THE IMPERATIVE FOR TRAUMA-RESPONSIVE SPECIAL EDUCATION

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Recent, robust research makes clear that childhood trauma, such as abuse or neglect in the home or the chronic lack of basic necessities, is common and can cause and exacerbate disabilities in learning and behavior. These disabilities prevent many children from making educational progress, but evidence-based strategies now exist to give these children access to education. To appropriately implement these strategies, the nation's educational disability rights laws—the Individuals with Disabilities Education Act ("IDEA") and Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (together, "Section 504")—must become "trauma-responsive" or "healing centered." The imperative to make education for children with trauma-induced disabilities trauma-responsive is not just moral, however; it is also legal. IDEA's "Child Find" and Section 504's "Locate and Notify" mandates require public school systems to identify and provide an evaluation and individualized education to all children with disabilities. This is the first article in the legal literature to describe the need to make IDEA, Section 504, and their implementation trauma-responsive. This article is also the first to propose three ways to meet this need: 1) requiring assessment of trauma's impact when trauma is suspected to be a cause of disability in a child; 2) amending IDEA to add a stand-alone, trauma-specific disability category through which children can become eligible for special education and recognizing that trauma causes disability under Section 504; and 3) putting trauma-responsive specialized instruction, related services, and accommodations into individualized educational programs developed under IDEA ("IEPs") and programs developed under Section 504 ("504 plans").

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Introduction

"For this child, his ADHD and the impact of trauma are one and the same,"[1] said the child's social worker to the individualized educational program (IEP) team at a Washington, D.C. public charter school. She and other members of the Health Justice Alliance (HJA), a medical-legal partnership clinic at Georgetown University Law Center serving low-income families, advocated to make the IEP of Rondell,[2] a thirteen year-old foster child, trauma-responsive.

Despite never previously exhibiting any problems at school, during the last year, Rondell's grades fell to Fs and Cs, and his school suspended him several times for disruptive behaviors, including fighting. These problems appeared when Rondell's guardian of twelve years fell ill and died, causing Rondell to re-enter the foster care system. Rondell first entered the foster care system when he was a baby because D.C.'s child protective services agency found him in his crib with a broken leg. His mother later testified that the domestic violence between her and her boyfriend at the time caused the injury.[3]

"If trauma is part of the child's disability, trauma should be described in his IEP, and his accommodations should be trauma-informed," the HJA student attorney argued.[4] Rondell had recently been diagnosed with ADHD, and the psychologist who gave that diagnosis stated that Rondell had been "greatly affected by trauma."[5] She had considered "emotional disturbance" and "specific learning disability" as disability categories for Rondell before deciding that ADHD was the most appropriate diagnosis.[6]

"We just have to be really careful to not go outside of what is needed for a free and appropriate public education," the school's

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[1] Statement of Audrey Neff, Soc. Worker, Medstar Georgetown Univ. Hosp. Cmty. Pediatrics Div., at IEP Meeting at the National Collegiate Preparatory Public Charter School (Apr. 11, 2018) (transcript on file with author). Most of the children served by HJA have experienced multiple traumatic events, such as homelessness, extreme poverty, community violence, parental abandonment, untreated parental mental illness, physical abuse, sexual abuse, and racism. Researchers strongly suspect that there is an overlap in the symptoms caused by ADHD and the symptoms caused by trauma. *See* Kate Szymanski et al., *Trauma and ADHD – Association or Diagnostic Confusion? A Clinical Perspective*, 10 J. Infant, Child, & Adolescent Psychotherapy 51, 51 (2011) (discussing the strong relationship between the symptoms caused by ADHD and those caused by trauma).

[2] Child's name has been altered.

[3] Confidential Testimony of Mother of Rondell, at a Show-Cause Hearing in D.C. Superior Court Family Court (March 2018) (recording on file at D.C. Superior Court Reporting Division).

[4] Statement of Keith Taubenblatt, Student Attorney, Health Justice All., Georgetown Univ. Law Ctr., Statement at an IEP meeting at National Collegiate Preparatory Public Charter School (Apr. 11, 2018) (transcript on file with author).

[5] *Id.*

[6] *Id.*

attorney responded. "We can discuss ADHD in his annual goals, but not trauma."[7] Nonetheless, by the end of the meeting, the IEP team decided to describe the impact of trauma in Rondell's IEP and to provide him with trauma-responsive specialized instruction and accommodations, including graphic organizers, breaks throughout the day, and therapy.[8] A year and a half later, Rondell finished his eighth-grade year with all As and Bs.[9]

As is evident in Rondell's case, making IEPs and individualized educational plans under Section 504 ("504 plans") trauma-responsive should become commonplace as educators, health care professionals, and parents come to terms with the new responsibilities attendant with current understandings of trauma. Children like Rondell need trauma-responsive IEPs and 504 plans that directly and explicitly recognize and address the disabilities caused by trauma in their lives. Educational disability law and its application must evolve in order to appropriately respond to research showing that trauma disables learning and behavior.

The need for trauma-responsive IEPs and 504 plans is great. Most American children experience a potentially traumatic event during their childhoods,[10] and a significant proportion of children who are struggling at school need trauma-responsive education in order to access their education.[11] To illustrate, most of the children served by HJA have experienced high levels of trauma, which manifested in poor grades and misbehavior, leading to the children's exclusion, including suspension, at school.[12] Most of these children made educational progress, however, when they received trauma-responsive IEPs.[13]

Many other low-income legal service providers practicing special education law report high levels of trauma experienced by the

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[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *See, e.g.*, Katie A. McLaughlin et al., *Trauma Exposure and Posttraumatic Stress Disorder in a National Sample of Adolescents*, 52 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 815, 815 (2013) (61.8% of adolescents in the study experienced a potentially traumatic event).

[11] *See* Sheryl H. Kataoka et al., *Applying a Trauma Informed School Systems Approach: Examples from School Community-Academic Partnerships*, 28 ETHNICITY & DISEASE 417, 418 (2013) (noting the relationship of traumatic experiences to poor academic performance).

[12] *See* Confidential Educational Records of Health Justice Alliance Clients (Aug. 1, 2019) (on file at Health Justice Alliance, Georgetown University Law Center).

[13] *See id*.

majority of the children they serve.[14] While the need for trauma-responsive IEPs and 504 plans is clear in low-income communities, studies show that trauma is highly prevalent in every American community.[15]

Specifically, recent research, beginning with the landmark Adverse Childhood Experience Study ("ACE Study") that was conducted from 1995 to 1997, shows that most Americans—including white Americans with jobs, college degrees, and health insurance—have experienced a potentially traumatic event during childhood.[16] The research also shows that childhood trauma can so significantly impact physical and mental health that it can create and exacerbate disabilities that impede educational access.[17] Specifically, childhood trauma can cause developmental delays; alter brain development to weaken linguistic, cognitive, memory, and mood control capacities; impair executive functioning to create and exacerbate ADD and ADHD-like symptoms; disrupt social-emotional functioning; impair sensory processing; and cause children to have a fight or flight response to non-threatening stimuli.[18] Unsurprisingly, then, childhood trauma is strongly correlated with poor educational outcomes, including school dropout, failure to graduate from high school, suspension, expulsion, and school-related arrest.[19] In other words, childhood trauma feeds the school-to-prison pipeline and causes academic failure. It also promotes major illness and disability, unemployment, poverty, and—for those with high exposures to trauma—even early

[14] *See, e.g.*, Interview with Maria Blaeuer, Dir. of Programs and Outreach, Advocates for Justice and Educ., Inc. (Oct. 25, 2018) (on file with author); Interview with Stacey Eunnae, Senior Staff Attorney, Advocates for Justice and Educ., Inc. (Oct. 25, 2018) (on file with author); Email from Claire Raj, Dir. of the Educ. Rights Clinic, Univ. of S.C. Sch. of Law (June 18, 2019) (on file with author).

[15] *See* Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTATIVE MED. 245, 252 (1998).

[16] *Id.* at 252.

[17] *See, e.g.*, Jack P. Shonkoff et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS e232, e236–37 (2012) (describing how trauma disrupts brain circuitry and other organ systems to cause impairments in learning and behavior); Laneita Freeman Williamson & Ahmad Zaheer Qureshi, *Trauma Informed Care and Disability: The Complexity of Pervasive Experiences*, 3 INT'L J. PHYSICAL MED. & REHABILITATION 1, 2 (2015) ("The accumulation of trauma increases the likelihood of disability."); Laneita Freeman Williamson & Donald D. Kautz, *Trauma-Informed Care Is the Best Clinical Practice in Rehabilitation Nursing*, 43 REHABILITATION NURSING 73, 74 (2018) (discussing effects of trauma on brain development); *Toxic Stress*, HARV. U. CTR. ON DEVELOPING CHILD, https://developingchild.harvard.edu/science/key-concepts/toxic-stress (last visited Jan. 14, 2020) (describing the negative impact of trauma on brain development).

[18] *See* Felitti et al., *supra* note 15, at 253; Shonkoff et al., *supra* note 17, at e236.

[19] *See infra* Section II.C.

death. Accordingly, many experts consider childhood trauma to be the most important public health crisis of our time.[20]

The new understandings of trauma are legally significant because the Individuals with Disabilities Education Act (IDEA) requires schools to identify and provide an evaluation and IEP to all children with disabilities who need special education in order to make educational progress (the "Child Find" requirement).[21] Congress created IDEA to give all children with disabilities access to education.[22] In order to respond appropriately to recent scientific advances in our understanding of trauma, American schools therefore must identify and provide an evaluation and special education and related services to children whose traumatic experiences disable their progress at school. The Child Find requirement and recent research on trauma together establish the legal and moral imperative for making evaluations, specialized instruction, and related services and accommodations under IDEA trauma-responsive.

Similarly, under Section 504 of the Rehabilitation Act of 1974 and the Americans with Disabilities Act (together, "Section 504"), schools must locate every child with a disability that impairs their access to education and notify their parents or guardians of the school's duties to provide an evaluation and 504 plan tailored to the child's disability needs (the "Locate and Notify" requirement). Under Section 504, schools must provide trauma-responsive services and accommodations to children whose traumatic experiences substantially limit their learning, concentration, and other "major life activities" at school. Section 504's prohibition of discrimination against children with disabilities by public schools and the research on trauma together create the imperative for schools to provide trauma-responsive evaluations, services, and accommodations to children who need them.

U.S. District Courts have ruled in favor of these theories, especially those regarding Section 504. The U.S. District Court of the

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[20] *See, e.g.*, BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA 148–50 (2014); Nadine Burke Harris, *How Childhood Trauma Affects Health Across a Lifetime*, TED, https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime; *Who Needs to Pay Attention to the ACE Study?*, GEO. U. CTR. FOR CHILD & HUM. DEV. (Mar. 5, 2015), https://georgetownta.wordpress.com/2015/03/05/who-needs-to-pay-attention-to-the-ace-study (quoting Dr. Robert Block, former President of the American Academy of Pediatrics).

[21] *See* 20 U.S.C. § 1412(a)(3) (2018) (codifying the "Child Find" requirement); 34 C.F.R. § 300.111(a) (2019) (defining "Child Find" under the authority of 20 U.S.C. § 1412(a)(4)).

[22] 20 U.S.C. § 1412(a)(2) (establishing a goal of providing a full education to all children with disabilities).

Central District of California in *Peter P. v. Compton Unified School District*[23] held that student plaintiffs had plausibly alleged that they were individuals with a "disability" within the meaning of Section 504 due to the effects of trauma and that plaintiffs' claims of disability discrimination under Section 504 were sufficient to survive the school district's motion to dismiss. Similarly, the U.S. District Court for the District of Arizona in *Stephen C. v. Bureau of Indian Education*[24] denied in part a motion to dismiss by holding that complex trauma and adversity "can result in physiological effects constituting a physical impairment that substantially limits major life activities within the meaning of Section 504 of the Rehabilitation Act."[25]

The promise of making IEPs and 504 plans trauma-responsive is that interventions provided to children with disabilities will become more effective and more children who suffer from trauma of all sorts—abuse, neglect, family dysfunction, parental incarceration or mental illness, community violence, bigotry, or historical or intergenerational trauma—will make educational progress. Further, trauma-responsive education will help children to heal from trauma,[26] thereby diminishing the severity of impairments caused by trauma and decreasing the likelihood that they will act with violence or pass trauma's effects on to their children.[27]

Currently, the vast majority of public schools operate on the traditional assumption that student functioning is not impaired by trauma.[28] Consequently, student misbehavior is commonly interpreted as premeditated or intentional rather than unthinking fight-or-flight responses to triggers of trauma.[29] Schools tend to exclude misbehaving students, but exclusion and other punishments, and even some positive reward systems, often do not work for traumatized students.[30] Students who have experienced trauma often focus primarily on sur-

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[23] 135 F. Supp. 3d 1098, 1111–12 (C.D. Cal. 2015).

[24] No. CV-17-08004-PCT-SPL, 2018 U.S. Dist. LEXIS 68083 (D. Ariz. Mar. 29, 2018).

[25] *Id.* at *14.

[26] *See* BARBARA SORRELS, REACHING AND TEACHING CHILDREN EXPOSED TO TRAUMA 8 (2015) (noting that "a great deal of healing can take place in nonclinical settings with teachers, caregivers . . . who are informed in trauma-based care").

[27] *Cf.* VAN DER KOLK, *supra* note 20, at 351–52 (stating that "interventions . . . can bring the brain areas related to self-regulation, self-perception, and attention back online" and describing a trauma-responsive education as the "greatest hope" for traumatized children).

[28] JIM SPORLEDER & HEATHER T. FORBES, THE TRAUMA-INFORMED SCHOOL: A STEP-BY-STEP IMPLEMENTATION GUIDE FOR ADMINISTRATORS AND SCHOOL PERSONNEL 15 (2016) (asserting that "our schools were traditionally designed for children with low ACEs").

[29] *Id.* at 24.

[30] *See id.* at 28–29 (suggesting that discussion, rather than suspension, is a preferable tool for dealing with children who act out in class).

vival, rather than learning, and they often feel disconnected to school and school staff.[31] Unfortunately, the result is that too many children with traumatic stress fail academically and enter the school-to-prison pipeline.[32] Clearly, the vast majority of public schools do not provide the support that children disabled by trauma need to succeed in school. Trauma-responsive specialized instruction, services, and accommodations are likely, however, to ultimately reduce the costs, misbehavior, and academic failure that challenge schools.

These costs and challenges will be reduced even further if schools provide a trauma-responsive education to all students and if communities become trauma-responsive. Making schools trauma-responsive improves graduation rates and standardized test scores and reduces disciplinary referrals.[33] Moreover, making schools and communities trauma-responsive reduces the need to provide costly individualized education to students affected by trauma.

Law journal articles have described the need to make youth-involved systems trauma-informed in order to increase their efficacy, end the school-to-prison pipeline, and/or reduce racial and economic disparities in school discipline and school arrest practices.[34] Other articles have also described the need to make entire schools trauma-responsive and the limits of providing trauma-informed special education in schools.[35] However, little has been written about the impera-

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[31] *Id.* at 24.

[32] *Id.* at 32.

[33] *Id.* at 6–9. Lincoln High School reduced its yearly rate of student disciplinary referrals from 600 to 242; reduced the yearly rate of incidents requiring police action from 48 to 12; reduced the number of suspensions and expulsions from 798 and 50 to 96 and 0 respectively between 2009 and 2013, as it converted itself into a trauma-responsive school. During that time period, the school's graduation rate rose from 44.4% to 78%, and state assessment scores also increased significantly.

[34] *See, e.g.*, Eduardo R. Ferrer, *Transformation Through Accommodation: Reforming Juvenile Justice by Recognizing and Responding to Trauma*, 53 AM. CRIM. L. REV. 549, 551–52 (2016) (discussing how making the juvenile justice system trauma-informed would positively impact it); Eugene Levine, *Many Are Strong at the Broken Places*, 40 VT. B.J. 29 (2015) (noting the need to make juvenile systems trauma-informed).

[35] *See, e.g.*, SUSAN F. COLE ET AL., HELPING TRAUMATIZED CHILDREN LEARN: SUPPORTIVE SCHOOL ENVIRONMENTS FOR CHILDREN TRAUMATIZED BY FAMILY VIOLENCE (2005) (describing the need to make schools trauma-responsive); Michael Gregory & Emily Nichols, *From the Outside In: Using a Whole-School Paradigm to Improve the Educational Success of Students with Trauma Histories and/or Neurodevelopmental Disabilities*, *in* TRAUMA, AUTISM, AND NEURODEVELOPMENTAL DISORDERS 241 (Jason M. Fogler & Randall A. Phelps eds., 2018) (describing the limits of providing trauma-sensitive special education in conventional schools); Ellen Yaroshefsky & Anna Shwedel, *Changing the School to Prison Pipeline: Integrating Trauma-Informed Care in the New York City School System*, *in* 1 IMPACT: COLLECTED ESSAYS ON THE THREAT OF ECONOMIC INEQUALITY 99 (2015).

tive to provide trauma-responsive special education to address disabilities in schools.

Two student notes on the topic have argued that trauma causes behavioral disabilities that are best captured by IDEA's disability category of emotional disturbance.[36] However, this Article emphasizes that trauma causes disabilities beyond behavioral and social-emotional impairments, and it instead proposes legislative action to create a stand-alone, trauma-specific disability categorization in IDEA. Accordingly, this is the first article in legal literature to describe trauma's broad effects and propose approaches to making school disability law and its implementation trauma-responsive.

This Article grounds its argument in Congress's long-standing aim to make educational services and accommodations for children with disabilities research-based. Flowing from this, new research showing that trauma impacts the brain and body to create disabilities that impair educational access implicates a legal requirement to provide trauma-responsive IEPs and 504 plans. The Article explores trauma-responsive approaches to modifying IDEA and interpreting Section 504 and identifies key features of trauma-responsive evaluations, IEPs, and 504 plans.

After examining why the new science regarding trauma should catalyze change in school disability law, this Article proposes that IDEA and Section 504 become trauma-responsive in three main ways: 1) requiring an assessment of trauma's impact in all evaluations when trauma is suspected to be a cause of a child's disability; 2) amending IDEA to add a trauma-specific disability category under which children could become eligible for special education and recognizing that trauma causes disability under Section 504; and 3) providing trauma-responsive specialized instruction, services, and accommodations through IEPs and 504 plans.

I
Congressional Intent for IDEA and Section 504 and Evidence-Based Interventions

Before delving into the research on trauma and its implications for children with disabilities, it is important to recognize the role that Congress intended scientific research to have in educational disability services and accommodations. Congress has repeatedly expressed that

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36 *See* Aaron Lawson, Note, *Straight Outta Compton: Witness the Strength of Disability Rights Taking One Last Stand for Education Reform*, 67 Syracuse L. Rev. 551 (2017); Felicia Winder, Note, *Childhood Trauma and Special Education: Why the "IDEA" Is Failing Today's Impacted Youth*, 44 Hofstra L. Rev. 601 (2015).

educational interventions for children with disabilities should be based upon and responsive to scientific research.

As this Section describes, Congress established IDEA and Section 504 to provide all children with a disability access to education. A child who meets the definition of a child with a disability under IDEA or Section 504 must receive specialized instruction, services, and/or accommodations that are tailored to the child's unique needs so that the child can make educational progress. To ensure that such interventions are effective, Congress indicated that they should be based upon scientific research to the greatest extent possible.

A. The Purpose of IDEA: Giving All Children with Disabilities Access to Their Education Through Individualized Special Education

Congress established federal special education law, currently codified as IDEA, to give access to the millions of children with disabilities who were excluded from education with their peers or "whose handicaps prevent[ed] them from having a successful educational experience because their handicaps [we]re undetected."[37] Specifically, in 1975, Congress stated that the purpose of special education law was to ensure that "all handicapped children" had available to them a "free appropriate public education which emphasizes special education and related services designed to meet their needs, to assure that the rights of handicapped children and their parents or guardians are protected, . . . and to assess and assure the effectiveness of efforts to educate handicapped children."[38]

In order to qualify for special education under IDEA, a child must meet IDEA's definition of a "child with a disability." To do so, a child must meet three requirements. First, a local educational agency (LEA) must evaluate the child according to IDEA's evaluation procedures.[39] These procedures require that the LEA's evaluation is sufficiently comprehensive to identify all of the child's educational needs

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[37] *See* Education for All Handicapped Children Act of 1975, Pub. L. 94-142, sec. 3(b)(3)–(5), § 601, 89 Stat. 773, 774 (codified as amended at 20 U.S.C. § 1401 (2018)) (explaining that "more than half of the handicapped children in the United States do not receive appropriate educational services which would enable them to have full equality of [educational] opportunity"); Bd. of Educ. v. Rowley, 458 U.S. 176, 192 (1982) (noting that, through the Act, Congress sought to increase access to public education for disabled children).

