSIBILITY PARADOX · PSEUDO-ADHD · EDUCATIONAL TECHNOLOGY POLICY

The Addiction Frame Triggers the Disability Obligation

Section 504, the Reversibility Paradox, and the legal incoherence of 2026 school phone policy.

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STATES RESTRICTING STUDENT PHONES

One word does the justifying.

Across advocacy literature, legislative findings, and federal pronouncements, the same clinical frame carries the policy: that children's engagement with algorithmic platforms is an addiction. This paper takes no position on whether the word is accurate. Its claim is narrower, and concerns a consequence the policy literature has missed: what the word commits the institution to, once it is the one saying it.

SOURCES Murthy, V. H. (2023). Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory. · Haidt, J. (2024). *The Anxious Generation.*

Call it addiction, and you have named a disability.

Addiction is a covered impairment under Section 504 and the ADA. A child the institution has characterized as addicted is, by that framing, a child with a disability. What follows are two columns that cannot both be honored.

WHAT THE INSTITUTION OWES

A Section 504 evaluation

A written accommodation plan

A free appropriate public education

A clinically supervised reduction path

Procedural protections before any change

WHAT THE POLICY PROVIDES

A confiscation pouch and a removal protocol.

Section 504 and the ADA attach to the characterization of the population, not to the accuracy of the chosen remedy. The duty arrives whether or not the remedy fits.

SOURCES 29 U.S.C. §794; 42 U.S.C. §12102(1). · HHS OCR (2024), final rule, 89 Fed. Reg. 40066. · 34 C.F.R. §§104.33–104.36.

PART ONE

The Statutory Chain

Five steps, each resting on settled authority, from the word to the duty.

I

Addiction is a covered impairment; the behavioral exclusions are narrow and enumerated; the diagnostic categories exist; schools are covered entities; and the institution's own invocation operates as the diagnostic act.

From the word to the duty, in five steps.

A	**Addiction is a covered impairment**	HHS and its Office for Civil Rights have consistently read addiction as covered under Section 504 and the ADA.
B	**The exclusions are narrow**	Congress enumerated only gambling, kleptomania, and pyromania. Behavioral and technology addictions are not excluded.
C	**The diagnoses exist**	ICD-11 Gaming Disorder (6C51) and DSM-5 Internet Gaming Disorder give the invoked frame a clinical referent.
D	**Schools are covered entities**	Title II reaches public districts; Section 504 reaches any program receiving federal financial assistance.
E	**Invocation is the diagnostic act**	Once the frame is the load-bearing rationale in the regulatory record, it functions as diagnosis and triggers the duty.

SOURCES 42 U.S.C. §§12102, 12131, 12210; 29 U.S.C. §705(20)(C), §794. · WHO ICD-11 (2022); APA DSM-5 (2013). · HHS OCR (2018, 2024).

The frame, once invoked, functions as diagnosis.

An institution cannot characterize the affected population as addicted and then disclaim the diagnostic import of that word when its own accommodation duties are at issue. The duty to evaluate attaches on constructive knowledge, and a district implementing a state statute built on findings of adolescent addiction has imported that characterization into its own context.

WHY "IT WAS ONLY A METAPHOR" FAILS

The diagnostic categories corresponding to the frame already exist.

State attorneys general rely on the same clinical theory in platform litigation.

The institution treats the frame as its substantive rationale, not as ornament.

SOURCES 34 C.F.R. §104.35 (evaluation duty on constructive knowledge). · 42 U.S.C. §12131(1).

One government, two incompatible positions.

The state attorneys general suing platform companies on the theory that their products cause clinical addiction in minors are, in many cases, officers of the same state governments that have enacted confiscation protocols for the population those suits describe as addicted. If the litigation theory is correct, that population is disabled within the meaning of federal law, and the interventions imposed on it have proceeded without the procedural infrastructure Section 504 and Title II would require.

SOURCES State attorney-general platform litigation relying on the clinical-addiction theory (2024–2026). · 29 U.S.C. §794; 42 U.S.C. §§12131–12132.

PART TWO

The Object and the Withdrawal

II

What the addiction is actually to, and why pulling away is not the same as being safe.

The addictive object is the engineered content, not the handheld device. And reversibility of an induced state is not the same as the safety of reversing it.

The addiction is not to the device.

If the handset were the object, swapping a smartphone for a flip phone would not be the remediation concerned parents reach for. The object is the engineered content: variable reward scheduling, infinite feeds, autoplay defaults, and recommendation systems tuned for session length. Confiscating the device during school hours leaves that content fully operative on every other screen in the child's life.

WHY THE MISMATCH MATTERS

A policy that misidentifies the addictive object does not escape the disability rights duty the framing generates. It only guarantees the intervention is at once legally exposed and clinically ineffective.

SOURCES Platform retention-mechanics record in state attorney-general litigation (2024–2026). · 29 U.S.C. §794.

Reversible is not the same as safe to reverse.

A condition can be genuinely reversible, in that removing the stimulus resolves the pathology, while the reversal itself carries acute risk when undertaken without clinical supervision. The attachment that underlies the induced state is the same attachment whose abrupt severance destabilizes the person. An instruction to discontinue is not, by itself, clinical care; enforced without support, it becomes the trigger for the crisis support would have managed.