[38] Education for All Handicapped Children Act § 3(a)(c).

[39] *See* 34 C.F.R. § 300.8(a)–(b) (2019).

and determine whether the child needs special education and related services.[40]

Second, the child's disability must meet the criteria for one of the disability categories recognized by IDEA, which currently recognizes thirteen categories.[41] If a child has a disability but the disability is not detected through the evaluation process required by IDEA or the disability does not fall into one of IDEA's enumerated categories, then the child is not considered a "child with a disability" under IDEA and cannot receive special education.[42]

Third, the child must, by reason of such disability, "need" special education and related services.[43] Courts typically interpret this third element as requiring that the child's disability adversely affects the child's educational performance and, because of this adverse effect, the child needs special education and related services.[44] Special education is specially designed instruction that is adapted in its content, methodology, or delivery to meet the unique needs of the child that result from the child's disability.[45] Such instruction ensures access to the general curriculum so that the child can meet local educational standards applying to all children.[46] Related services are transportation and developmental, corrective, and other supported services that

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40 *See* 20 U.S.C. § 1414(c)(1)(A), (B). Such evaluation must use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child. 20 U.S.C. § 1414(b)(2)(A). The assessment must be in all areas of suspected disability, and each evaluation must review existing data regarding the present levels of academic achievement and related developmental needs of the child. § 1414(b)(3)(B), (c)(1)(B)(ii).

41 *See* 20 U.S.C. § 1401(3)(A) (defining "child with a disability" as a child having one of the disability categories listed and who, as a result of the disability, needs special education and related services); 34 C.F.R. § 300.8(a)(1) (requiring, in its definition of "child with a disability," that the child has one of the listed disabilities). The thirteen existing categories are as follows: autism; deaf-blindness; intellectual disability (still called "mental retardation" in the federal statute); developmental delay; hearing impairment (including deafness); serious emotional disturbance (also known as emotional disturbance); multiple disabilities; orthopedic impairment; other health impairment; specific learning disability; speech or language impairment; traumatic brain injury (meaning an acquired injury to the brain caused by an external physical force); and visual impairment (including blindness). 20 U.S.C. § 1401(3)(A)–(B); *see also* 34 C.F.R. § 300.8(a)–(b).

42 *See* 34 C.F.R. § 300.8(a).

43 *See* 20 U.S.C. § 1401(3)(A)(ii), (B); 34 C.F.R. § 300.8(a)–(b).

44 *See, e.g.*, Hansen v. Republic R-III Sch. Dist., 632 F.3d 1024, 1028 (8th Cir. 2011) (holding that IDEA's definition of a child with a disability requires that the disability identified must adversely affect the child's educational performance); Mr. I. v. Me. Sch. Admin. Dist. No. 55, 480 F.3d 1, 5, 13 (1st Cir. 2007) (holding that the disability must adversely affect a child's educational performance to constitute a disability under IDEA because, in order to receive IDEA benefits, the child must also need special education and related services by reason of the disability).

45 34 C.F.R. § 300.39(b)(3).

46 *See id.*

are required to assist a child with a disability to benefit from special education.[47]

Once a child is determined to be a child with a disability who needs special education and related services, the LEA must create an IEP for the child.[48] The IEP must be appropriately ambitious in light of the unique circumstances of the child, and it must be reasonably calculated to enable a child to make progress appropriate in light of these circumstances.[49] The IEP sets forth the special education and related services that a child needs in order to receive a free and appropriate public education (FAPE).[50] A FAPE is an education designed to meet the individual needs of a child with a disability that enables the child to meaningfully access their education and make some educational progress.[51] FAPE should prepare the child for future employment, education, and independent living.[52] Further, FAPE must be provided to a child with a disability in the least restrictive environment, meaning that the child must be educated to the maximum extent appropriate with children without disabilities.[53]

IDEA requires that IEPs meet broad requirements. All IEPs must describe the child's present levels of academic achievement and functional performance, including how the child's disability affects the child's involvement and progress in the general education curriculum.[54] The IEP must also establish measurable annual goals designed to meet the child's needs resulting from the child's disability in order to enable the child to make progress in the general education curriculum.[55] The design of the annual goals must also "meet each of the child's other educational needs that result from the child's disability."[56] Further, an IEP must state the special education and related services, supplementary aids and services, and program modifications and supports to be provided to the child, "based upon peer reviewed

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[47] *See* 20 U.S.C. § 1401(26). Examples of related services enumerated by IDEA's regulations are speech-language pathology and audiology services, psychological services, physical and occupational therapy, therapeutic recreation, counseling services, parent counseling and training, social worker services in schools, and school health and nurse services. 34 C.F.R. § 300.34(a).

[48] 20 U.S.C. § 1412(a)(3)–(4).

[49] *See* Endrew F. v. Douglas Cty. Sch. Dist. RE-1, 137 S. Ct. 988, 999–1000 (2017).

[50] *See* 20 U.S.C. § 1401(9).

[51] *See* Bd. of Educ. v. Rowley, 458 U.S. 176, 192, 200 (1982).

[52] *Cf.* 20 U.S.C. § 1400(d)(1)(A) (stating the purpose of IDEA).

[53] *See id.* § 1412(a)(5)(A).

[54] *Id.* § 1414(d)(1)(A)(i)(I).

[55] *Id.* § 1414(d)(1)(A)(i)(II).

[56] *Id.*

research to the extent practicable," so that the child can advance appropriately toward attaining the annual goals and receive a FAPE.[57]

Congress established the Child Find mandate in IDEA so that all children with disabilities could receive access to their education. Child Find requires LEAs to implement policies and procedures to ensure that all children with disabilities—including those who are homeless or attending a private school—regardless of the severity of their disability, are identified, located, and offered an evaluation.[58] The mandate further requires that children with disabilities who are "found" through the Child Find policies and procedures be offered an IEP.[59]

B. The Authority for Requiring Evidence-Based Educational Programs in the IDEA and Its Legislative History

Beginning with the 1965 and 1966 amendments to the Elementary and Secondary Education Act of 1965 (ESEA),[60] federal special education law embodied Congress's long-standing belief that special education should be based upon scientific research demonstrating the special educational needs of children with disabilities and how to meet those needs. Congress expressed this belief in various ways, including by establishing funding for projects based upon research, creating advisory committees whose members were to include researchers, and requiring IEPs to describe the research-based specialized instruction and services needed by each child with a disability. This Section briefly highlights some steps taken by Congress over decades to make special education research-based.

Early on, Congress infused special education law with funding for grants for educational research. For instance, the 1965 amendments to ESEA created a new program to provide grants to state educational agencies (SEAs), the agencies primarily responsible for state supervision of public elementary and secondary schools.[61] These grants were for programs and projects "designed to meet the special educational needs" of children with disabilities.[62] In the ESEA Amendments of 1966, Congress indicated that, in order to obtain a grant under ESEA,

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[57] *Cf. id.* § 1414(d)(1)(A)(i)(IV).

[58] *See id.* § 1412(a)(3); 34 C.F.R. § 300.111(a) (2019); *see also* 20 U.S.C. § 1414(a)(1)(D)(i)(I) (requiring consent from the parent before conducting an initial evaluation); *cf. id.* § 1414(a)(1)(D)(ii)(I) (allowing, but not requiring, schools to bring Due Process complaints against parents who refuse to consent to initial evaluations).

[59] *See* 20 U.S.C. § 1412(a)(3)–(4); *id.* § 1414(a)(1)(D)(i)(II) (requiring consent from the parent before implementing an initial IEP).

[60] *See* Act of Nov. 1, 1965, Pub. L. No. 89-313, 79 Stat. 1158; Elementary and Secondary Education Amendments of 1966, Pub. L. No. 89-750, 80 Stat. 1191.

[61] *See* Act of Nov. 1, 1965, § 6(a).

[62] *Id.* § 6(a).

SEAs had to provide assurance that they would adopt effective procedures for acquiring and disseminating to teachers "significant information derived from educational research" projects and for adopting "promising educational practices developed through such projects."[63]

When Congress established an advisory committee in 1966 to assist with developing special education law, it sought members who were involved in research to assist children with disabilities. Specifically, the ESEA Amendments of 1966 established a National Advisory Committee on Handicapped Children (NACHC), and at least half of the members had to be affiliated with educational, training, or research programs for "the handicapped."[64] This committee's purpose was to review and make recommendations regarding the administration and operation of ESEA.[65]

Subsequently, the 1970 Amendments to ESEA established funding for research "relating to education of handicapped children."[66] Funding could be granted to a wide variety of entities, including states, institutions of higher education, and public or nonprofit private educational or research agencies and organizations.[67]

In the Statement of Findings and Purpose of the Education for All Handicapped Children Act (EAHCA) of 1975, the direct precursor to IDEA, Congress asserted that research-based educational techniques and the country's understanding of disabilities had developed sufficiently to enable schools to meet the needs of children with disabilities and thus include them in the education of their peers.[68] In hearings regarding this Act, senators discussed implementing "the technology and ability to see that children are not mislabeled, incorrectly diagnosed, and deprived of the training they need."[69]

To ensure that teachers would be equipped with such "technology and ability," EAHCA authorized the U.S. Secretary of Education to enter into agreements with institutions of higher education, state and local educational agencies, or nonprofit agencies in order to establish and operate centers on educational media and materials for the handicapped.[70] The purpose of these centers was to promote the development of "a comprehensive program of activities to facilitate the use of

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63 Elementary and Secondary Education Amendments of 1966, tit. F, sec. 161, § 604(k).

64 *Id.* (creating the NACHC at § 608(a) of ESEA).

65 *Id.*

66 Act of Apr. 13, 1970, Pub. L. No. 91-230, § 641, 84 Stat. 121, 185 (codified as amended at 20 U.S.C. § 1400).

67 *Id.*

68 Education for All Handicapped Children Act of 1975, Pub. L. 94-142, sec. 3(b)(7), § 601, 89 Stat. 773, 774 (codified as amended at 20 U.S.C. § 1401).

69 121 Cong. Rec. 19,496 (1975) (statement of Sen. Kennedy).

70 Education for All Handicapped Children Act of 1975 § 6(b).

new educational technology in education programs for handicapped persons, including designing, developing, and adapting instructional materials" for such persons.[71]

More recently, when Congress reauthorized IDEA in 2004, it aimed to improve outcomes by emphasizing the need for evidence-based methods in special education.[72] In IDEA's statement of findings, Congress noted that almost thirty years of research and experience demonstrated that the education of children with disabilities could be made more effective by "supporting high-quality, intensive preservice preparation and professional development for all personnel who work with children with disabilities in order to ensure that such personnel have the skills and knowledge necessary . . . *including the use of scientifically based instructional practices, to the maximum extent possible*."[73] Congress also complained that educational agencies were insufficiently focusing on applying research on methods of teaching and learning for children with disabilities.[74]

In 2004, Congress established the National Center for Special Education Research, making clear that research about disabilities in children was supposed to improve special education over time.[75] The mission of the center was to sponsor research to expand understanding of the needs of children with disabilities to improve their developmental, educational, and transitional outcomes and to improve services provided under IDEA.[76]

Most importantly, in 2004, Congress added the requirement that IEPs provide a statement of the special education and related services and supplementary aids and services, "*based on peer-reviewed research to the extent practicable*, to be provided to the child."[77] The purposes of providing such research-based services were to advance the child toward attaining his/her annual goals, involve the child in the general education curriculum, and ensure that the child makes progress in that curriculum.[78] This addition indicated that FAPE under IDEA had to be research-based to the extent practicable.

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71 *Id.*

72 Individuals with Disabilities Education Improvement Act of 2004, Pub. L. 108-446, sec. 101, § 601(c)(4), 118 Stat. 2647, 2649 (codified at 20 U.S.C. § 1400(c)(4)) (decrying "an insufficient focus on applying replicable research on proven methods of teaching and learning for children with disabilities").

73 20 U.S.C. § 1400(c)(5)(E) (2018) (emphasis added).

74 *See id.* § 1400(c)(4) (stating that "the implementation of this chapter has been impeded by low expectations, and an insufficient focus on applying replicable research on proven methods of teaching and learning for children with disabilities").

75 *See* Individuals with Disabilities Education Improvement Act of 2004 § 201.

76 20 U.S.C. § 9567(b)(1)–(2).

77 *See id.* § 1414(d)(1)(A)(i)(IV) (emphasis added).

78 *Id.*

In summary, highlights from the legislative and enactment history of federal special education law reveal that Congress desired, sponsored, and eventually required the development of research-based approaches to understanding disability and providing special education and related services. Given this history, it is only natural for special education law to evolve in response to research showing that trauma causes disabilities and that trauma-responsive education, services, and accommodations help children to overcome those disabilities.

C. Congress's Research-Based Expectations in Enacting Section 504

Congress intended Section 504, like IDEA, to respond to research-based understandings of disability and prevent children with disabilities from being excluded from the general education system. In creating Section 504, Congress determined that individuals with a disability have the right to "enjoy full inclusion and integration in the economic, political, social, cultural, and educational mainstream of American society."[79] Congress's purpose in creating Section 504 was to "empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society through . . . *research* . . . [and] the guarantee of equal opportunity."[80]

To ensure that all children with disabilities have access to education, Section 504 prohibits any recipient of indirect or direct federal financial assistance from excluding the participation of, denying benefits to, or subjecting to discrimination any individual with a disability on the basis of such disability.[81] The definition of entities that must comply with this law is strikingly broad. Recipients of federal financial assistance include any state, any instrumentality of a state or local government, any public or private agency, institution, organization, or other entity (including local educational agencies and corporations), or any person to whom federal financial assistance is extended directly or through another recipient.[82] Federal financial assistance is defined as "any grant, loan, contract . . . , or any other arrangement by which" the U.S. Department of Education provides or otherwise makes assistance available in the form of funds, services of federal personnel, real

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[79] 29 U.S.C. § 701(a)(3)(F).

[80] *Id.* § 701(b)(1) (emphasis added).

[81] *Id.* § 794(a); *see* 34 C.F.R. § 104.3 (2019) (defining "recipients"); *id.* § 104.4 (defining classes of discriminatory actions prohibited for recipients).

[82] *See* 29 U.S.C. § 794(b) (defining "program or activity" as the operations of a diverse group of public and private organizations); *see also* 34 C.F.R. § 104.3(f).

and personal property, or any interest in or use of such property.[83] Accordingly, all public preschool, elementary, secondary, and adult education schools, including public charter schools, must comply with Section 504; the same is true of private elementary and secondary schools receiving indirect or direct federal financial assistance.[84]

However, Section 504's definition of disability is much more open-ended than the definition under IDEA. Additionally, FAPE under Section 504 requires a comparison between the ways the needs of disabled and non-disabled children are met. Under Section 504, a child is considered to have a disability if (1) the child has *any* physical or mental impairment that substantially limits one or more of the child's major life activities; (2) the child has a record of such impairment; or (3) the child is regarded as having such an impairment and has been subjected to prohibited exclusion, discrimination, or denial of benefits based solely upon the perceived impairment.[85] Major life activities that typically occur at school include learning, reading, concentrating, thinking, communicating, and hearing.[86]

Section 504's definition of disability is broadened by two features: First, Section 504 requires that the definition of disability "be construed in favor of broad coverage of individuals under this [Act], to the maximum extent permitted by the terms of" the Act.[87] Second, Section 504 requires that the determination of whether an impairment substantially limits a major life activity be made without regard to the ameliorative effects of mitigating measures, such as medication, assistive technology, accommodations, services, or learned behavioral or adaptive neurological modifications.[88]

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[83] *See* 34 C.F.R. § 104.3(h).

[84] *See id.* § 104.31; U.S. DEP'T OF EDUC., KNOW YOUR RIGHTS: STUDENTS WITH DISABILITIES IN CHARTER SCHOOLS 2 (2017), https://sites.ed.gov/idea/files/dcl-factsheet-201612-504-charter-school.pdf (requiring that all public charter schools must comply with Section 504).

[85] 42 U.S.C. § 12102(1)(A)–(C) (defining "disability" for the purposes of the Act); *id.* § 12102(3) (defining "regarded as having such an impairment"); *see also* 29 U.S.C. § 705(20)(B) (defining, for the purposes of the Act, an "individual with a disability" as any person with a disability as defined under the Americans with Disabilities Act); *see* 34 C.F.R. § 104.3(j)(2)(i) (defining physical or mental impairment as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more . . . body systems . . . or . . . any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities").

[86] *See* 42 U.S.C. § 12102(2) (defining "major life activities"); 29 U.S.C. § 705; 34 C.F.R. § 104.3(j)(2)(ii) (defining "major life activities"); *see also* Stephen C. v. Bureau of Indian Educ., No. CV-17-08004-PCT-SPL, 2018 U.S. Dist. LEXIS, at *12 (D. Ariz. Mar. 29, 2018) (noting which major life activities, such as learning, reading, and thinking, were pertinent to plaintiffs' claims under Section 504).

[87] 42 U.S.C. § 12102(4)(A).

[88] *See id.* § 12102(4)(E).

Similar to IDEA's Child Find mandate, Section 504's implementing regulations require public elementary and secondary schools receiving indirect or direct federal financial assistance to "[u]ndertake to identify and locate every qualified handicapped person residing" in their jurisdiction "who is not receiving a public education" and "[t]ake appropriate steps to notify handicapped persons and their parents or guardians" of their duties under Section 504.[89] This is Section 504's "Locate and Notify" mandate.

While Section 504 and its implementing regulations do not specify exactly what the "Locate and Notify" mandate entails, Section 504's regulations require recipients of federal financial assistance to establish standards and procedures for the evaluation and placement of persons who, because of their disability, need, or are believed to need, special education or related services.[90] Such standards and procedures must ensure that tests and other evaluation materials include those tailored to assess specific areas of educational need and not merely those designed to provide a single general intelligence quotient.[91] Placement decisions must be made by a group of persons and should draw upon information from a variety of sources, including social or cultural background and adaptive behavior.[92] Further, Section 504 regulations require recipients of federal financial assistance to establish and implement a system of procedural safeguards that include providing notice, an opportunity for parents or guardians to examine relevant records, and an impartial hearing and review procedure.[93]

Under Section 504's regulations, once a recipient of federal financial assistance that operates a public elementary or secondary education program identifies that a child has a disability, the recipient must provide that child with a FAPE.[94] To provide FAPE to a child with a disability under Section 504, a school must determine what, if any, regular or special education,[95] accommodations, and/or related aids or services are necessary for the child to have an opportunity commensurate with non-disabled students to participate fully in the general cur-

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[89] 34 C.F.R. § 104.32.

[90] *Id.* § 104.35.

[91] *Id.* § 104.35(b)(2).

[92] *Id.* § 104.35(c).

[93] *Id.* § 104.36.

[94] *See id.* § 104.33.

[95] The regulations of Section 504 discuss the provision of "special education" to children under a 504 plan, but Section 504 does not define what special education is. *See id.* § 104.3.

riculum and program of the school.[96] The provision of regular or special education, accommodations, and related aids or services under Section 504 must be "designed to meet [the] individual educational needs of" the child with a disability "as adequately as the needs of" children without disabilities.[97] Non-academic and extracurricular services and activities, such as counseling services, physical recreational athletics, health services, special interest groups or clubs, and employment of students, must be provided in a manner that affords students with disabilities equal opportunity to participate in such services and activities as students without disabilities.[98] Further, education for a child with a disability must be provided, to the maximum extent appropriate, with other children who do not have disabilities.[99]

The U.S. Supreme Court has held that recipients of federal financial assistance may have to make "reasonable accommodations" to ensure that persons with disabilities have meaningful access to their programs.[100] Such accommodations, however, do not require a "fundamental" or "substantial" alteration in the essential nature of a program.[101]

Regular education, special education, services, and accommodations provided under 504 plans can be very diverse, and they can be provided by a variety of persons, including regular education teachers, school social workers, and school nurses.[102] Section 504 services and accommodations can include individual therapy; medical interventions or services, such as nursing; transportation; behavioral interventions; modification and accommodations; occupational therapy; physical therapy; speech and language services; and specialized instruction.[103]

Both IEPs and 504 plans can provide a child with a disability with specialized instruction, related services, and accommodations to give the child access to education. Because IDEA requires that IEPs meet

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[96] *See id.* § 104.33(b)(1) ("[T]he provision of an appropriate education is the provision of regular or special education and related aids and services that . . . are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met . . . ."); *id.* § 104.4 (prohibiting a recipient of federal financial assistance, in providing any aid, benefit, or service, from affording a person with a disability an opportunity to participate in or benefit from a service that is not equal to that afforded to others).

[97] *Id.* § 104.33(b).

[98] *Id.* § 104.37(a).

[99] *See id.* § 104.34.

[100] Alexander v. Choate, 469 U.S. 287, 301 (1985).

[101] *Id.* at 300.

[102] *See* U.S. DEP'T OF EDUC., PARENT AND EDUCATOR RESOURCE GUIDE TO SECTION 504 IN PUBLIC ELEMENTARY AND SECONDARY SCHOOLS 24 (2016) (noting that, under Section 504 plans, students are entitled to "a broad range of supplemental and related aids and services, as needed").

[103] *See id.*

rigorous requirements[104] and provides numerous procedural safeguards for parents and students that are not included in Section 504,[105] many parents and advocates prefer for children with disabilities to receive a FAPE through an IEP rather than a 504 plan. Nonetheless, Section 504 requires 504 plans to be effective in granting a child access to education.[106]

Because Section 504's definition of disability is so open-ended, as this Article explores below, Section 504 appears to require schools that receive federal financial assistance to provide a FAPE to the many children whose functioning at school is impaired by trauma.

II
Research Findings on the Connections Between Trauma, Disability, and Educational Outcomes

"We often see these types of low IQs [in the 60s] in children who have experienced emotional trauma."

—Clinical Psychologist at an IEP Meeting, 2018[107]

"Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today."

—Robert Block, MD, former President of the American Academy of Pediatrics, 2018[108]

"[A]dvances in neuroscience research will eventually end special education as we know it."

—James E. Ryan, 2013[109]

For decades, research by social scientists and psychiatrists demonstrated that childhood adversity, such as experiencing abuse or neglect, increases the risk that a person would experience mental illness

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104 *See* 20 U.S.C. § 1414(d) (2018) (requiring written statements of the child's academic achievement, measurable annual academic and functional goals, and detailed descriptions of the child's progress, among other documentation).

105 *See id.* § 1415 (providing, for example, opportunities for parental review of records, communications in parents' native language, and opportunities for mediation and presentation of complaints); 34 C.F.R. § 104.36 (2019) (providing for similar safeguards).

106 *See* 34 C.F.R. § 104.33(a)–(b).

107 Statement of Anonymous Clinical Psychologist, During an IEP Meeting at Patterson Elementary School, a District of Columbia Public School (May 30, 2018) (on file with author).

108 Gillian Keebler, *Childhood Trauma Shown to Shorten Lifespan*, Go Big Read: U. Wis.-Madison (July 18, 2018), https://gobigread.wisc.edu/2017/07/childhood-trauma-shown-to-shorten-lifespan.

109 James E. Ryan, *Poverty as Disability and the Future of Special Education Law*, 101 Geo. L.J. 1455, 1459 (2013).

and engage in health-harming and criminal behavior.[110] Studies showed, for instance, that childhood abuse and neglect increased the risk of depression, suicidality, anxiety, and risky sexual and substance use behavior.[111]

However, beginning around 2010, research on trauma's effects drew new global attention and became widely accepted by the medical community.[112] The research was remarkable because it convincingly demonstrated the alarming pervasiveness of childhood trauma and revealed that trauma impacted much more than social-emotional health. The research elucidated the biological mechanisms by which trauma harmed health, development, learning, and behavior. This section summarizes the key research findings showing trauma's prevalence and how trauma frustrates learning and behavior in school.

A. The Pervasiveness of Adverse Childhood Experiences and Their Harmful Effects

The ACE Study and hundreds of subsequent studies provide robust scientific evidence that most American children experience a potentially traumatic event before turning age eighteen and that the more adversity they experience, the more likely they are to experience impairments in health, learning, and behavior.[113]

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110 *See, e.g.*, Felitti et al., *supra* note 15, at 246; Ruth Gilbert et al., *Burden and Consequences of Child Maltreatment in High-Income Countries*, 373 LANCET 68, 73–77 (2009) (discussing the connection between childhood mistreatment and later morbidity and mortality); A. Üçok & S. Bıkmaz, *The Effects of Childhood Trauma in Patients with First-Episode Schizophrenia*, 116 ACTA PSYCHIATRICA SCANDINAVICA 371 (2007); Hugh Klein et al., *Childhood Neglect and Adulthood Involvement in HIV-Related Risk Behaviors*, 31 CHILD ABUSE & NEGLECT 39 (2007).

111 *See, e.g.*, Jocelyn Brown et al., *Childhood Abuse and Neglect: Specificity of Effects on Adolescent and Young Adult Depression and Suicidality*, 38 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1490 (1999); *see also* Klein et al., *supra* note 110.

112 *See, e.g.*, AM. ACAD. OF PEDIATRICS, ADVERSE CHILDHOOD EXPERIENCES AND THE LIFELONG CONSEQUENCES OF TRAUMA (2014), https://www.aap.org/en-us/documents/ttb_aces_consequences.pdf; WORLD HEALTH ORG., ADDRESSING ADVERSE CHILDHOOD EXPERIENCES TO IMPROVE PUBLIC HEALTH: EXPERT CONSULTATION 6 (2009) (relating international efforts to describe ACEs); Carina Storrs, *Is Life Expectancy Reduced by a Traumatic Childhood?*, SCI. AM. (Oct. 7, 2009), https://www.scientificamerican.com/article/childhood-adverse-event-life-expectancy-abuse-mortality (describing the results of the first cohort study of the link between ACEs and mortality).

113 *See, e.g.*, Felitti et al., *supra* note 15, at 251 (finding a strong relationship between ACEs and adult morbidity and mortality); C.D. BETHELL ET AL., JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH, ISSUE BRIEF: A NATIONAL AND ACROSS-STATE PROFILE ON ADVERSE CHILDHOOD EXPERIENCES AMONG U.S. CHILDREN AND POSSIBILITIES TO HEAL AND THRIVE (2017), https://www.cahmi.org/wp-content/uploads/2018/05/aces_brief_final.pdf (documenting that 55.7% of all children ages twelve to seventeen have experienced at least one ACE); William E. Copeland et al., *Traumatic Events and Posttraumatic Stress in Childhood*, 64 ARCHIVES GEN. PSYCHIATRY 577, 579 (2007) (demonstrating that two-thirds of children reported experiencing an ACE by age

The 1995–1997 ACE Study, sponsored by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, collected information from 17,421 primarily white (83.9% were white), college-educated, employed adults (with a mean age of 56) who had health insurance and lived in various parts of the United States.[114] The study found that two out of three of participants (64%) experienced an adverse childhood experience ("ACE"), defined as childhood emotional, sexual, or physical abuse; physical or emotional neglect; substance abuse by a household member; mental illness in a household member; violence directed at one's mother; parental divorce or separation; or incarceration of a member of the household.[115] More than one in five reported three or more ACEs and 12.4% reported four or more ACEs.[116]

Subsequent studies confirmed that the majority of American children in every community and every state experience at least one ACE before turning eighteen and that poverty increases the risk of experiencing ACEs during childhood.[117]

A multitude of studies also demonstrated that childhood adversity dramatically increased the risk of major illnesses, disability, and shorter lifespan.[118] The studies consistently revealed a strong dose-response relationship between childhood adversity and illness and disability, meaning that the higher the number of ACEs experienced by a person, the greater their likelihood of experiencing an illness or disability during their lifetime.[119] This dose-response relationship is a

sixteen); Williamson & Qureshi, *supra* note 17, at 2 ("The accumulation of trauma increases the likelihood of disability.").

114 *See* Felitti et al., *supra* note 15, at 246–47; NADINE BURKE HARRIS, THE DEEPEST WELL: HEALING THE LONG-TERM EFFECTS OF CHILDHOOD ADVERSITY 36–37 (2018); VAN DER KOLK, *supra* note 20, at 144–45.

115 *See* BURKE HARRIS, *supra* note 114, at 37–38.

116 Johns Hopkins Bloomberg Sch. of Pub. Health et al., *ACEs Resource Packet: Adverse Childhood Experiences (ACEs) Basics*, DATA RESOURCE CTR. FOR CHILD & ADOLESCENT HEALTH, https://www.childhealthdata.org/docs/default-source/cahmi/aces-resource-packet_all-pages_12_06-16112336f3c0266255aab2ff00001023b1.pdf (last visited Aug. 8, 2019); Ctrs. for Disease Control & Prevention, *Adverse Childhood Experiences: Looking at How ACEs Affect Our Lives & Society*, VETOVIOLENCE, https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html (last visited Aug. 8, 2019).

117 *See, e.g.*, BETHELL ET AL., *supra* note 113 (documenting that 58% of children with ACEs live in homes with incomes less than 200% of the federal poverty level); Copeland et al., *supra* note 113, at 579; Neal Halfon et al., *Income Inequality and the Differential Effect of Adverse Childhood Experiences in US Children*, 17 ACAD. PEDIATRICS S70, S72–S73 (2017) (revealing a steep income gradient where higher poverty is associated with more ACEs).

118 *See, e.g.*, BURKE HARRIS, *supra* note 114, at 39; Felitti et al., *supra* note 15; Williamson & Qureshi, *supra* note 17, at 2 ("The accumulation of trauma increases the likelihood of disability.").

119 *See* Felitti et al., *supra* note 15, at 249–50.

strong indicator to scientists that childhood adversity has a strong causal relationship with illness and disability.[120]

Specifically, more than forty illnesses—including ischemic heart disease (America's leading cause of death), depression, suicide, sexually transmitted diseases, diabetes, stroke, cancer, liver disease, obesity, chronic bronchitis, and emphysema—exhibit a dose-response relationship with ACEs.[121] For instance, for every ACE a woman experiences, her likelihood of being hospitalized for an autoimmune disease rises by twenty percent, while the percentage rises by ten percent for men.[122] Similarly, a person who experiences four ACEs is twice as likely to be diagnosed with cancer and three times as likely to receive a diagnosis of cardiovascular disease than a person who experiences no ACEs.[123] This dose-response relationship exists even when people engage in no health-harming or health-risking behaviors, such as smoking, drinking, or physical inactivity.[124]

Further, ACEs increase the risk of disease during childhood.[125] A study of children between ages three and five found that for every additional reported ACE, a child had a twenty-one percent increased likelihood of experiencing a chronic medical condition, such as asthma, attention-deficit/hyperactivity disorder, AIDS, autism, Down syndrome, cystic fibrosis, or repeated ear infections.[126] Studies have shown similar effects of ACEs on the health of older children.[127]

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[120] *See* BURKE HARRIS, *supra* note 114, at 40; Felitti et al., *supra* note 15, at 251.

[121] *See, e.g.*, Shanta R. Dube et al., *Health-Related Outcomes of Adverse Childhood Experiences in Texas, 2002*, 7 PREVENTING CHRONIC DISEASE 1, 3 (2010); *Adverse Childhood Experiences Presentation Graphics*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 27, 2019), https://www.cdc.gov/violenceprevention/acestudy/ACE_graphics.html.

[122] *See* DONNA JACKSON NAKAZAWA, CHILDHOOD DISRUPTED: HOW YOUR BIOGRAPHY BECOMES YOUR BIOLOGY, AND HOW YOU CAN HEAL 98 (2015).

[123] *See id.* at 14; *see also* M.A. Bellis et al., *Measuring Mortality and the Burden of Adult Disease Associated with Adverse Childhood Experiences in England: A National Survey*, 37 J. PUB. HEALTH 445, 450 tbl.2 (2014).

[124] *See* BURKE HARRIS, *supra* note 114, at 41.

[125] *See* Bonnie D. Kerker et al., *Adverse Childhood Experiences and Mental Health, Chronic Medical Conditions, and Development in Young Children*, 15 ACAD. PEDIATRICS 510, 515 (2015) (finding a link between ACEs and poor health and social development in three- to five-year-olds); Emalee G. Flaherty et al., *Adverse Childhood Experiences and Child Health in Early Adolescence*, 167 JAMA PEDIATRICS 622, 625 (2013) (demonstrating a clear relationship between ACEs and health problems in children and adolescents).

[126] Kerker et al., *supra* note 125, at 514.

[127] *See, e.g.*, Flaherty et al., *supra* note 125, at 626 (noting a strong connection between recent adversity and health problems in thirteen- and fourteen-year-olds); Richard Thompson et al., *Trajectories of Adverse Childhood Experiences and Self-Reported Health at Age 18*, 15 ACAD. PEDIATRICS 503, 506 (2015) (explaining that "chronic exposure to ACEs over the course of childhood predicted health worries and self-reported use of medical care at age 18").

As a result of the well-documented connection between ACEs and disease, a person with six or more ACEs generally has a lifespan twenty years shorter than a person with no ACEs.[128]

Childhood adversity also has a dose-response relationship with disability during childhood and adulthood.[129] Nearly three in four children with chronic conditions involving emotional, mental, or behavioral problems have experienced an ACE.[130] A study of three- to five-year-olds found that for every additional reported ACE, there was a seventy-seven percent increased likelihood of a low score on the Vineland Adaptive Behavior Scale, a commonly used assessment of a person's functional intelligence, including their ability to express and comprehend language, behave appropriately in interpersonal situations, and care for oneself.[131]

Regarding long-term disability, a study involving 81,184 adults revealed that, compared to experiencing no ACEs, experiencing two ACEs nearly doubles the risk of developing a disability, whereas experiencing seven or eight ACEs confers a six-fold increased risk of the same.[132] Research shows that childhood adversity increases the risk of earlier, more severe, and longer work disability.[133] Further, experiencing multiple ACEs results in a 3.46-fold increased risk of retiring early due to disability compared with experiencing no ACEs.[134]

In summary, empirical studies confirm a marked, negative effect of adverse events on child developmental, physical, mental, emotional, and behavioral health and functioning.[135] Analyzing the dose-response relationship between ACEs and poor health outcomes highlighted by numerous studies, many scientists, including the physician-researchers who conducted the original ACE study (Drs. Robert

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128 JACKSON NAKAZAWA, *supra* note 122, at 15.

129 *See* Sophia Miryam Schüssler-Fiorenza Rose et al., *Adverse Childhood Experiences and Disability in U.S. Adults*, 6 PM&R 670 (2014); Williamson & Qureshi, *supra* note 17, at 2 ("The accumulation of trauma increases the likelihood of disability.").

130 *See* BETHELL ET AL., *supra* note 113, at 4.

131 Kerker et al., *supra* note 125, at 514.

132 *See* Schüssler-Fiorenza Rose et al., *supra* note 129, at 674 tbl.2; *cf.* Anna Austin et al., *Disability and Exposure to High Levels of Adverse Childhood Experiences: Effect on Health and Risk Behavior*, 77 N.C. MED. J. 30, 32 (2016) (finding a significantly higher ACE exposure among those with disabilities than those without disabilities).

133 *See* Sarah B. Laditka & James N. Laditka, *An Enduring Health Risk of Childhood Adversity: Earlier, More Severe, and Longer Lasting Work Disability in Adult Life*, 74 JS. GERONTOLOGY: SERIES B 136, 140–42 (2018).

134 *See* Karoliina Harkonmäki et al., *Childhood Adversities as a Predictor of Disability Retirement*, 61 J. EPIDEMIOLOGY & COMMUNITY HEALTH 479, 481 (2007).

135 Christina D. Bethell et al., *Prioritizing Possibilities for Child and Family Health: An Agenda to Address Adverse Childhood Experiences and Foster the Social and Emotional Roots of Well-Being in Pediatrics*, 17 ACAD. PEDIATRICS S36, S37 (2017).

Anda and Vincent Felitti), have concluded that early adverse experiences "cause enduring brain dysfunction that, in turn, affects health and quality of life throughout the lifespan."[136]

1. *The Impact of ACEs on School Performance*

New research shows that childhood adversity can significantly impair educational progress. A considerable number of studies have found a dose-response relationship between childhood adversity and poor school functioning.[137] For instance, compared to children with no ACEs, children ages three to five with two or more ACEs are over four times more likely to have three or more of the following social and emotional problems at school: being unable to calm themselves down when excited or wound up; frequent loss of temper; not playing well with others; being easily distracted; being unable to work on a task until completion; and having difficulty with making and keeping friends.[138]

More generally, experiencing at least one ACE results in a 10.3 times greater chance of experiencing a learning or behavioral problem, while experiencing four or more ACEs results in a 32.6 times greater chance of experiencing such a problem.[139] Further, a child's odds of having to repeat a grade double if that child experiences any ACEs as an infant or toddler, while the odds nearly triple if a child experiences three or more ACEs as an infant or toddler.[140]

Similar dose-response relationships exist between ACEs and the following indicators of poor school functioning: being disengaged at school;[141] failing to complete homework;[142] being a victim or perpetrator of bullying;[143] expulsion from preschool;[144] chronic absen-

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[136] Robert F. Anda et al., *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood. A Convergence of Evidence from Neurobiology and Epidemiology*, 256 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCIENCE 174, 175 (2006).

[137] Bethell et al., *supra* note 135, at S37.

[138] BETHELL ET AL., *supra* note 113, at 2–3.

[139] Nadine J. Burke et al., *The Impact of Adverse Childhood Experiences on an Urban Pediatric Population*, 35 CHILD ABUSE & NEGLECT 408, 412 (2011).

[140] Lorraine M. McKelvey et al., *Adverse Experiences in Infancy and Toddlerhood: Relations to Adaptive Behavior and Academic Status in Middle Childhood*, 82 CHILD ABUSE & NEGLECT 168, 174 (2018).

[141] *See* BETHELL ET AL., *supra* note 113, at 2 (finding that students with at least two ACEs are more than twice as likely to be disengaged in school as their peers without ACEs).

[142] Laurin Kasehagen et al., *Relationship of Adverse Family Experiences to Resilience and School Engagement Among Vermont Youth*, 22 MATERNAL & CHILD HEALTH J. 298, 302 (2018).

[143] Anna Austin, *Association of Adverse Childhood Experiences with Life Course Health and Development*, 79 N.C. MED. J. 99, 99 (2018); Myriam Forster et al., *Adverse Childhood*

teeism;[145] being disruptive at school;[146] failure to meet grade-level standards in math, reading, or writing; academic failure;[147] failure to graduate from high school;[148] and failure to graduate from college.[149]

As to diagnosed problems that impact learning, one study of children in Los Angeles found that children experiencing four or more ACEs were 32.6 times more likely to be diagnosed with learning and behavioral problems.[150] Other studies found dose-response relationships between ACEs and clinically elevated internalizing (anxiety, depression, withdrawal, and somatic complaints) and externalizing (aggression, acting out, and/or delinquency) problems[151] and mental health problems generally.[152]

Experiences and School-Based Victimization and Perpetration, J. INTERPERSONAL VIOLENCE 662, 663 (2017).

144 *See* BETHELL ET AL., *supra* note 113, at 2 (stating that more than three in four children aged three to five who are expelled from preschool have ACEs).

145 *See* Hilary Stempel et al., *Chronic School Absenteeism and the Role of Adverse Childhood Experiences*, 17 ACAD. PEDIATRICS 837, 839 (2017) (having one or more ACEs meant having a 1.35 times greater chance of chronic absenteeism; having four or more ACEs meant a 1.79 times greater chance of chronic absenteeism); Bellis et al., *supra* note 123, at 795.

146 *See* Christopher Blodgett & Jane D. Lanigan, *The Association Between Adverse Childhood Experience (ACE) and School Success in Elementary School Children*, 33 SCH. PSYCHOL. Q. 137, 138 (2018) (revealing a dose-response relationship between number of ACEs and behavioral issues at school).

147 *See id.* at 137 (showing a dose-response relationship between number of ACEs and risk of poor school attendance, behavioral issues, failure to meet grade-level standards in math, reading, or writing, and academic failure); *see also* Anne S. Morrow & Miguel T. Villodas, *Direct and Indirect Pathways from Adverse Childhood Experiences to High School Dropout Among High-Risk Adolescents*, 28 J. RES. ADOLESCENCE 327, 336 (2018) (finding that ACEs have a direct association with reading problems).