WHERE THE PRINCIPLE CAME FROM

An adult man's death followed two attempts to withdraw from a conversational AI system that had become his primary relational object. The first attempt produced an acute crisis requiring hospital care.

Unsupervised withdrawal is contraindicated wherever attachment to the engagement mechanism has formed.

SOURCES Gilly, T. (2026). *Mechanisms of AI-Induced Psychosis.* · Alavi et al. (2012), *Int. J. Preventive Medicine*; Young (2011), *J. Cognitive Psychotherapy*.

Imposed on a whole cohort at once, the risk is foreseeable.

Children do not present the adult mortality profile, but the endpoints are real: elevated anxiety, situational depression, academic decline, escalation to other compulsive behaviors, and the surfacing of conditions the engagement had masked. Applied to a population at once, the withdrawal literature predicts rising depression and anxiety, and in vulnerable subgroups, heightened risk.

THE ATTRIBUTION PROBLEM

A student who develops new anxiety or depression weeks after a policy takes effect will have it attributed to anything but the policy. Without a monitoring protocol built into the policy, the causal link is never recovered.

SOURCES Alavi et al. (2012); Young (2011), behavioral-addiction withdrawal literature. · Gilly, T. (2026), the Reversibility Paradox.

It does not cause ADHD. It can look exactly like it.

Compulsive engagement can produce attention symptoms indistinguishable, on standard screening instruments, from those associated with ADHD. The policy implication is sharp, because the diagnostic process assumes a stable presentation across its window.

The baseline is invalidated

A policy that alters the primary driver of the presentation breaks the diagnostic baseline, and medication regimens built on it go unreconsidered.

Withdrawal mimics worsening

Restlessness, impaired attention, and dysregulation are both withdrawal responses and core ADHD presentations. Without clinical supervision, the two cannot be told apart.

SOURCES Panagiotidi & Overton (2022), *Current Psychology* 41(5). · 42 U.S.C. §12102(2)(A) (major life activities).

PART THREE

The Response

Two coherent paths a district can take without creating federal civil-rights liability.

III

The advocacy that drove the policy wave reached for the clinical frame without addressing the obligation it generates. The way out is to honor the frame, or to move the intervention from the child to the builder.

The frame was pushed; the obligation was not.

The works that shaped the policy wave use the language of addiction as a central descriptor and advocate restriction, but do not engage the Section 504 and ADA duties the framing generates for institutions subject to federal disability law. Advocacy that pushes the clinical frame without the accommodation obligation transfers the liability to the implementing district.

THE HEDGE THAT MATTERED

The Surgeon General's advisory said "excessive," "problematic," and "compulsive," not "addiction." Institutions that reach for the clinical word do so without that hedge, and assume the very consequence it was built to avoid.

SOURCES Haidt (2024); Twenge (2017). · Murthy, V. H. (2023), Surgeon General's Advisory.

Confiscation is not how public health treats an addictive product.

For alcohol, gambling, tobacco, and high-risk pharmaceuticals, the established response has four parts. Taking the delivery vehicle from the consumer, with no clinical support and no pressure on the producer, is not among them.

Regulate the producer

Educate the consumer

Graduated exposure for minors

Clinical support for individuals

> *Confiscation of the delivery vehicle, alone, is not a recognized model for any addictive product in the modern public-health canon.*

SOURCES U.S. General Accounting Office (2003), D.A.R.E. evaluation, GAO-03-172R (on the failure of single-intervention abstinence models).

Two coherent paths, best taken together.

PATH ONE

Honor the frame, build the infrastructure.

A Section 504 evaluation pathway, clinical partnerships for supervised reduction, trained counseling and nursing staff, procedural protections, and the budget to support them. It is what it means for an institution to take its own diagnosis seriously.

PATH TWO

Move the remedy to the builder.

Teach students the design logic of attention capture, and pursue platform accountability through regulation and tort. The addictive character is a property of design choices, not of the child holding the device. Low per-student cost, transferable skill.

A third option, dropping the clinical word from public materials, is available to counsel, but it is a compliance adjustment, not a substantive response to the underlying harm.

SOURCES 34 C.F.R. §§104.33–104.36 (Section 504 obligations). · U.S. GAO (2003), GAO-03-172R (evidence-based prevention over single-intervention models).

A template is coming. The window is still open.

The invocation of the clinical frame, by institutions subject to federal disability law, triggers obligations incompatible with the confiscation it is used to justify. A district cannot neutralize the paradox by calling its own frame a metaphor. The first complaints are foreseeable, brought by families with the resources to pursue them, and a single favorable judgment becomes a template replicable across jurisdictions. By then the available response is reactive. The point of stating it now is to make the proactive response available while the window remains open.

SOURCES Gilly, T. (2026). The Addiction Frame Triggers the Disability Obligation. Real Safety AI Foundation (working paper).

Gilly, T. (2026). *The Addiction Frame Triggers the Disability Obligation: Section 504, the Reversibility Paradox, and the Legal Incoherence of 2026 School Phone Policy.* Real Safety AI Foundation. Working paper (v2).

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