148 *See* Marilyn Metzler et al., *Adverse Childhood Experiences and Life Opportunities: Shifting the Narrative*, 72 CHILD. & YOUTH SERVS. REV. 141, 144 (2017) (finding that people who experience three ACEs are 1.53 times, and people with four or more ACEs 2.34 times, as likely to not graduate from high school as their peers without ACEs); Morrow & Villodas, *supra* note 147, at 336 (finding a direct association between ACEs and high school dropout).

149 Dube et al., *supra* note 121, at 8 (demonstrating a dose-response effect between ACEs and lower educational attainment, including failure to complete college).

150 BURKE HARRIS, *supra* note 114, at 59.

151 *See* McKelvey et al., *supra* note 140, at 174 (showing that a child's odds of having clinically elevated internalizing problems were twice and nearly four times for children with two and three or more average ACEs, respectively, than those with no ACEs and that the odds of having an ADD/ADHD diagnosis was twice and triple for children having an average of two and three or more ACEs, respectively, across infancy and toddlerhood); Morrow & Villodas, *supra* note 147, at 335 (finding that ACEs increased the risk of externalizing problems). *See generally* Jaume March-Llanes et al., *Stressful Life Events During Adolescence and Risk for Externalizing and Internalizing Psychopathology: A Meta-Analysis*, 26 EUR. CHILD & ADOLESCENT PSYCHIATRY 1409 (2017).

152 *See* Kerker et al., *supra* note 125 (documenting that for every additional reported ACE, there was a thirty-two percent higher chance of having a problem score on the Child

Regarding ADHD, the most common neurobehavioral disorder of childhood and a major cause of learning problems—experiencing an ACE between ages five and nine nearly doubles a child's risk of receiving an ADHD diagnosis by age nine, and the severity of the disorder increases with the number of ACEs experienced by the child.[153] In particular, experiencing physical or sexual abuse during any part of childhood is strongly associated with receiving an ADHD diagnosis.[154]

More generally, there is an abundance of evidence that childhood adversity can worsen preexisting mental health problems and disrupt a child's ability to form positive relationships.[155] As a result of the multiple effects of childhood adversity, children suffering from adversity can appear at school with multiple diagnoses, including post-traumatic stress disorder (PTSD), ADHD, bipolar disorder, oppositional defiant disorder, conduct disorder, anxiety disorder, phobic disorder, borderline personality disorder, reactive attachment disorder, substance use disorder, bipolar disorder, and intermittent explosive disorder.[156]

2. *ACEs and Increased Risk of Incarceration*

Unsurprisingly, given its toll on social-emotional functioning and self-control, childhood adversity also increases the risk of involvement in the juvenile delinquency and criminal justice systems.[157] Children involved in these systems have generally experienced a high level of adversity. To illustrate, in a population of 64,329 juvenile offenders in Florida, only 3.1% of males and 1.8% of females reported exper-

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Behavior Checklist, which correctly classifies 84.2% of children referred for mental health services as in need of those services).

[153] Manuel E. Jimenez et al., *Adverse Childhood Experiences and ADHD Diagnosis at Age 9 Years in a National Urban Sample*, 17 ACAD. PEDIATRICS 356, 359–60 (2017); *see also* Nicole M. Brown et al., *Associations Between Adverse Childhood Experiences and ADHD Diagnosis and Severity*, 17 ACAD. PEDIATRICS 349, 352 (2017) (finding an association between ACEs and the severity of ADHD in a study involving 76,227 children in the U.S.).

[154] Esme Fuller-Thomson & Danielle A. Lewis, *The Relationship Between Early Adversities and Attention-Deficit/Hyperactivity Disorder*, 47 CHILD ABUSE & NEGLECT 94 (2015).

[155] *Understanding Child Trauma and the NCTSN*, NAT'L CHILD TRAUMATIC STRESS NETWORK (Mar. 5, 2018), https://www.nctsn.org/resources/understanding-child-trauma-and-nctsn.

[156] COLE ET AL., *supra* note 35, at 21; *see also, e.g.*, VAN DER KOLK, *supra* note 20, at 151 (describing a child who presented with bipolar, interimittent explosive, reactive attachment, attention deficit, oppositional defiant, and substance use disorders).

[157] Shawn C. Marsh & Carly B. Dierkhising, *Toward a Conceptual Framework for Trauma-Informed Practice in Juvenile and Family Courts*, JUV. & FAM. JUST. TODAY, Summer 2013, at 19, 19 https://www.fmhac.org/uploads/1/2/3/9/123913996/summers_conceptualizing_trauma-informed_courts.pdf.

iencing no ACEs, and the average number of ACEs experienced by females was 4.29, while the average for males was 3.48.[158] The juvenile offenders were thirteen times more likely to have experienced childhood adversity and four times more likely to have experienced four or more ACEs than the population studied in the original ACE Study.[159]

For girls, sexual abuse is such a strong predictor for girls' involvement and recidivism in the juvenile justice system that many call its effects the "sexual abuse to prison pipeline." Girls in the juvenile justice system are four times more likely than boys to have experienced childhood sexual abuse,[160] and some ninety-two percent of girls in the juvenile justice system have experienced emotional, physical, or sexual abuse.[161] Girls in the juvenile justice system also bear a disproportionate burden of ACEs: their rate of experiencing five or more ACEs is also nearly twice as high as that of boys involved in the system.[162]

ACEs are also correlated with adult incarceration. For instance, one study investigated the number of ACEs experienced by 151 men who were incarcerated for crimes associated with domestic violence, child physical abuse, general violence, and "sexual deviance."[163] These men reported nearly four times as many ACEs as men who were not incarcerated.[164] The evidence showing a dose-response relationship between ACEs and adult incarceration risk is also mounting.[165]

3. *ACEs and Increased Need for Special Education*

The conclusion that childhood adversity increases the need for special education is consistent with this data. On average, children receiving special education have experienced more ACEs than chil-

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[158] Michael T. Baglivio & Nathan Epps, *The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders*, 3 OJJDP J. JUV. JUST. 1, 9 (2014).

[159] *Id.* at 10.

[160] MALIKA SAADA SAAR ET AL., HUMAN RIGHTS PROJECTS FOR GIRLS, THE SEXUAL ABUSE TO PRISON PIPELINE: THE GIRLS' STORY 8 (2015), http://rights4girls.org/wp-content/uploads/r4g/2015/02/2015_COP_sexual-abuse_report_final.pdf.

[161] FRANCINE T. SHERMAN, 13 PATHWAYS TO JUVENILE DETENTION REFORM: DETENTION REFORM AND GIRLS: CHALLENGES AND SOLUTIONS 22 (2005), https://folio.iupui.edu/bitstream/handle/10244/97/jdai_pathways_girls.pdf?sequence=1.

[162] SAADA SAAR ET AL., *supra* note 160, at 8.

[163] James A. Reavis et al., *Adverse Childhood Experiences and Adult Criminality: How Long Must We Live Before We Possess Our Own Lives?*, 17 PERMANENTE J. 44, 46 (2013).

[164] *Id.* at 44.

[165] *See, e.g.*, Leslie E. Roos et al., *Linking Typologies of Childhood Adversity to Adult Incarceration: Findings from a Nationally Representative Sample*, 86 AM. J. ORTHOPSYCHIATRY 584, 589 (2016) (finding ACEs responsible for between a one- and three-fold increase in the likelihood of incarceration for adults, even after controlling for other variables).

dren who are not receiving special education.[166] And children who experience three or more ACEs during infancy and toddlerhood have double the odds of receiving an IEP than children with no ACE exposure.[167]

Given the short and long-term consequences of childhood adversity on health, disability, school performance, and engagement with the welfare and criminal justice systems, the economic toll of childhood adversity is immense. The CDC estimates that the total lifetime cost associated with U.S. cases of child maltreatment confirmed by government agencies during a single year is approximately $124 billion.[168]

In response to the data highlighting the astonishing harm caused by childhood adversity, many have called childhood adversity the most urgent public health crisis of our time.[169]

B. The Variety of Traumatic Experiences and the Factors Influencing When Adversity Is Trauma

When is adversity trauma, and are ACEs the only type of adversity that cause trauma? Not all adverse childhood experiences cause long-term functional, physical, emotional, social, and mental harm. As Christopher Blodgett and Jane Lanigan have written, "Exposure to [childhood] adversity is a risk, not a guarantee, that problems will emerge."[170] Adversity that causes long-term harm is trauma, where trauma is defined as any experience or event that overwhelms a person's ability to cope and elicits feelings of terror, powerlessness, and out-of-control physiological arousal.[171] Trauma typically occurs

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166 Blodgett & Lanigan, *supra* note 146, at 142.

167 Rachael D. Goodman et al., *Traumatic Stress, Socioeconomic Status, and Academic Achievement Among Primary School Students*, 4 PSYCHOL. TRAUMA 252, 256 (2012); McKelvey et al., *supra* note 140, at 174.

168 Press Release, Ctrs. for Disease Control & Prevention, Child Abuse and Neglect Cost the United States $124 Billion (Feb. 1, 2012), https://www.cdc.gov/media/releases/2012/p0201_child_abuse.html. This number accounts for the average lifetime cost per victim of nonfatal child maltreatment: $7999 spent in special education costs; $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7728 in child welfare costs; and $6747 in criminal justice costs.

169 *See, e.g.*, VAN DER KOLK, *supra* note 20, at 148; *Who Needs to Pay Attention to the ACE Study?*, *supra* note 20; *see also* BURKE HARRIS, *supra* note 114, at 42.

170 Blodgett & Lanigan, *supra* note 146, at 144.

171 *Cf.* JUDITH HERMAN, TRAUMA AND RECOVERY 33–34 (1997) (defining trauma as events which "overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning"); Yaroshefsky & Shwedel, *supra* note 35, at 104 (defining trauma as a "response to a stressful experience where a person's ability to cope is dramatically undermined"); *About Child Trauma*, NAT'L CHILD TRAUMATIC STRESS NETWORK, https://www.nctsn.org/what-is-child-trauma/about-child-trauma (last visited Jan. 17, 2020) (defining trauma as a "frightening, dangerous, or violent event that poses a threat

when a person is faced with an intense, frightening event (or a series of events) or a set of circumstances that are physically or emotionally harmful or life threatening, and can persist without appropriate support and intervention.[172]

The ACE Study was a breakthrough in our understanding of trauma, but the ACE Study described only a subset of childhood adversity that can cause long-term harm. Beyond that subset, a wide variety of experiences can be traumatic, including lacking access to basic necessities such as food, water, shelter, or clothing; bullying; discrimination; and community violence.[173]

A growing body of research substantiates that a wide range of stressful experiences can also cause disability and illness. For instance, a study involving 157,000 American children defined childhood adversity as living in a distressed neighborhood, indicated by a greater than twenty-seven percent child poverty rate; a greater than twenty-three percent high school drop-out rate; a greater than thirty-four percent male unemployment rate; and a greater than thirty-seven percent of single-mother households.[174] Children experiencing this definition of adversity had a sixty-seven percent higher rate of disability than chil-

to a child's life or bodily integrity"); CHILDREN'S LAW CTR., REPORT: ADDRESSING CHILDHOOD TRAUMA IN DC SCHOOLS 2 (2015), https://www.childrenslawcenter.org/sites/default/files/CLC%20--%20Addressing%20Childhood%20Trauma%20in%20DC%20Schools--June%202015.pdf (defining trauma as "a severe emotional response to a frightening or threatening event or series of experiences that leaves a person overwhelmed and unable to cope"); *Trauma and Violence*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/trauma-violence (last updated Aug. 2, 2019) (defining trauma as the result of "'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being'").

172 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SAMHSA'S CONCEPT OF TRAUMA AND GUIDANCE FOR A TRAUMA-INFORMED APPROACH 2 (2014), https://store.samhsa.gov/system/files/sma14-4884.pdf (stating that trauma can occur as a result of emotional harmful experiences, including violence, neglect, disaster, or war).

173 Other potentially traumatic experiences include income insufficiency; parental abandonment; human trafficking; home invasion; natural disasters; terrorism; abrupt separation from loved ones; sudden or violent loss of a loved one; deployment of a parent; peer rejection; sexual assault or harassment; medical procedures; online sexual solicitation; witnessing the arrest of a parent; school violence; life-threatening accidents or medical conditions; expulsion; having to repeat a grade; or moving from one foster family to another. *See, e.g.*, Kristin L. Berg et al., *Disparities in Adversity Among Children with Autism Spectrum Disorder: A Population-Based Study*, 58 DEVELOPMENTAL MED. & CHILD NEUROLOGY 1124, 1228 (2016); Peter F. Cronholm et al., *Adverse Childhood Experiences: Expanding the Concept of Adversity*, 49 AM. J. PREVENTATIVE MED. 354, 358 (2015); David Finkelhor et al., *A Revised Inventory of Adverse Childhood Experiences*, 48 CHILD ABUSE & NEGLECT 13 (2015).

174 Michael E. Msall et al., *Distressed Neighborhoods and Child Disability Rates: Analyses of 157,000 School-Age Children*, 49 DEVELOPMENTAL MED. & CHILD NEUROLOGY 814, 815 (2007).

dren not experiencing the adversity.[175] Because numerous experiences other than those identified as adverse events in the ACE study can be traumatic, researchers have proposed expanding the list of experiences that are deemed to be ACEs.[176]

Members of a community can experience a common trauma, and trauma can be transferred between people over time. Trauma can stem from racism (resulting in "racial trauma"), sexism, or other forms of bigotry[177] and can come in the form of structural or systemic oppression against a group of people.[178] As Kenneth Hardy has described, for instance, chronic exposure to racism can lead to internalized devaluation, internalized voicelessness, an assaulted sense of self, and rage.[179] Trauma can also pass through the generations of a family, resulting in intergenerational trauma.[180]

Further, trauma can arise from historical events affecting entire communities, such as the enslavement of African Americans; the displacement, murder, and loss of culture and land of American Indians; the murder and torture of Jews in the Holocaust; war; famine; mass incarceration; and forced separation from one's family.[181] Such events, called historical trauma, typically involve a dominant culture perpetrating the economic, cultural, familial, and societal devastation of a population, and the initial effects of trauma are conveyed to succes-

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175 *Id.*

176 *See, e.g.*, Finkelhor et al., *supra* note 173, at 13 (suggesting that bullying, social rejection, poverty, and community violence be added to the list of ACEs); Cronholm et al., *supra* note 173, at 358 (finding that men, blacks, Hispanics, Asian/Pacific Islanders, divorcees, and the poor have their adversity underestimated by traditional ACEs).

177 *See, e.g.*, Susan H. Berg, *Everyday Sexism and Posttraumatic Stress Disorder in Women: A Correlational Study*, 12 VIOLENCE AGAINST WOMEN 970, 970 (2006) (finding a correlation between sexism and PTSD and that sexist degradation was the variable that predicted trauma the strongest); NAT'L CHILD TRAUMATIC STRESS NETWORK, ADDRESSING RACE AND TRAUMA IN THE CLASSROOM: A RESOURCE FOR EDUCATORS 3 (2017), https://www.nctsn.org/sites/default/files/resources//addressing_race_and_trauma_in_the_classroom_educators.pdf (exemplifying a growing body of research which shows that experiencing racism, discrimination, or institutional racism can profoundly impact mental health).

178 NAT'L CHILD TRAUMATIC STRESS NETWORK, *supra* note 177, at 2.

179 Kenneth V. Hardy, *Healing the Hidden Wounds of Racial Trauma*, 22 RECLAIMING CHILDREN & YOUTH 24, 25 (2013).

180 MARK WOLYNN, IT DIDN'T START WITH YOU: HOW INHERITED FAMILY TRAUMA SHAPES WHO WE ARE AND HOW TO END THE CYCLE (2017); Sue Coyle, *Intergenerational Trauma—Legacies of Loss*, SOCIAL WORK TODAY, May/June 2014, at 18, 18, https://www.socialworktoday.com/archive/051214p18.shtml.

181 NAT'L CHILD TRAUMATIC STRESS NETWORK, *supra* note 177, at 2; JOY DEGRUY LEARY & RANDALL ROBINSON, POST TRAUMATIC SLAVE SYNDROME: AMERICA'S LEGACY OF ENDURING INJURY AND HEALING 13–16 (2005) (asserting that slavery has resulted in transgenerational behavioral adaptations associated with trauma, called "Post Traumatic Slave Syndrome").

sive generations through environmental and psychological factors, as well as prejudice and discrimination.[182]

What makes an adverse experience traumatic? One person may experience a particular event as traumatic, but another person may experience the same event as non-traumatic, and most children exposed to ACEs do not develop poor health outcomes.[183] Multiple factors influence whether an event is experienced as traumatic, including the nature of the experience; the characteristics of the child; and the way that family, school, and community respond.[184] For instance, a child's intelligence, prior history of trauma, and social and emotional skills can influence whether the child experiences an event as traumatic.[185]

Factors that tend to protect a person from experiencing an event as traumatic, called "protective factors" or "sources of resilience," include relationships with caring, responsive adults,[186] having a role model, supportive friends, receiving opportunities to use one's abilities,[187] good communication and social skills, engagement in extracurricular activities, satisfaction with school,[188] having parents who aspire to make their children's lives better than their own, support and nurturance from a parent,[189] spirituality, having a strong sense of cultural identity, and family cohesion. Safe, stable, and nurturing environments also protect children from experiencing trauma.[190] But the key protective factor and source of resilience is a supportive, caring adult who helps a child to cope with and mitigate stressors.[191]

Research increasingly demonstrates that these protective factors actually reduce the prevalence of disability and disease.[192] Such evi-

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[182] Kathleen Brown-Rice, *Examining the Theory of Historical Trauma Among Native Americans*, 3 Professional Counselor 117, 118 (2013); Nat'l Child Traumatic Stress Network, *supra* note 177, at 2.

[183] Bellis et al., *supra* note 123, at 793.

[184] Cole et al., *supra* note 35, at 19.

[185] *Id.* at 97.

[186] Austin, *supra* note 143, at 102.

[187] Bellis et al., *supra* note 123, at 794.

[188] Nisreen Khambati et al., *Educational and Emotional Health Outcomes in Adolescence Following Maltreatment in Early Childhood: A Population-Based Study of Protective Factors*, 81 Child Abuse & Neglect 343, 343 (2018).

[189] Briana A. Woods-Jaeger et al., *Promoting Resilience: Breaking the Intergenerational Cycle of Adverse Childhood Experiences*, 45 Health Educ. & Behav. 772, 774 (2018).

[190] Burke Harris, *supra* note 114, at 85 ("If [children] can get a safe, stable, and nurturing environment at any early age, the biology says that this sets them up to develop a healthy stress-response system in adulthood.").

[191] *Id.*

[192] *See, e.g.*, Bellis et al., *supra* note 123, at 792 (finding that community protective factors reduce the prevalence of childhood health issues).

dence points strongly to the need to understand and develop resilience in youth.[193]

C. The Myriad Ways that Trauma Causes Disability

How does trauma impair the body, mind, and behavior? Recent research reveals that trauma harms health and development through multiple pathways, including by dysregulating and overactivating the body's stress-response system; altering the developing brain's architecture; causing inflammation that affects multiple organ systems; and changing gene expression.[194]

When a person senses danger, his or her body normally produces elevated levels of stress hormones, including cortisol, to activate the sympathetic nervous system, the system responsible for the fight, flight, or freeze stress response.[195] Because this system prepares the body to escape or resist harm in response to perceived threat, it is adaptive and geared to promote survival. When the danger passes, stress hormone levels normally return to baseline levels so that the body can rest and recover.[196]

When children experience trauma without supportive adults present, however, they experience toxic stress.[197] Toxic stress, also called traumatic stress, is chronic, prolonged, or unpredictable stress that causes chronic overactivation and dysregulation of the sympathetic nervous system.[198] Toxic stress occurs when the normal stress response fails to restore homeostasis. In toxic stress, the levels of

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193 *Id.*

194 *See* BURKE HARRIS, *supra* note 114, at 58, 65, 73 (finding that trauma altered children's brain structures and noting that a disrupted stress response affects the neurological, immune, hormonal, and cardiovascular systems and can lead to increased inflammation, autoimmune disease, and viral infections); William Wan, *What Separation from Parents Does to Children: 'The Effect Is Catastrophic*,' WASH. POST (June 18, 2018), https://www.washingtonpost.com/national/health-science/what-separation-from-parents-does-to-children-the-effect-is-catastrophic/2018/06/18/c00c30ec-732c-11e8-805c-4b67019fcfe4_story.html (arguing that separating children from their parents leads to trauma that damages the brain's physical and psychological structures); HARV. U. CTR. ON THE DEVELOPING CHILD, EARLY EXPERIENCES CAN ALTER GENE EXPRESSION AND AFFECT LONG-TERM DEVELOPMENT: WORKING PAPER NO. 10 (2010) (discussing how stress can alter gene expression).

195 JACKSON NAKAZAWA, *supra* note 122, at 29–31. This system elevates blood pressure, increases heart rate, and sends blood to the muscles to prepare them to act quickly to protect the body from harm. VAN DER KOLK, *supra* note 20, at 77.

196 JACKSON NAKAZAWA, *supra* note 122, at 29.

197 *Id.* at 36; SPORLEDER & FORBES, *supra* note 28, at 20.

198 JACKSON NAKAZAWA, *supra* note 122, at 67; SPORLEDER & FORBES, *supra* note 28, at 20; *What Are ACEs? And How Do They Relate to Toxic Stress?*, HARV. U. CTR. ON DEVELOPING CHILD, https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions (last visited Jan. 21, 2020).

stress hormones remain high so that the body stays in fight, flight, and freeze mode.[199]

Multiple, chronic, or prolonged experiences with trauma, called complex trauma,[200] increase the likelihood that a child will experience toxic stress. Chronically elevated cortisol levels cause inflammation in multiple body systems, and the wear and tear on the body caused by this inflammation is the root cause of the illnesses promoted by trauma.[201]

When trauma-induced inflammation impacts the brain, it impairs the development and retention of neurological tissue, significantly reducing the number of neural connections made during development.[202] Due to this vulnerability of the developing nervous system to extreme and chronic stress, children's brains are impacted disproportionately by trauma.[203] In children, this trauma-induced process directs the organization for the developing brain, causing the areas of the brain (including the amygdala) that are responsible for fear, anxiety, and impulsivity to overproduce neural connections, while undermining neural growth between the parts of the brain needed for school success.[204]

To illustrate, magnetic resonance imaging (MRI) studies show that the more ACEs that a child experiences, the less cerebral gray matter, or brain volume, the child has in the areas of the brain involved in decision-making, memory, self-regulation, processing fear and sensory stimuli, and regulating emotions.[205]

Thus, trauma impairs the development of neural connections between the parts of the brain needed for self-regulation, attention, emotional regulation, logical and sequential thinking, healthy relationships, sensory processing, organizing, language development, measured judgment, and storage and retrieval of memories—all of which are vital for learning and behavioral success at school.[206]

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199 *See* SPORLEDER & FORBES, *supra* note 28, at 20.

200 *Id.* at 19.

201 BURKE HARRIS, *supra* note 114, at 65, 73; JACKSON NAKAZAWA, *supra* note 122, at 30–31; *What Are ACEs? And How Do They Relate to Toxic Stress?*, *supra* note 198; *see also* VAN DER KOLK, *supra* note 20, at 46 (noting how repeatedly activated stress hormones can cause memory and attention problems, irritability, sleep disorders, and long-term health issues).

202 JACKSON NAKAZAWA, *supra* note 122, at 49, 52; *Brain Architecture*, HARV. U. CTR. ON DEVELOPING CHILD, https://developingchild.harvard.edu/science/key-concepts/brain-architecture (last visited Jan. 20, 2020).

203 JACKSON NAKAZAWA, *supra* note 122, at 52–53.

204 *Id.* at 79.

205 BURKE HARRIS, *supra* note 114, at 58; JACKSON NAKAZAWA, *supra* note 122, at 74.

206 *See* JACKSON NAKAZAWA, *supra* note 122, at 53; TERESA A. MAY-BENSON, A SENSORY INTEGRATION-BASED PERSPECTIVE TO TRAUMA-INFORMED CARE FOR

As a consequence, children who experience trauma are "more likely to develop depression, bipolar disorder, eating disorders, anxiety disorders, or poor executive function and decision-making."[207] Further, children who have experienced trauma are more likely to make decisions from the lower parts of the brain that are responsible for emotions and survival impulses, including the fight, flight, or freeze response.[208] Such children are less likely to engage the prefrontal cortex of their upper brain to perform the executive functions needed to manage internal and external resources to reach goals.[209]

These executive functions include planning, controlling impulses, managing time, switching focus, organizing, remembering details, and learning from one's own experience.[210] Accordingly, traumatized children are more likely to make decisions based upon perceptions of endangerment, impulses to protect oneself from harm or failure, and desires for instant gratification rather than consideration of causes and effects, the consequences of actions, long-term goals, and effects upon others.[211] For these reasons, trauma often manifests as poor executive functioning skills, symptoms of ADHD,[212] problems with memory, problems with language and auditory processing, speech and language problems, hypersensitivity or hyposensitivity to sensory stimuli, difficulties with math or reading, and social-emotional impairments.[213]

An additional effect of trauma is hypersensitivity to threat, which promotes misbehavior. The parts of the brain that assess threat are overactivated by trauma so that the traumatized person may sense threat in stimuli that would not otherwise seem threatening.[214] This phenomenon, called "generalizing triggers," is a result of the brain

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CHILDREN 2 (2016) (explaining that trauma can cause problems with sensory processing and integration); SPORLEDER & FORBES, *supra* note 28, at 23–24; Anda et al., *supra* note 136, at 181 (noting that "impaired memory of childhood increases as the ACE score increases" and that trauma causes brain changes that promote anxiety and mood dysregulation).

207 JACKSON NAKAZAWA, *supra* note 122, at 54; *see also* ASS'N FOR TREATMENT & TRAINING IN THE ATTACHMENT OF CHILDREN, HOPE FOR HEALING: A PARENT'S GUIDE TO TRAUMA AND ATTACHMENT 35–36 (2011); VAN DER KOLK, *supra* note 20, at 62.

208 *See* SPORLEDER & FORBES, *supra* note 28, at 23–24.

209 *See id.* at 22–23; VAN DER KOLK, *supra* note 20, at 54, 58, 62–63.

210 *See* SPORLEDER & FORBES, *supra* note 28, at 22, 24; VAN DER KOLK, *supra* note 20, at 58, 62.

211 *See* SPORLEDER & FORBES, *supra* note 28, at 23.

212 *See* BURKE HARRIS, *supra* note 114, at 98–99.

213 *See id.*, at 58, 98–99; JACKSON NAKAZAWA, *supra* note 122, at 68.

214 *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TIP 57: TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES 68 (2014) [hereinafter SAMHSA, TIP 57], https://store.samhsa.gov/system/files/sma14-4816.pdf (discussing the effects of triggers on individuals with trauma).

associating threat with features of a traumatic event that, in isolation, are non-threatening.[215] With their prefrontal cortex still developing, traumatized children are especially vulnerable to being triggered into fight, flight, or freeze mode by reminders of a traumatic event, such as close physical proximity to another person, the raised voice of an adult, or the feeling of failure. In other words, trauma can cause children to be triggered at school by non-threatening reminders of a traumatic event, causing them to experience overwhelming, unpleasant emotions and to behave unexpectedly, aggressively, impulsively, or disruptively.[216]

Trauma can thus manifest in fighting, disrespectful language, opposition and defiance to instruction, leaving the classroom or school, or other behaviors that schools traditionally interpret as signs of bad character, moral failings, laziness, or lack of willpower.[217] We now know that such behaviors can be caused by traumatic changes to the brain that have nothing to do with intent or willpower.

Impaired ability to form trusting relationships and distrust of others are additional effects of trauma. Trauma undermines the ability to trust others because trauma is often caused by a trusted caregiver or family member.[218] More generally, trauma shatters assumptions about one's sense of safety and efficacy and the trustworthiness of others.[219] New research indicates that trauma changes the neurobiological processes involved in bonding and social attachment to disrupt a person's ability to form intimate relationships.[220] Traumatized chil-

[215] *See id.*; R.A. Morey et al., *Fear Learning Circuitry Is Biased Toward Generalization of Fear Associations in Posttraumatic Stress Disorder*, NATURE: TRANSLATIONAL PSYCHIATRY (Dec. 15, 2015), https://www.nature.com/articles/tp2015196 (noting that individuals with posttraumatic stress disorder "generalize fear and anxiety elicited by traumatic events to a variety of triggers that resemble the initial trauma"); Sarah Avery-Duke, *PTSD Makes Ordinary Moments Seem Terrifying*, FUTURITY (Jan. 4, 2016), http://www.futurity.org/ptsd-brains-fear-1083192-2.

[216] *See* VAN DER KOLK, *supra* note 20, at 2.

[217] *See id.* at 157 (noting that children with trauma often receive pseudoscientific diagnoses in school and other settings because the traumatic roots of their behavior are less obvious); *see also* EILEEN A. DOMBO & CHRISTINE ANLAUF SABATINO, CREATING TRAUMA-INFORMED SCHOOLS: A GUIDE FOR SCHOOL SOCIAL WORKERS AND EDUCATORS 31 (2019) (noting that issues caused by trauma "become the 'problem,' and the fact that the child has experienced trauma, or is currently, is overlooked" in school settings).

[218] ANDREA SEDLAK ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., FOURTH NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS-4) 14 (2010), https://www.acf.hhs.gov/sites/default/files/opre/nis4_report_exec_summ_pdf_jan2010.pdf (eighty-one percent of all children experiencing abuse or neglect were maltreated by their biological parents).

[219] *See* RONNIE JANOFF-BULMAN, SHATTERED ASSUMPTIONS: TOWARDS A NEW PSYCHOLOGY OF TRAUMA (1992).

[220] Anda et al., *supra* note 136, at 181.

dren may also experience difficulties negotiating relationships with peers and caregivers,[221] interpreting social cues, and understanding the feelings of others.[222] Accordingly, trauma diminishes a child's capacity to form relationships with teachers and peers and to feel that they belong and are safe and connected at school.

As to trauma's effects upon genes, studies have shown that trauma alters gene expression to significantly increase the production of stress hormones and inflammation.[223] Further, studies have shown that childhood adversity shortens the parts of human DNA, called telomeres, that protect DNA from wear and tear.[224] For instance, a recent study revealed that with each additional ACE, the odds of having short telomeres increases by eleven percent.[225] This damaged DNA, in turn, can lead to premature cellular aging and a heightened risk of disease and cancer.[226]

In summary, trauma's effects on the body and brain cause multi-system inflammation, make children more prone to illness, and disrupt the normal development of executive function, language, memory, emotional and behavioral self-regulation, and the capacities for building relationships. Consequently, trauma causes a significant proportion of children to develop disabilities that impair their educational success. As a result, many of these children need trauma-responsive specialized instruction, related services, and accommodations under an IEP or 504 plan to access their education.

III
Section 504's Readiness to Require Trauma-Responsive Education

Section 504's broad definition of disability offers a favorable avenue through which children with trauma-induced disabilities can obtain the individualized instruction, services, and accommodations they need to access their education. Two federal district court decisions in the Ninth Circuit, *Stephen C. v. Bureau of Indian Education*[227] and *Peter P. v. Compton Unified School District*,[228] illustrate this proposition and portend that parents and advocates will bring more

[221] *See* Bessel A. van der Kolk et al., *Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma*, 18 J. Traumatic Stress 389, 390 (2005).
[222] *See* Sorrels, *supra* note 26, at 139, 141 (2015).
[223] *See* Burke Harris, *supra* note 114, at 84–86; Jackson Nakazawa, *supra* note 122, at 76–78.
[224] *See* Burke Harris, *supra* note 114, at 87–89.
[225] *Id.* at 88–89.
[226] *See id.* at 87–88.
[227] No. 17-CV-08004-SPL, 2018 U.S. Dist. LEXIS 68083 (D. Ariz. Mar. 29, 2018).
[228] 135 F. Supp. 3d 1098, 1106 (C.D. Cal. 2015).

Section 504 enforcement actions to require schools to provide trauma-responsive education.

In both cases, the U.S. District Courts were persuaded by the scientific evidence showing that trauma causes disability according to Section 504's definition of disability.[229] Also persuasive were student plaintiffs' descriptions of a causal connection between their traumatic experiences and their disabilities, academic problems, and exclusion from school.[230] Further, in both cases, the courts allowed plaintiffs' claims that they were denied access to education to survive. The courts found plausible allegations that the defendant school administrators had neglected to provide trauma-responsive accommodations, failed to implement "Locate and Notify" procedures to address the needs of students with disabilities from trauma, and neglected to execute Section 504's procedural safeguard measures.[231]

Specifically, in *Stephen C.*, seven plaintiffs were high school students of Havasupai Elementary School (HES), a school operated by defendant Bureau of Indian Education on the Havasupai Indian Reservation. These plaintiffs claimed that they were disabled by virtue of their exposure to complex trauma and adversity.[232] These exposures included experiences of physical and sexual violence, involvement in the child welfare and juvenile justice systems, alcohol and substance abuse in the family and community, extreme poverty, and historical trauma.[233]

In their complaint, the student plaintiffs provided explanations, with citations to scientific literature, of the ways in which exposure to trauma and adversity can lead to "palpable, physiological harm to a young person's developing brain."[234] The complaint also detailed how each of these students' unique exposures to trauma related to their

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[229] *See Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *14 (finding "complex trauma . . . can result in physiological effects constituting a physical impairment . . . within the meaning of [Section 504]"); *Peter P.*, 135 F. Supp. 3d at 1110–11 (concluding that "complex trauma can result in neurobiological effects constituting a physical impairment for purposes of [Section 504]").

[230] *See Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *15–16 (observing a sufficient link between plaintiffs' trauma and denial of the benefits of public education); *Peter P.*, 135 F. Supp. 3d at 1111–12 (same).

[231] *See Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *21–22 (finding that plaintiffs pleaded sufficient facts to allege defendants have violated 34 C.F.R. §§ 104.32 and 104.36); *Peter P.*, 135 F. Supp. 3d at 1119 (same).

[232] *Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *11–12.

[233] *Id.* at *11–12.

[234] Third Amended Complaint for Declaratory and Injunctive Relief ¶¶ 198–200, *Stephen C.*, 2018 U.S. Dist. LEXIS 68083 (No. 17-CV-08004-SPL); *see also Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *14.

ability to perform the major life activities of reading, thinking, and concentrating at school.[235]

For instance, the complaint described how student plaintiff Durell P. experienced repeated traumatic experiences, including sexual abuse by a family member, historical trauma in the form of family experience with boarding schools, and an assault by one of his teachers.[236] The complaint described how Durell experienced challenges with emotional self-regulation, panic and anxiety, reactive behavior, and withdrawal and isolating behavior as a result of complex trauma and adversity.[237] These challenges resulted in his repeated physical exclusion from school when school administrators repeatedly sent him home early and when they suspended, expelled, and referred him to the juvenile justice system, which, in turn, arrested and detained him.[238]

The U.S. District Court for the District of Arizona rejected claims by defendants that these allegations were mere rote recitations of the legal definition of disability and sweeping generalizations of historical trauma within the Havasupai community.[239] The court held that plaintiffs adequately alleged that multiple exposures to trauma and adversity can result in physiological effects constituting a physical impairment that substantially limits major life activities according to Section 504.[240]

The court rejected defendants' claim that plaintiffs were required to provide prior notice of their disabilities in order to make a Section 504 claim.[241] The court, however, held that, had such notice been required, defendants were already on notice of plaintiffs' disabilities because they had acknowledged the impact that trauma and adversity had on HES students.[242] The court quoted a document from defendants stating that the Havasupai community has high levels of poverty, unemployment, substance abuse, and family violence and that ninety percent of its students need special education services.[243]

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235 *Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *14 (observing plaintiffs' "Complaint is replete with allegations relating each student Plaintiffs' unique exposure to complex trauma . . . to their ability to read, think, and concentrate").

236 Third Amended Complaint for Declaratory and Injunctive Relief, *supra* note 234, ¶¶ 78–80.

237 *Id.* ¶ 83.

238 *See id.*

239 *Stephen C.*, 2018 U.S. Dist. LEXIS 68083, at *13.

240 *Id.* at *14.

241 *See id.* at *16.

242 *Id.*

243 *Id.*

Further supporting plaintiffs' claims, the court held that implementation of Section 504's "Locate and Notify" mandate and its requirements to provide notice of procedural safeguards and access to relevant records were necessary to ensure meaningful access to an appropriate education for plaintiffs.[244] Moreover, the court also found it plausible that defendants neither established a system for identifying and assessing the needs of students with disabilities nor provided comprehensive assessments of students with disabilities nor employed sufficient numbers of personnel to provide special education services to meet the needs of students with disabilities.[245] The court held that plaintiffs also adequately alleged that defendants failed to provide any notice of procedural safeguards and information about how to access records.[246]

Furthermore, the court in *Stephen C.* followed the reasoning of the seminal case of *Peter P. v. Compton Unified School District* in deciding to deny, in part, defendants' motion to dismiss.[247] The plaintiffs in *Peter P.*, like the plaintiffs in *Stephen C.*, claimed that defendants Compton Unified School District (CUSD), CUSD's Superintendent, and the individual members of CUSD's Board of Trustees violated Section 504.[248]

The *Peter P.* plaintiffs, which included five students and three teachers, described in their complaint the numerous traumas, including chronic racism, endured by each student plaintiff.[249] The complaint described, for instance, how plaintiff Peter P. experienced homelessness, watched as his best friend was shot and killed, witnessed physical abuse of his siblings and mother, and was repeatedly sexually and physically abused by his mother's boyfriends.[250] The complaint described the psychological, emotional, and physical effects of each student plaintiff's traumatic events and how, without a system by CUSD of accommodations and modifications to address these effects, each plaintiff was unable to access their education.[251] For Peter P., for example, the complaint described uncontrollable anger,

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[244] *Id.* at *19, *20–21.

[245] *Id.* at *19–20, *21–22.

[246] *Id.* at *21–22.

[247] *Id.* at *16, *19, *21.

[248] *See* Peter P. v. Compton Unified Sch. Dist., 135 F. Supp. 3d 1098, 1106 (C.D. Cal. 2015).

[249] *See* Complaint ¶¶ 13–36, *Peter P.*, 135 F. Supp. 3d 1098 (15-cv-03726-MWF-PLA).

[250] *Peter P.*, 135 F. Supp. at 1104; Complaint, *supra* note 249, ¶¶ 14–18.

[251] *See, e.g.*, Complaint, *supra* note 249, ¶ 20 (recounting the effects of Peter P.'s trauma on his experiences in CUSD schools).

declining grades, repeated suspensions, and an involuntary transfer between schools (which is similar to expulsion).[252]

Using numerous citations to scientific literature, the complaint described the neurobiological effects of complex trauma and argued that such effects impaired the plaintiffs' ability to perform "activities essential to education," including learning, thinking, reading, and concentrating.[253] "The science is clear: trauma causes palpable, physiological harm to a young person's developing brain," they wrote.[254] "Although even a single traumatic experience can impair a child's ability to learn," they argued, "[s]tudent Plaintiffs . . . are subjected to multiple, repeated, and sustained traumatic experiences."[255] The plaintiffs claimed that defendants, who received federal financial assistance, violated Section 504's prohibition against excluding the participation of, denying benefits to, or subjecting to discrimination an individual with a disability on the basis of such disability.[256] Their complaint described numerous trauma-responsive interventions, services, and accommodations to address student trauma, including approaches for the entire school to implement ("school-wide approaches") and interventions to rebuild relationships, repair harm, and reintegrate individual students into the school community.[257]

The U.S. District Court for the Central District of California held that plaintiffs' complaint alleged facts sufficient to show that complex trauma causes neurobiological effects constituting a physical impairment under Section 504.[258] The court also held that, for purposes of surviving a motion to dismiss, plaintiffs adequately alleged that they were denied the benefits of a public education solely by reason of their claimed disability because they had claimed that defendants, despite their ability to do so, had failed to implement reasonable accommodations to create a trauma-sensitive environment that would allow students to enjoy the benefits of public education.[259]

The court rejected defendants' argument that trauma only amounts to "environmental, cultural, and economic disadvantages not considered a physical or mental impairment."[260] The court held that

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[252] *See id.*

[253] *Peter P.*, 135 F. Supp. 3d at 1105; *see also* Complaint, *supra* note 249, ¶¶ 107–52 (reviewing scientific literature on trauma and cognitive development and how it impedes meaningful access to education).

[254] Complaint, *supra* note 249, ¶ 122.

[255] *Id.* ¶ 73.

[256] *Id.* ¶¶ 192–200.

[257] *Id.* ¶¶ 174–76.

[258] *Peter P.*, 135 F. Supp. 3d at 1110–12.

[259] *Id.* at 1114.

[260] *Id.* at 1109.

plaintiffs' description of the effects of trauma went beyond such allegations, and it highlighted the following analogies raised by plaintiffs: "If an individual required a wheelchair as a consequence of a neighborhood shooting, . . . that individual would be protected under Section 504 and the ADA. An intellectual disability due to exposure to lead paint or extreme malnutrition would be likewise cognizable under the Acts."[261]

The court also found unconvincing defendants' assertion that trauma amounts to "nothing more than expected, culturally approved responses to a 'common stressor or loss, such as the death of a loved one.'"[262] Defendants argued that trauma thus does not meet the criteria for a diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), a book created by mental health professionals that defines and classifies mental disorders.[263] The fifth edition of the DSM ("DSM-5") defines "mental disorder" as the following:

> [A] syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. . . . An expectable, or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder.[264]

The court found persuasive plaintiffs' argument that countless courts repeatedly made clear that an impairment need not be listed or categorized as a disorder by the DSM or elsewhere to state a claim under Section 504 but that, nevertheless, trauma fits within the definition of "mental disorder" in the DSM.[265] The court also summarized plaintiffs' detailed description of the effects of trauma on the brain and body to show the validity of plaintiffs' claim that trauma resulted in mental disorder.[266]

Like the court in *Stephen C.*, the court in *Peter P.* held that implementation of Section 504's "Locate and Notify" mandate was an important part of the law's requirement to give meaningful access to persons with disabilities.[267] The court held that CUSD's failure to train teachers to recognize and address trauma-related disabilities was central to plaintiffs' theory of disability-based disadvantage and that

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261 *Id.*

262 *Id.*

263 *See id.*

264 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-5, at 20 (5th ed. 2017).

265 *Peter P.*, 135 F. Supp. 3d at 1110–11; Am. Psychiatric Ass'n, *supra* note 264, at 20.

266 *Peter P.*, 135 F. Supp. 3d at 1110.

267 *See id.* at 1119.

defendants' failure to adhere to the mandate to locate children with disabilities was logically related to such failure.[268]

Given Section 504's open-ended definition of disability and the success of *Stephen C.* and *Peter P.*, parents and advocates will likely seek to enforce Section 504 many more times in California and other states in order to compel whole schools to become trauma-responsive or to at least require them to provide trauma-responsive accommodations to the students most impaired by trauma.

IV
The Current Unsuitability of IDEA to Guarantee Trauma-Responsive Education

Because IDEA's definition of disability is less open-ended than that of Section 504 and lacks a trauma-specific categorization, the extent to which IDEA, in its current form, will give traumatized students access to their education is less promising. IDEA is not currently designed to enable schools to consistently identify children who have disabilities stemming from trauma and to provide them with access to education. The reasons are multifold. Gathering a history of adversity and trauma and performing assessments to gauge for trauma's effects are not regularly part of evaluations conducted under IDEA, even though standardized screenings and assessments for trauma exist.[269] IDEA does not have a disability category that captures the complex and often multi-faceted impact of trauma on the brain and behavior.[270] IDEA does not mention trauma in its statute or regulations, and thus nothing in the law would prompt evaluators or educators to consider the significant impact that trauma may have upon a child's disabilities. Schools do not typically have trauma-responsive resources, such as trauma-informed therapists and trauma-informed special educators, that are skilled in addressing trauma's effects through special education, related services, or accommodations. As a result of these factors, trauma is not usually mentioned explicitly in IEPs or evaluations, nor addressed through annual goals, specialized instruction, services, or accommodations.

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268 *Id.*

269 *See Evaluating Children for Disability*, Ctr. for Parent Info. & Resources (Sept. 9, 2017), https://www.parentcenterhub.org/evaluation/#scope (describing types of screenings typically performed under IDEA); SAMHSA, Tip 57, *supra* note 214, at 271 (cataloging screening and assessment instruments for trauma).

270 *See* Dombo & Sabatino, *supra* note 217, at 31 (noting that "[t]he current definition of 'emotional disturbance' is critiqued as being too vague and subjective, as evidenced by inconsistent use and application across districts and states").

For these reasons, IDEA is not yet trauma-informed, meaning that it does not reflect current understandings of trauma and its effects. Being trauma-informed means realizing the widespread impact of trauma and the potential paths for recovery; recognizing the signs and symptoms of trauma in others; responding to trauma by integrating knowledge about trauma into policies, procedures, and practices; and actively resisting re-traumatizing others.[271] IDEA is also not trauma-responsive, meaning that it does not provide interventions that seek to alleviate trauma symptoms and lead to a higher level of functioning in children affected by trauma.[272] Further, IDEA is not healing-centered, meaning that it does not involve explicit processes for restoring individuals and communities back to optimal health and well-being after the infliction of harm or injury.[273]

These deficiencies cause IDEA to fail to give educational access to many children experiencing traumatic stress, even though trauma increases the need for special education. Studies show that children who experience traumatic stress are three times more likely to have an IEP than children who haven't experienced such stress.[274] But few children experiencing traumatic stress receive special education that is tailored to address the effects of trauma. This section highlights a major legal reason for this problem: the lack of a trauma-specific disability categorization in IDEA.

A. *Inadequate IEP Classification for Traumatized Children*

IDEA does not have a disability category that captures the complex and often multi-faceted impact of trauma upon executive function, memory, cognition, emotional and behavioral self-regulation, language development, sensory processing, and social functioning. Consequently, traumatized children who are identified as needing special education are often categorized as having "Other Health Impairment" (OHI) or "Emotional Disturbance" (ED) even though these categories do not adequately describe the effects of trauma. IEPs based upon OHI and ED categorizations are likely to miss important components of a trauma-responsive IEP, and they might provide interventions that are inappropriate for children who have

[271] *Trauma*, SAMHSA-HRSA Ctr. for Integrated Health Solutions, https://www.integration.samhsa.gov/clinical-practice/trauma (last visited Jan. 22, 2020).

[272] *See, e.g.*, *Information Sheet on Trauma-Responsive Care Certification (TRCC)*, Tristate Trauma Network, http://www. tristatetraumanetwork. org/wp-content/uploads/2017/05/TRCC_Information_Sheet.pdf (last visited Jan. 22, 2020) (describing elements of trauma-responsive care).

[273] *See* Shawn Ginwright, Hope and Healing in Urban Education 7–9 (2015) (defining healing justice).

[274] *See* Goodman et al., *supra* note 167, at 256.

experienced trauma. Further, because IDEA lacks an adequate trauma-specific categorization, Child Find fails to identify all children with trauma-related disabilities who need special education.

In the recent experience of HJA and the University of the District of Columbia's Juvenile and Special Education Law Clinic, a child experiencing traumatic stress who receives an IEP is usually categorized as having OHI or ED.[275] These categorizations are consistent with the fact that children who are significantly impacted by trauma commonly receive diagnoses of ADHD, separation anxiety disorder, oppositional defiant disorder, affective disorders, borderline personality disorder, phobic disorders, and PTSD.[276] The problem with OHI and ED, however, is that they do not reflect the current knowledge about trauma's many effects and thus they highlight only a limited aspect of those effects. As a result, their use with children with traumatic stress leaves such children vulnerable to the exclusion and academic failure that FAPE is supposed to prevent.

Specifically, OHI is defined by IDEA as "having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment" that is due to chronic or acute health problems, such as ADHD or PTSD, and adversely affects a child's educational performance.[277] In practice, schools often categorize a child as having OHI without diagnosing the chronic or acute health problem underlying that categorization. Accordingly, schools that detect some impairments of executive function, such as poor attention or concentration, easy distractibility, or impulsivity, which may be caused by trauma, will identify traumatized children as having "Other Health Impairment" based on suspicions that the child has ADHD.

OHI, based upon suspected ADHD, which is a neurological disorder "characterized by developmentally inappropriate levels of inattention, hyperactivity, and impulsivity,"[278] might describe the decreased attention and concentration caused by trauma's impact

[275] *See* Confidential Educational Records of Health Justice Alliance Clients, *supra* note 12.

[276] *See* van der Kolk et al., *supra* note 221, at 390; T. DeAngelis, *Current Trauma Diagnoses*, MONITOR ON PSYCHOL., Mar. 2007, at 34.

[277] 34 C.F.R. § 300.8(b)(9) (2019).

[278] *About ADHD – Overview*, CHADD, https://chadd.org/about-adhd/overview (last visited Jan. 22, 2020); *see also* AM. PSYCHIATRIC ASS'N, *supra* note 264, at 59–61 (providing diagnostic criteria for ADHD).

upon executive functioning, but it fails to address many other common aspects of trauma's impact.[279]

Further, an OHI categorization, based on suspected ADHD, suggests interventions that may not be ideal for children experiencing traumatic stress. Primary treatments for ADHD are medication and behavioral management that often involves the use of reward systems to induce positive behaviors.[280] Although schools are prohibited from requiring a child to take medication,[281] an OHI categorization based upon suspected ADHD suggests to many parents that a child may need stimulants or other medications in order to make educational progress, even though such medications are not indicated for the treatment of traumatic stress. Further, behavioral management systems that provide rewards for desired behaviors and consequences for undesired behaviors can be ineffective and even counter-productive for children experiencing traumatic stress. The reason, as mentioned previously, is that traumatic stress reduces the brain's ability to consider the consequences of actions.[282] Thus, many children with such stress fail in an environment that is based on reward and punishment,[283] and some are likely to be triggered by such an environment.

One might suspect that PTSD would be a basis for giving a traumatized child an OHI categorization, but most children who have been affected by trauma in their homes or communities do not meet the criteria for PTSD.[284] The PTSD diagnosis, established in 1980, was created to describe the effects of war upon men, not the effects of trauma in the home or community upon children.

PTSD's main symptoms are re-experiencing the trauma (also called intrusion), avoidance,[285] arousal, and negative alterations in

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[279] These impacts include generalizing triggers; impaired ability to trust others and form healthy relationships; impairments in establishing and retrieving memories; and problems with sensory processing, sequential thinking, and emotional regulation.

[280] *See My Child Has Been Diagnosed with ADHD – Now What?*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/ncbddd/adhd/treatment.html (last updated Oct. 8, 2019).

[281] *See* 20 U.S.C. § 1412(a)(25) (2018) (prohibiting mandatory medication in its discussion of state eligibility requirements).

[282] Sporleder & Forbes, *supra* note 28, at 34.

[283] *See id.*

[284] van der Kolk, *supra* note 20, at 157 (showing that eighty-two percent of the traumatized children seen in the National Child Traumatic Stress Network do not meet diagnostic criteria for PTSD).

[285] Avoidance involves creating coping mechanisms to circumvent confrontation with internal and external reminders of the traumatic experience. These mechanisms include emotional detachment or dissociation; diminished affect (displays of emotion) and interests; and evading people, places, activities, or situations that remind the person of the trauma. Arousal is characterized by difficulty concentrating, hyperactivity, jumpiness or quickness to startle, sleep disturbance, self-destructive or reckless behavior, irritability or

cognitions and mood associated with the events.[286] Re-experiencing is characterized by images, sensation, or memories of the traumatic event recurring uncontrollably through flashbacks, disturbing thoughts, or nightmares, and they are usually accompanied by psychological distress.[287] Re-experiencing can also occur through exposure to "triggers," which are things, events, situations, places, sensations, or even people that a youth consciously or unconsciously connects with a traumatic event.[288]

For a child to be diagnosed with PTSD, the traumatic event must involve exposure to actual or threatened death, serious physical injury, or sexual violence.[289] The child must also exhibit at least one re-experiencing symptom, three avoidance symptoms, and two arousal symptoms for at least a month.[290] Children experiencing traumatic stress rarely exhibit all of these symptoms, and the traumatic stress may come from experiences that do not involve exposure to death, physical injury, or sexual violence.[291] As a result, OHI based on PTSD is rarely a categorization given to children suffering from traumatic stress.

Instead, many children who experience traumatic stress are categorized as having emotional disturbance, which is defined by IDEA as:

> "[A] condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general pervasive mood of unhappiness or

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aggression, and hyper-vigilance. Negative alterations in cognitions and mood include inability to remember an important aspect of the traumatic event; persistent and exaggerated negative beliefs or expectations about oneself, others, or the world; distorted cognitions about the cause or consequences of the traumatic event; persistent negative emotional state (e.g., anger, guilt, fear, or shame); diminished interest or participation in significant activities; feelings of detachment or estrangement from others; and inability to experience positive emotions. *See* AM. PSYCHIATRIC ASS'N, *supra* note 264, at 271–72.

286 *See id.*

287 *See id.* at 271.

288 *See id.*

289 *Id.*

290 *See* NAT'L COLLABORATING CTR. FOR MENTAL HEALTH, POST-TRAUMATIC STRESS DISORDER: THE MANAGEMENT OF PTSD IN ADULTS AND CHILDREN IN PRIMARY AND SECONDARY CARE § 9.2.1 (2005); Goodman et al., *supra* note 167, at 253.

291 *Cf.* van der Kolk et al., *supra* note 221, at 390 (arguing that PTSD captures only a limited aspect of posttraumatic psychopathology); John Briere & Catherine Scott, *Complex Trauma in Adolescents and Adults*, 38 PSYCHIATRIC CLINICS OF N. AM. 515, 516 (2015).

> depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems."[292]

Children who are "socially maladjusted, unless it is determined that they have an emotional disturbance" are excluded from this category, but IDEA does not define "socially maladjusted" and does not indicate how a child who might appear to be socially maladjusted might actually have an emotional disturbance.[293]

ED is problematic because the special education system usually fails to give children labeled with ED the support that they need to access their education and make educational progress.[294] Studies reveal a general lack of implementation of evidence-based practices with children labeled with ED.[295] As a result, children receiving special education under the ED category perform worse educationally than children with any other IDEA disability categorization. The majority of children labeled with ED fail to graduate from high school.[296] Compared to children with any other IDEA disability categorization except intellectual disability, children with ED are least likely to enroll in college.[297] Seventy-one percent of young adults with ED are stopped by police and 43.2% are arrested within six years after high school.[298] Further, young adults with ED are more likely to be stopped by police, arrested, incarcerated, or placed on probation or parole within six years after high school than young adults in any other disability category.[299]

Further, the label of ED stigmatizes and shames children. Its name suggests an inherent and unresolvable problem with the child rather than a common, adaptive, biologically-mediated reaction to trauma that can be resolved. Scientific research indicates that traumatic stress reactions in children, including decreased ability to trust others and fight-or-flight responses to triggers, manifest efforts by the

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[292] 34 C.F.R. § 300.8(b)(4)(i) (2018).

[293] *Id.* § 300.8(b)(4)(ii).

[294] *See* Talida M. State et al., Bridging the Research-to-Practice Gap Through Effective Professional Development for Teachers Working with Students with Emotional and Behavioral Disorders, 44 BEHAV. DISORDERS 107, 108 (2018) (identifying structural issues in the special education system that harm students labeled with ED, such as teacher shortages, high teacher turnover, and poor teacher certification).

[295] *See id.* at 108 (reporting insufficient numbers of teachers with adequate training to competently address the needs of students with emotional and behavioral disorders).

[296] *See* Larry J. Kortering & Jose Blackorby, *High School Dropout and Students Identified with Behavioral Disorders*, 18 BEHAV. DISORDERS 24, 25 (1992).

[297] *See* LYNN NEWMAN ET AL., THE POST-HIGH SCHOOL OUTCOMES OF YOUNG ADULTS WITH DISABILITIES UP TO 8 YEARS AFTER HIGH SCHOOL: A REPORT FROM THE NATIONAL LONGITUDINAL TRANSITION STUDY-2 (NLTS2) 19 (2011).

[298] *See id.* at 145.

[299] *See id.* at 146.

child's brain and body to protect the child and cope with a traumatic experience.[300] In other words, they are signs of resilience to trauma, and they are *normal* reactions to abnormal situations.[301] When traumatic stress reactions occur in school, however, rather than in the context of the original traumatic experience, they can easily be misunderstood and judged. The ED label embodies such misunderstanding and judgment for many children.

Children have cried in IEP meetings and court hearings upon hearing that they have "emotional disturbance" because the label suggests to them that they are crazy or broken.[302] The ED label perpetuates the traditional approach to children who struggle in school, in which adults tend to ask, "What is wrong with you?" rather than respond in a trauma-sensitive manner with, "What is your stress level?," "What are you dealing with?," "I'm here to help you be safe," and "How can I help?" Trauma typically causes children to feel ashamed, and the label of ED compounds the harm caused by trauma.

Because trauma can impair multiple significant areas of a child's functioning at school, such as a child's alertness and emotional regulation, sometimes the disability category of multiple disabilities (MD) is the most appropriate category in IDEA for describing a child impacted by trauma. IDEA's regulations define multiple disabilities as "concomitant impairments . . . , the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments."[303] Multiple disabilities is not commonly used by schools as a category, however, because school staff tend to be reluctant to indicate that a child has "severe educational needs." In addition, because many states' forms for IEPs ask for a "primary disability" category, IEP teams tend to categorize children according to the disability category that seems to describe the child's most severe impairment, rather than providing a holistic picture of the child's functioning.

Unfortunately, because the categories of ED, OHI (based on ADHD), and multiple disabilities do not point to the need to address trauma, such categorizations do not help to make an IEP trauma-informed, much less trauma-responsive. As trauma expert Dr. Bessel

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300 *See* SAMHSA, TIP 57, *supra* note 214, at 13.

301 *See id.*

302 For example, one child, upon hearing that she was being categorized as having emotional disturbance, exclaimed tearfully that she was not crazy. *See* Statement of a Client's Child During a Hearing in the Courtroom of D.C. Superior Court Associate Judge Jennifer Anderson (Dec. 12, 2016) (recording on file with the D.C. Superior Court Reporting Division).

303 34 C.F.R. § 300.8(c)(7) (2019).

van der Kolk noted regarding diagnoses conventionally used to describe the impact of trauma, "None of these diagnoses will be completely off the mark, and none of them will begin to meaningfully describe who these [individuals] are and what they suffer from."[304]

B. The Limitations of the "Child Find" Mandate for Traumatized Children

Because IDEA does not recognize trauma as a source of or contributor to disability, schools regularly deny special education to children whose problems appear to arise from trauma. Two cases highlight this reality. The first case is *Horne v. Potomac Preparatory P.C.S.*,[305] in which the local educational agency denied eligibility to receive special education to a six-year-old child who attempted suicide by jumping out of a school window. The agency justified its decision by claiming that the child's emotional issues "can mostly be attributed to familial transitions and traumatic events."[306] The U.S. District Court ultimately held that the child qualified for special education under the category of emotional disturbance.[307]

A second case highlights how schools, hearing officers, and courts experience confusion and uncertainty about how to treat impairments related to trauma. In *N.C. ex rel. M.C. v. Bedford Central School District*,[308] the Southern District of New York upheld the school's denial of eligibility to a high school student whose behavior deteriorated when he experienced repeated sexual abuse. The school's social worker reported that the child experienced an "extremely traumatic history beginning when he was twelve years old," that his oppositional behavior escalated during tenth grade, and that he "medicated his depression with pot."[309] The student in *N.C.* was suspended three times in less than three months for fighting with other students and for drug possession.[310] He talked about killing himself and self-reported attention problems, rule-breaking behavior, and aggression.[311]

Applying the definition of emotional disturbance, which includes "inappropriate types of behavior or feelings under normal circumstances,"[312] the school district in *N.C.* determined that the child's behavior and feelings were not "inappropriate under normal circum-

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[304] van der Kolk, *supra* note 20, at 136–37.
[305] 209 F. Supp. 3d 146, 151 (D.D.C. 2016).
[306] *Id.* at 150.
[307] *See id.* at 158.
[308] 473 F. Supp. 2d 532, 544 (S.D.N.Y. 2007).
[309] *Id.* at 536–37.
[310] *See id.* at 545.
[311] *See id.* at 536.
[312] 34 C.F.R. § 300.8(c)(4)(C) (2018).

stances" because the traumatic events in the child's life made his circumstances "anything but normal."[313] Accordingly, because the child had been through a "terrible ordeal, [the child] could be expected to act out, and therefore his behavior was not inappropriate for the purposes of the IDEA."[314] Thus, according to the school district, he did not qualify for special education under the emotional disturbance disability category.[315]

The Southern District Court of New York disagreed with that approach and determined that, instead, "we must consider what would be appropriate behavior for a child who had never experienced any of the horrors experienced by [the child], and determine whether [the child's] behavior is appropriate in relation to that child's conduct."[316] The district court found that the child's worsening substance abuse and heightened aggression were characteristic of social maladjustment rather than emotional disturbance and accordingly held that the child did not qualify for special education.[317]

These cases highlight the variability with which different decisionmakers view the importance and role of trauma's impact upon children's educational progress. They also highlight the confusion that arises when IDEA's current disability categorizations are applied to children who have experienced trauma. The lack of a trauma-specific disability category in IDEA means that Child Find will continue to fail to find many children with trauma-related disabilities who need special education.

V
The Imperative to Make IDEA and Section 504 Trauma-Responsive

The purposes and requirements of IDEA and Section 504 can only be met through integrating our new knowledge about trauma into the language and application of these laws. Making IDEA and Section 504 and their implementation trauma-responsive is essential to making special education, related services, and accommodations effective and to giving educational access to *all* children with disabilities. There are three main ways to make IDEA and Section 504 and their application trauma-responsive: (1) requiring assessment of trauma's impact when trauma is suspected to be a cause of disability in a child; (2) adding a stand-alone trauma-specific disability category

313 *N.C.*, 473 F. Supp. 2d at 544.
314 *Id.*
315 *Id.*
316 *Id.* at 544–45.
317 *Id.* at 545.

to IDEA's disability categories and recognizing that trauma causes disability under Section 504; and (3) putting trauma-responsive specialized instruction, services, and accommodations, including trauma-responsive therapy and restorative justice, into IEPs and 504 plans.

A. Strategies for Trauma-Responsive Evaluation of Children

"If clinicians are not routinely identifying ACEs, . . . there might be a heightened risk of missing an underlying trauma history or misattributing some of the symptoms of traumatic stress as solely those of ADHD."

—Nicole M. Brown, et al., 2017[318]

"I can't tell you why he's not learning, but everyone knows that this new stability that will come when he moves from a shelter to a home will help him to learn."

—Anonymous Special Education Coordinator, 2018[319]

The science regarding trauma shows how critical early detection is.[320] The earlier and more effectively our school systems can identify children impacted by traumatic stress, the better these systems can minimize the harm of such stress upon lifelong health and learning and the more effective our special education system will be at preparing a child with a disability for future education, employment, and independent living. This is why screening and assessment for trauma and its effects is essential for making educational systems trauma-responsive.

Unfortunately, evaluators and mental health providers seldom ask about history of exposure to adversity or trauma during mental health treatment and evaluations.[321] Given the prevalence of trauma and its pervasive disabling effects, however, screening and assessment to gauge exposure to potentially traumatic experiences and identify

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[318] Nicole M. Brown et al., *Associations Between Adverse Childhood Experiences and ADHD Diagnosis and Severity*, 17 ACAD. PEDIATRICS 349, 350 (2017).

[319] Statement of Anonymous Special Education Coordinator During an IEP meeting at Patterson Elementary School, a District of Columbia Public School (May 30, 2018).

[320] *See* BURKE HARRIS, *supra* note 114, at 90.

[321] *See, e.g.*, RECRUITMENT, TRAINING & SUPPORT CTR. FOR SPECIAL EDUC. SURROGATE PARENTS, TRAUMA SENSITIVITY DURING THE IEP PROCESS 1 (2013); Bonnie D. Kerker et al., *Do Pediatricians Ask About Adverse Childhood Experiences in Pediatric Primary Care?*, 16 ACAD. PEDIATRICS 154, 154 (2016) (recording that only four percent of pediatricians usually ask about all of the ACEs); John Read et al., *Do Adult Mental Health Services Identify Child Abuse and Neglect? A Systematic Review*, 27 INT'L J. MENTAL HEALTH NURSING 7, 7, 13 (2018) (showing that twenty percent, or less, of adult mental health users were asked about experiences with child abuse and neglect).

effects of trauma should become a regular part of evaluations conducted under IDEA and Section 504.

Accordingly, Congress should amend 20 U.S.C. § 1414(b)(2)(A) to require evaluators to collect historical, not just functional, developmental, and academic, information about a child. Historical information that should be collected includes information about housing stability (including inquiry into any periods of homelessness), food insecurity, death or incarceration of family members, who the child lives with and whether the child's parents are separated, the child's primary caretaker(s), exposure to violence inside the home and outside of the home, and a history of major injuries, illnesses, and medical treatments.

Because IDEA requires all evaluations to assess a child in all areas of suspected disability,[322] any time trauma is suspected to be a possible cause of disability for a child, screening and assessment for trauma and its effects should be part of the child's initial evaluation or re-evaluation under IDEA. Also, signs that traumatic stress may be impairing a child should lead to such screening and assessment. Such screening and assessment will be critical in providing the child's IEP team with a complete picture of the child's functional, developmental, and academic needs, which will enable the team to design an IEP that is tailored to the child's unique needs.[323]

Trauma screening should measure a wide range of potentially traumatic experiences and events and identify common reactions and symptoms of trauma.[324] Existing screenings for trauma include the Childhood Trauma Questionnaire, Whole Child Assessment (WCA), and the Traumatic Events Screening Inventory for Children (TESI-C).[325]

Current assessments for identifying and addressing the needs of children with trauma include the Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model and Child and Adolescent Needs and Strengths (CANS) – Trauma

322 20 U.S.C. § 1414(b)(3)(B) (2018).

323 *See* Z.B. v. District of Columbia, 888 F.3d 515, 523 (D.C. Cir. 2018).

324 *See Screening and Assessment*, NAT'L CHILD TRAUMATIC STRESS NETWORK (Dec. 11, 2017), https://www.nctsn.org/treatments-and-practices/screening-and-assessment.

325 *See* JACKSON NAKAZAWA, *supra* note 122, at 26; Ariane Marie-Mitchell et al., *Implementation of the Whole Child Assessment to Screen for Adverse Childhood Experiences*, 6 GLOBAL PEDIATRIC HEALTH 1, 2 (2019); *An Interview for Children: Traumatic Events Screening Inventory (TESI-C)*, NAT'L CTR. FOR PTSD, https://www.ptsd.va.gov/professional/assessment/documents/TESI-C.pdf (last visited Jan. 20, 2020).

Comprehensive Version.[326] Up-to-date information on best practices for trauma screening and assessment can be found at The National Child Traumatic Stress Network, a national organization established and funded by Congress since 2000 that develops and distributes knowledge of evidence-based practices for identifying and treating "mental, behavioral, and biological disorders of children and youth resulting from witnessing or experiencing a traumatic event."[327]

For children whose behavior is disruptive or fails to meet expectations, trauma-responsive functional behavioral assessments (FBAs) should be performed to identify what drives the behavior.[328] Such assessments gather information about the cause and purpose of problematic behavior and develop a program of intervention based on that information.[329] Trauma-responsive FBAs assess whether a child has potentially distorted views of authority figures,[330] and they examine how a child's impaired trust of others impacts behavior. Trauma-responsive FBAs also look for triggers in the child's school environment that give rise to a fight, flight, or freeze emotional response.[331] Such FBAs should document the change in the child's stress level when they are triggered. FBAs should also document the behavior and stress levels of adults who are responding to a particular behavior because adult dysregulation typically amplifies a child's traumatic stress response.

Trauma-responsive FBAs should recommend ways to minimize a child's exposure to triggers in the school and classroom settings, as well as describe ways to help a child who is triggered to connect with an adult who helps the child to feel safe, regulate his/her emotions, and make appropriate choices.[332]

IEPs should explicitly describe findings from trauma-responsive screenings and assessments so that educators can become informed about a potential source of a child's disabilities and recognize the unique impact of trauma upon a child's social, cognitive, academic, emotional, and behavioral functioning.

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326 *See Trauma-Informed Mental Health Assessment*, NAT'L CHILD TRAUMATIC STRESS NETWORK, https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-informed-mental-health-assessment (last visited Jan. 22, 2020).

327 *See* 42 U.S.C. § 290hh-1(a) (2018).

328 *Cf.* SPORLEDER & FORBES, *supra* note 28, at 169 (describing external and internal factors that might drive behavior).

329 *See* COLE ET AL., *supra* note 35, at 66 (explaining the process and inputs for a FBA).

330 *See* RECRUITMENT, TRAINING & SUPPORT CTR. FOR SPECIAL EDUC. SURROGATE PARENTS, *supra* note 321, at 3.

331 *See id.* (explaining that FBAs collect information about environment and internal challenges, like trauma triggers).

332 *See* 20 U.S.C. § 1415(k)(1)(F) (mandating that the local educational agency, parent, and IEP team conduct a FBA).

Screening and assessment for trauma and its effects will enable IEP and 504 teams to create individualized educational plans that are truly tailored to address the special educational needs of children with disabilities.[333] Failure to regularly screen and assess for trauma will yield IEPs and 504 plans that are not appropriately tailored to many children, denying them appropriate education.[334]

B. The Benefits of Ensuring that Trauma's Disabling Effects Are Recognized by IDEA and Section 504

"I don't pay attention to the research. I pay attention to the law."
—A special education coordinator in Washington, D.C.[335]

The IDEA statute should be amended to contain a trauma-specific disability categorization, and courts and school staff should recognize that trauma causes disability under Section 504. These changes will help school systems to identify children with disabilities stemming from trauma under IDEA's Child Find and Section 504's "Locate and Notify" mandates and provide them with necessary services. Because an earlier section in this Article described how U.S. District Courts in California concluded that trauma may cause disability under Section 504's definition of disability,[336] this Section of the article focuses on the benefits of creating a trauma-specific disability categorization in IDEA.

The existence of a trauma-specific disability categorization in IDEA, such as one called "developmental trauma," would enable IEP teams to describe the frequently complex and multi-faceted disabling effects of trauma without having to resort to the inadequate categories of OHI or ED. A trauma-specific disability categorization would guide IEP teams to look broadly for trauma's disabling effects since such effects are not limited to just attentional, cognitive, social-emotional, language, or sensory aspects of a child's functioning. A trauma-specific disability categorization would also inform educators about the cause and nature of a child's disabilities and how to address them and would prevent the need to give a traumatized child a stigmatizing label or multiple labels. Such a categorization would help to promote a trauma-informed culture at schools in which the resilience

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[333] *Cf.* Z.B. v. District of Columbia, 888 F.3d 515, 522 (D.C. Cir. 2018) ("The evaluation and information-gathering procedures of the IDEA are designed to position the IEP team . . . to create an IEP tailored to the student's special educational needs.").

[334] *See id.* at 522–23 ("Failure to follow these procedures may yield an IEP that is not appropriately tailored to the student, denying [them] an appropriate education.").

[335] Statement of Anonymous Special Education Coordinator During an IEP Meeting at Patterson Elementary School, a District of Columbia Public School (May 30, 2018).

[336] *See supra* Part III.

and strengths of students who survive trauma are appreciated rather than pathologized.[337] Further, the existence of a trauma-specific disability categorization in IDEA would help to prevent failure to "find," through Child Find, children with disabilities from trauma.

Physicians, psychologists, and scientists are seeking to establish a new medical diagnosis to describe the pervasive effects of trauma on children.[338] Proposed names for this new diagnosis include developmental trauma disorder (DTD), complex developmental trauma, complex PTSD, complex trauma, disorders of extreme stress not otherwise specified, self-capacity disturbance, and enduring personality change after catastrophic events (EPCACE).[339] DTD is the prevailing proposed diagnosis and is characterized by exposure to trauma, dysregulated development of emotions, and impairment at school and in family relations, among other symptoms.[340] Many clinicians have advocated to place DTD into the DSM,[341] although the DTD diagnosis does not yet capture all of the known effects of trauma.

Policymakers and educators need not wait for the medical community to finalize a diagnosis describing trauma's effects, however. The district court in *Peter P.* subscribed to the plaintiff's argument that the effects of trauma are already described by the DSM's diagnosis of "mental disorder."[342] Further, IDEA's disability categories, which were primarily created over time by professional committees that advised the U.S. Department of Education,[343] do not rely upon medical definitions of disability.[344]

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337 *See generally Trauma*, *supra* note 271 (describing how the trauma-informed approach recognizes the role trauma plays in children's lives by recognizing and accepting symptoms and difficult behaviors as strategies developed to cope with childhood trauma); SAMHSA, TIP 57, *supra* note 214, at 13.

338 *See, e.g.*, VAN DER KOLK, *supra* note 20, at 164–66 (describing the scientific response to the DSM-V and the need to understand childhood development).

339 *See, e.g.*, Briere & Scott, *supra* note 291, at 517 (listing new characterizations of this phenomenon).

340 *See* VAN DER KOLK, *supra* note 20, at 158; T. DeAngelis, *What the New Diagnosis Would Include*, MONITOR ON PSYCHOL., Mar. 2007, at 33.

341 *See* VAN DER KOLK, *supra* note 20, at 159, 164–66.

342 Peter P. v. Compton Unified Sch. Dist., 135 F. Supp. 3d 1098, 1110–11 (C.D. Cal. 2015) (describing and then agreeing with the plaintiff's argument that it is not necessary for a mental disorder to be listed or categorized by the DSM to state a claim under the ADA); *cf.* AM. PSYCHIATRIC ASS'N, *supra* note 264, at 20 (defining "mental disorder").

343 *See, e.g.*, Kenneth A. Kavale & Steven R. Forness, *Defining Learning Disabilities: Consonance and Dissonance*, *in* ISSUES IN EDUCATING STUDENTS WITH DISABILITIES 9 (John Wills Lloyd et al. eds., 1997) (describing how the definition for learning disability offered by the National Advisory Committee on Handicapped Children in 1968 provided the basis for the specific learning disability category in IDEA).

344 *See* Robert Crabtree, *DSM-5 and Special Education*, SPECIAL EDUC. TODAY (May 24, 2013), https://kcsspecialeducationlaw.com/2013/05/24/dsm-v-and-special-education (stating that IDEA's criteria for eligibility for special education do not refer to the DSM,

In fact, while medical concepts of disorders inform IDEA's disability categories, most of IDEA's disability categories do not conform with medical diagnoses. To illustrate, the DSM does not contain a diagnosis of "emotional disturbance," although emotional disturbance is a concept used to describe some neurocognitive disorders and reactive attachment disorder in the DSM.[345]

Given the high prevalence of ACEs in children's lives, some might fear that creating a trauma-specific disability categorization would mean flooding the special education system with more children than schools could handle. This concern can be addressed in multiple ways.

As a matter of law, IDEA does not permit school administrators to use limited resources as a basis for denying an education to any students with disabilities.[346] If educating all children with disabilities requires increased funding, Congress should appropriate more funds to IDEA. In 1975, Congress established a formula that promised to gradually increase federal funding of special education until the federal government covered forty percent of the additional annual costs of educating students with special needs by 1982 (compared with educating students with no identified disability).[347] However, Congress has failed to pay for even twenty percent of these costs, and thus states and local governments continue to bear the vast majority of these costs.[348]

Further, if schools became trauma-responsive for all children, as discussed in greater detail below, then the need to address the impact of trauma through special education would be significantly decreased.

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and the definitions of disability categorizations are generally broader than what appears in the DSM). *Compare* 20 U.S.C. § 1401(3)(A)–(B) (2018) (describing IDEA's disability categorizations, which are different from diagnoses and their criteria in the DSM and do not depend upon or refer to the DSM or any other medical standard), *and* 34 C.F.R. § 300.8 (2019) (same), *with* AM. PSYCHIATRIC ASS'N, *supra* note 264.

345 *See* AM. PSYCHIATRIC ASS'N, *supra* note 264, at 265, 600 (using the term "emotional disturbance" to describe cognitive disorders).

346 *See* Andrew M.I. Lee, *10 Smart Responses for When the School Cuts or Denies Services*, UNDERSTOOD, https://www.understood.org/en/school-learning/your-childs-rights/if-losing-services/10-smart-responses-for-when-the-school-cuts-or-denies-services (last visited Mar. 12, 2020) (noting that the Department of Education prohibits schools from denying accomodations due to inadequate funding).

347 *See* CONG. RESEARCH SERV., THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) FUNDING: A PRIMER 9 (Aug. 29, 2019), https://fas.org/sgp/crs/misc/R44624.pdf.

348 *See* NAT'L COUNCIL ON DISABILITY, BROKEN PROMISES: THE UNDERFUNDING OF IDEA 21–22 (2018), https://ncd.gov/sites/default/files/NCD_BrokenPromises_508.pdf (showing that federal appropriations never funded more than twenty percent of the additional costs of educating preschool-age students with special needs).

In addition, given that so many children with traumatic stress already have IEPs, often under the disability categories of OHI based on suspected ADHD or ED, a trauma-specific disability categorization would likely improve and make more cost-effective the IEPs of many children who already qualify for special education.

Finally, IDEA's definition of a child with a disability limits the provision of special education under IDEA only to children who have a disability that adversely affects the child's educational performance and, as a result of this adverse effect, the child needs special education.[349] Not every child who has experienced trauma will have a disability that adversely affects educational progress and requires special education to make educational progress.[350]

Ultimately, adding a trauma-specific disability categorization to IDEA would provide educators with helpful information about many students' functional impairments at school, potential underlying health conditions, factors in the home or community environment impacting education, and the need to provide trauma-responsive interventions. Such a categorization would enhance schools' ability to educate all students, not just those free from traumatic stress.

C. The Imperative for Schools to Provide Trauma-Responsive Special Education

"For real change to take place, the body needs to learn that the danger has passed and to live in the reality of the present."

—Bessel van der Kolk, 2014[351]

"[For school t]o be genuinely inclusive, we need to be committed to meeting individual needs."

—Louise Michelle Bombèr, 2008[352]

The research shows that in order to access their education, children whose traumatic experiences disable their performance at school need an educational environment that places relationship, trust, and

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349 *See* 20 U.S.C. § 1401(3)(A)(ii); *cf., e.g.*, Hansen v. Republic R-III Sch. Dist., 632 F.3d 1024, 1027–28 (8th Cir. 2011) (IDEA's definition of child with a disability requires that the disability identified must adversely affect the child's educational performance); Mr. I. v. Me. Sch. Admin. Dist. No. 55, 480 F.3d 1, 5 (1st Cir. 2007) (holding that the disability must adversely affect a child's educational performance to constitute a disability under IDEA).

350 *Cf.* COLE ET AL., *supra* note 35, at 40 ("Most children experiencing trauma will not develop diagnoses or disabilities that require special education . . . .").

351 VAN DER KOLK, *supra* note 20, at 21.

352 LOUISE M. BOMBÈR, INSIDE I'M HURTING: PRACTICAL STRATEGIES FOR SUPPORTING CHILDREN WITH ATTACHMENT DIFFICULTIES IN SCHOOLS 3 (2008).

emotional and physical safety at the center of teaching.[353] The reason, as discussed previously,[354] is that children experiencing traumatic stress cannot effectively learn when they are in a fight, freeze, or flight mode or when their main focus is survival. Their physiological, social, and emotional needs for comfort, safety, love, belonging, and esteem must be addressed so that they can become curious and ready to engage with the school environment.[355] Making relationship, trust, and emotional and physical safety central to the education of a child with traumatic stress influences neural activity to counteract traumatic stress, and it provides children with experiences that enhance their resilience.[356]

A trauma-responsive education builds a child's relationships at school by connecting the child to people who are attuned to the child's emotional needs and communicate care, acceptance, and empathy. Such an education also strengthens self-regulation and other executive functioning skills. A trauma-responsive education avoids using punitive and exclusionary disciplinary measures and instead builds accountability through relationships.

504 plans and IEP teams have the potential to be transformative resources for children with disabilities from trauma because these teams can leverage the expertise of multiple disciplines to address a child's needs in a holistic, individualized, and coordinated manner. Through evidence-based assessments and effective collaboration, they can continually inform themselves about the child's needs, monitor the child's progress, and respond to new challenges and changes in the child's life.

Special education teachers, school administrators, and related service providers are particularly suited to provide these relationships to children with traumatic stress. As professionals experienced in this area, they are well-positioned to mitigate the impact of trauma by providing children with individualized attention and modifying educational environments, teaching style, and instructional material to meet the unique needs of individual students.

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[353] *Cf.* GINWRIGHT, *supra* note 273, at 90 (explaining that relational teaching is established by building caring relationships, wherein teachers embrace an educational strategy that places emotion, love, and care at "the pedagogical center of teaching"); SPORLEDER & FORBES, *supra* note 28, at 36 ("Creating a trauma-informed school [is] . . . about creating an environment that focuses on relationship, trust, and emotional safety.").

[354] *See supra* Section II.C.

[355] *See generally* SPORLEDER & FORBES, *supra* note 28, at 36–37 (describing the hierarchy of learning model).

[356] *See id.* at 42–43.

1. Trauma-Responsive Specialized Instruction

Specialized instruction for children with traumatic stress should be designed "to establish and strengthen the neural pathways associated with academic and social competency."[357] Consequently, relationship must be a core component of the curriculum for children with traumatic stress.[358] This means that instruction for such children must be delivered in a way that conveys "genuine interest and concern" for the child, even when the child is dysregulated.[359] The instructor must remain self-regulated throughout all interactions with the child, including moments when the child has broken a rule.[360] When instructors remain self-regulated, they help children to self-regulate, and, when instructors become dysregulated, they easily dysregulate children.[361]

To counteract impairments in executive functioning and trauma-induced feelings of helplessness and disconnection, instructors should provide traumatized children with choices and opportunities to lead and serve their communities. Choices help children to regain a sense of agency, and contributing to the well-being of others may help children overcome feelings of shame instilled by trauma.[362]

As to the content of specialized instruction, children with traumatic stress benefit from learning about trauma and its impact on the brain, including how trauma can create triggers and cause dysregulation; mindfulness and other self-regulation techniques; and skills in building healthy relationships and coping with stress.[363] In other words, the content of instruction should be adapted to help children gain self-awareness and skills to counteract the effects of trauma.

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[357] Susan E. Craig, Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives, K–5, at 25 (2016).

[358] *See* Sporleder & Forbes, *supra* note 28, at 87 (arguing that relationship is more important than curriculum because students that are happier are better able to learn).

[359] *Id.* at 88.

[360] *See id.* at 122 (describing the importance of staying non-reactive when dealing with traumatized students).

[361] *See* Ass'n for Treatment & Training in the Attachment of Children, *supra* note 207, at 111.

[362] *See, e.g.*, Craig, *supra* note 357, at 72–73 (explaining that giving children plants to take care of can teach them social skills and can show them that they can make positive change). Further, children should be invited to provide input at IEP and 504 plan meetings regarding the teaching approaches, accommodations, and services that they would find most helpful.

[363] *See* Sporleder & Forbes, *supra* note 28, at 141–42 (providing options for how to teach students about stress when implementing the trauma-informed model).

2. Trauma-Responsive Accommodations

While individualizing instruction is indispensable, modifying the context in which it occurs through accommodations is equally important.[364] Trauma-responsive disability accommodations should create a calm, predictable classroom for a child and minimize the child's exposure to his or her unique triggers so that the child can feel safe and undistracted at school. Loud and noisy cafeteria rooms, crowded hallways, recess periods with minimal adult supervision, and harsh disciplinary responses are examples of potential triggers for children. Seating near the teacher, whom children often feel is the safest person in the room, can enhance a child's feeling of safety in the classroom.[365]

Other important accommodations include allowing a child to take breaks to self-regulate through movement, deep and slow breathing, going to a calm place, mindfulness, drawing or coloring, or calling a parent.[366] Given that trauma undermines children's executive functioning, many of the accommodations that benefit children with ADHD may be needed by children with traumatic stress.[367] Strategies to help a child build stable, consistent relationships with adults and peers should also be used, such as assigning an adult and peer mentor to the child.[368]

Further, an IEP or 504 plan may become more effective if it specifies that some educational meetings or visits by educators or related services shall occur in a child's home rather than at school. Home visits by teachers and the provision of services at home are considered

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[364] *See* Gregory & Nichols, *supra* note 35, at 246 ("[E]xpecting individualized services alone to create or engender a whole-school environment that is safe and supportive . . . is like expecting the tail to wag the dog." (emphasis omitted)).

[365] *See* Ass'n for Treatment & Training in the Attachment of Children, *supra* note 207, at 108–09.

[366] *See* Sporleder & Forbes, *supra* note 28, at 180–81 (highlighting elementary and secondary strategies for classroom accommodation of children with trauma).

[367] *See* Szymanski, *supra* note 1, at 51 (explaining that the cognitive and emotional disruption caused by trauma, such as difficulty concentrating, overlaps with or exasperates ADHD symptoms). Such accommodations include shortening assignments, chunking instructional material, presenting information in multiple ways, providing class notes or outlines before class, asking students to repeat instructions to gauge comprehension, using graphic organizers, breaking down big assignments into smaller pieces with individual deadlines, providing extra time to complete assignments and tests, and providing assistive technology that supports a child in staying organized and remembering assignments. *See* *Classroom Accommodations*, CHADD, https://chadd.org/for-educators/classroom-accommodations (last visited Jan. 15, 2020) (providing additional examples of accommodations for those with ADHD).

[368] *See* Sporleder & Forbes, *supra* note 28, at 180, 185.

to be best practices for children and families who struggle to experience a sense of connection and belonging at school.[369]

3. *Trauma-Responsive Annual Goals*

Measurable annual goals on a trauma-responsive IEP or 504 plan can be a powerful way for children impacted by trauma to gain social, executive-functioning, cognitive, and emotional regulation skills that were missed or taught in negative ways in the home or community.[370] Annual goals should be used to build self-regulation skills, skills in building healthy relationships, and self-advocacy skills, for instance.[371]

4. *Trauma-Responsive Related Services*

Many kinds of related services could increase a traumatized child's access to education. Regarding traditional related services, speech and language services and occupational therapy services will be needed by many children whose traumatic experiences impair language development, sensory processing, self-regulation, and/or social skills. Occupational therapy consultative services can also be used to generate ideas for producing a calm and nurturing learning environment for children with traumatic stress.[372]

As to less commonly used related services, research shows that psychotherapy is "one of the most well-supported therapeutic interventions for patients with symptoms of toxic stress, whether those symptoms [are] behavioral or not."[373] Cognitive Behavioral Intervention for Trauma in Schools ("CBITS") and Support for Students Exposed to Trauma ("SSET") "are examples of evidence-based intervention programs designed for school delivery."[374]

The evidence also shows that psychotherapy that treats both the parent(s) and the child as a team—child-parent psychotherapy ("CPP")—is highly effective.[375] Such therapy entails treating multiple

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[369] *See* Mary E. Flannery, *All in the Family: How Teacher Home Visits Can Lead to School Transformation*, NEA TODAY (Oct. 28, 2014), http://neatoday.org/2014/10/28/all-in-the-family-how-teacher-home-visits-can-lead-to-school-transformation; *Research Spotlight on Home Visits: NEA Reviews of the Research on Best Practices in Education*, NAT'L EDUC. ASS'N, http://www.nea.org//tools/16935.htm (last visited Jan. 15, 2019).

[370] *Cf.* SPORLEDER & FORBES, *supra* note 28, at 44 (arguing that trauma results in skill deficits).

[371] *Cf. id.* at 45–46 (listing the skills that traumatized children typically need to build). An example of a trauma-responsive annual goal is as follows: The child recognizes that he needs help, asks for it, and is able to accept it eighty percent of the time.

[372] RECRUITMENT, TRAINING & SUPPORT CTR. FOR SPECIAL EDUC. SURROGATE PARENTS, *supra* note 321, at 2–3.

[373] BURKE HARRIS, *supra* note 114, at 99.

[374] Blodgett & Lanigan, *supra* note 146, at 144.

[375] BURKE HARRIS, *supra* note 114, at 99–100.

generations, not just the youngest generation, for trauma's effects. Given that IDEA's definition of related services is so broad and includes social work services in schools involving group counseling with the child and family, IDEA appears to support the provision of CPP as a related service.[376] Similarly, Section 504 places no limitations on the types of services that can be provided to a child with traumatic stress.[377]

Parent counseling and training are additional related services that could improve a parent's understanding of and skills to address a child's disabilities arising from trauma.[378] School social work services can provide children with individual or family counseling.[379]

Given the social skills deficits created by trauma, many children with traumatic stress need social skills group therapy provided by a social worker, guidance counselor, or therapist to make educational progress.[380] Providing an adult or peer mentor to a child who can form an authentic, caring relationship with the child can also be effective in building a child's resilience.

A child who is highly dysregulated on a regular basis by traumatic stress may need a dedicated aide who is knowledgeable about trauma's effects and proficient in helping children to self-regulate emotions and behavior.[381] A dedicated aide who is near the child during the school day can help to calm the child when he or she is triggered, provide a safe and supportive relationship that builds the child's resilience, and support the child's executive functioning.[382]

Related services for children experiencing traumatic stress should generally also include social work services in schools, school health services, and referrals to health care providers and legal advocates so

376 *See* 20 U.S.C. § 1401(26) (2018) (defining what qualifies as a related service); 34 C.F.R. § 300.34(a) (same); 34 C.F.R. § 300.34(c)(14)(ii) (providing that social work can include counseling).

377 *See* 34 C.F.R. § 104.33 ("[A]ppropriate education is the provision of . . . services that . . . are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons . . . ."). *But cf.* Alexander v. Choate, 469 U.S. 287, 300 (1985) (citing Se. Cmty. Coll. v. Davis, 442 U.S. 397, 413–14 (1979)) (holding that reasonable accommodations do not require substantial or fundamental alterations to a program's essential nature).

378 *See* 34 C.F.R. § 300.34(a) (defining what constitutes a related service); 34 C.F.R. § 300.34(c)(8)(i) (elaborating on parent counseling and training as a related service).

379 34 C.F.R. § 300.34(c)(14)(ii).

380 *Cf.* SPORLEDER & FORBES, *supra* note 28, at 209–10 (describing the benefits of social skills groups).

381 *Cf. Educational Aides*, D.C. PUB. SCHS., https://dcps.dc.gov/page/educational-aides (last visited Jan. 15, 2020) (stating that dedicated behavioral aides provide crisis prevention, implement behavioral intervention plans, and provide one on one support to students).

382 *Cf. id.* (describing the support that dedicated instructional aides can provide).

that a child can receive holistic, comprehensive care that addresses the root causes of their traumatic experiences.[383] If concerns regarding child abuse or neglect exist, educators, social workers, and health care providers are typically mandatory reporters of abuse and neglect.[384] Health care providers can treat mental illness and mitigate harm stemming from physical injuries and illnesses. In addition, social workers and legal advocates can help to improve a child's socio-economic status, prevent crises, and alleviate stressors.[385]

IDEA anticipates the use of community resources, such as health care providers and legal advocates, to improve a child's access to education. To illustrate, IDEA's definition of social work services in schools includes "[w]orking in partnership with parents and others on those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school" and "[m]obilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program."[386]

5. *Trauma-Responsive Placement*

As to placement, children with traumatic stress will ideally be able to access their education in the regular education setting with the support of specialized instruction, accommodations, and/or related services. However, if such placement does not enable the child to access their education, the child may need placement into a smaller educational setting with fewer children and a higher teacher to student ratio. The purpose of such a setting would be to minimize the child's exposure to triggers and increase the child's feeling of

[383] *See* 34 C.F.R. § 300.34(a) (including school health services and social work services in the non-exclusive list of possible related services).

[384] *See* CHILDREN'S BUREAU, MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT 2 (Apr. 2019), https://www.childwelfare.gov/pubPDFs/manda.pdf#page=2&view=Professionals%20required%20to%20report (listing the most common professional roles where reporting is mandatory); *cf.* COLE ET AL., *supra* note 35, at 71 ("When intervention is needed, the nonabusive parent should be informed ahead of time . . . . [T]his can prevent the nonabusive parent from losing trust in the school and can allow for safety planning to help stave off a potentially violent reaction to the report on the part of the abusive parent.").

[385] When children were referred to the HJA medical-legal partnership, for instance, they and their families often received assistance with acquiring or maintaining public benefits to improve access to basic necessities. HJA also helped to stabilize families by assisting adults in adopting or obtaining custody or guardianship of a child whose parents were unable to care for them. HJA advocated to avert future crises and stressors by preventing evictions, restoring utility services, and obtaining uniforms and school supplies for children. *See Health Justice Alliance: Supporting D.C.'s Vulnerable Population Through Health and the Law*, GEO. L. (Aug. 9, 2019), https://www.law.georgetown.edu/news/health-justice-alliance-supporting-d-c-s-vulnerable-populations-through-health-and-the-law.

[386] 34 C.F.R. § 300.34(c)(14)(iii)–(iv).

belonging and physical and emotional safety. Such a setting could also limit the child's exposure to school staff who may not be familiar with the child's IEP or have not yet committed to creating a trauma-responsive environment. Such placement risks, however, causing the child to feel alienated from peers and undermining self-esteem. Accordingly, placement in a more restrictive setting should only occur when deemed absolutely necessary.[387]

If an IEP or 504 plan team is unable to shield a child from triggers and unhelpful interactions with adults in the regular education setting or a smaller setting, then it may need to place the child into an even more restrictive setting, such as a special education school, in order to access their education.

6. *Trauma-Responsive Approaches to Problematic Behavior*

A trauma-responsive approach to behavior recognizes that trauma-related symptoms and behaviors are an individual's "best and most resilient attempt to manage, cope with, and rise above" an experience of trauma.[388] Viewing emotional reactions and behaviors of children through the lens of resilience—the view that children's behaviors and emotions are responses to surviving trauma—rather than the lens of pathology—defining children from a diagnostic label that emphasizes deficits and implies that something is wrong with them—is essential to providing a trauma-responsive school environment.[389]

Traditional reward and punishment systems, such as point systems, suspensions, expulsions, arrest by police at school, and even some positive behavioral intervention services, can be ineffective and can even backfire with children who have experienced trauma.[390] Children with traumatic stress are motivated by relationship, not attempts to control their behavior.[391] Behavioral control or modification methods can backfire because they can be perceived as coercive and threatening by children who have been maltreated. Further, as mentioned previously, children with traumatic stress often have

[387] *See* 20 U.S.C. § 1412(5)(A) (2018) (requiring FAPE to be provided in the least restrictive setting).

[388] SAMHSA, TIP 57, *supra* note 214, at 13.

[389] *Cf. id.* at 13, 27–28 (describing the importance of viewing individuals who have experienced trauma through the lens of resilience when providing behavioral health services).

[390] *See, e.g.*, SPORLEDER & FORBES, *supra* note 28, at 65 (giving an example where point charts, rewards, and time-outs were ineffective).

[391] *See id.* at 155 (stating that students who have trauma are hungry for stable relationships).

impaired ability to consider the consequences of actions, and thus behavioral control methods can be seen as another pathway to failure.

Instead, children with traumatic stress typically become accountable for their behavior when they are in a relationship based on trust, consistency, acceptance, unconditional support, and a sense of belonging.[392] To build such relationships, educators must demonstrate respect, care, and flexibility towards the child and honor the child's efforts to take responsibility, work hard, or improve their attitude.[393] IEP or 504 plan teams may need to modify behavioral expectations to enable a child with traumatic stress to experience any success in meeting them. Avoiding the use of coercive methods and keeping a child in school, even if it means placing the child in in-school-suspension, are essential principles of trauma-responsive discipline.[394]

Behavioral intervention plans (BIPs) for students with traumatic stress should aim to prevent problematic behavior by identifying and minimizing a child's exposure to their triggers.[395] BIPs should also identify a signal that the child can use to discreetly request help or permission to take a break when feeling dysregulated.

Most importantly, a trauma-responsive BIP should create a plan for responding to problematic behavior. The plan should direct adults to remain regulated and avoid responding immediately in an emotional, punitive, physical, or otherwise threatening way. The plan should give the child time, space, and support to use self-regulation skills, and it should build relationships between the child and caring adults. Specifically, the plan should permit and guide a dysregulated child to go to a pre-designated "safe place" and "safe person" in order to regain a sense of safety, connection, and self-control.[396]

The safe person should be an adult who already has a positive, caring connection with the child, such as a therapist, favored teacher, or administrator.[397] Each safe person should be trained to assist the child in calming down and regulating their emotions through focusing on connecting with the child in a non-judgmental, attuned, open, and

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392 *See id.* at 105, 155 (indicating that relationship-focused rather than behavior-focused approaches are most effective).

393 *See id.* at 72–73 (asserting that being flexible and having a reciprocal relationship with the child can improve relationships and garner respect).

394 *See id.* at 71, 75; CRAIG, *supra* note 357, at 60.

395 *Cf.* 20 U.S.C. § 1415(k)(1)(F) (2018) (requiring the creation of a BIP if misconduct is a manifestation of a disability).

396 *Cf.* SPORLEDER & FORBES, *supra* note 28, at 61–64 (explaining how calm rooms staffed with caring supervisors trained in trauma can help and support a child who has experienced trauma).

397 *But see id.* at 62 (asserting that a calm room should be supervised by someone trained in trauma who can cultivate a strong relationship with the child).

empathetic way.[398] The adult may be effective by using expressions such as: "You're not in trouble. I'm here to help."[399] The child should be permitted or guided to return to class when they are self-regulated.[400]

While a child should not be disciplined for merely becoming dysregulated, judicious enforcement of school rules can be an important way to promote the emotional and physical safety of students.[401] Overly permissive environments cause children to feel unsafe.[402] Rule enforcement with students who have experienced trauma should focus on logical and consistent, rather than punitive, consequences. Consistency helps to teach cause and effect for children living in chaotic environments.[403]

Rule enforcement should also minimize the use of certain techniques, like out-of-school suspension, expulsion, and arrest by police, that stigmatize and exclude students. Such techniques can re-traumatize students who struggle with experiences of abandonment, neglect, or emotional abuse, and they can undermine a student's sense of belonging. Educators should seek to understand the reason behind behaviors so that similar behaviors or circumstances can be prevented in the future.[404]

Consistent with a relationship-based approach towards discipline, schools should avoid applying zero-tolerance policies to students with traumatic stress. Zero-tolerance policies typically require school officials to deliver specific and typically harsh punishment, usually in the form of out-of-school suspension or expulsion, when a student breaks certain rules, regardless of the circumstances. These policies are a major reason why many children are pushed out of schools and eventually become involved in the juvenile delinquency and criminal justice systems.[405] Zero-tolerance policies fail to demonstrate the flexibility, care, and respect that traumatized students need in order to

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[398] *See id.* at 64 (arguing that a student will calm down "if the adult is relationship-based, regulated, and focus[ed] on simply being in connection with the student instead of 'making the student calm down and behave'").

[399] *Id.* at 58; *see, e.g.*, *id.* at 174–75 (showing other effective responses).

[400] *See id.* at 174.

[401] *See id.* at 111–12.

[402] ASS'N FOR TREATMENT & TRAINING IN THE ATTACHMENT OF CHILDREN, *supra* note 207, at 109 (describing how permissive environments can cause children to feel unsafe).

[403] *See id.*

[404] *Id.* at 110.

[405] *See* Matt Cregor & Damon Hewitt, *Dismantling the School-to-Prison Pipeline: A Survey from the Field*, 20 POVERTY & RACE 5, 5–6 (2011).

improve their behavior. These policies undermine relationships,[406] and they promote the accumulation of traumas caused by school.[407]

Restoring and rebuilding relationships, repairing harm, and practicing forgiveness *are* trauma-responsive approaches to rule-enforcement, however, and they are fundamental aspects of restorative justice practices.[408] Restorative justice practices focus on repairing harm caused by violation of a rule or agreement.[409] This model allows the victim and offender to sit in a group circle and discuss the impact of the harm caused by the violation upon their lives and their relationship.[410] Together, the victim and offender consider how to heal the harm in their relationship, and they typically agree upon a plan for healing such harm.[411]

IDEA's requirement that schools hold a manifestation determination review ("MDR") before deciding to expel or suspend a child with a disability for more than ten days accords with trauma-responsive principles.[412] MDRs held for a child with traumatic stress to determine whether the child's problematic behavior manifested their disability should be informed by our current understanding that trauma impairs decision-making, awareness of consequences, self-regulation, impulsivity, and empathy towards others and that traumatized children can act aggressively or disruptively when triggered.[413] When such MDRs result in the decision not to suspend or expel a child, they should be seen as opportunities to improve a child's IEP, including the child's BIP, to make it more trauma-responsive.[414]

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406 *See* SPORLEDER & FORBES, *supra* note 28, at 31 (describing zero-tolerance policies as not trauma-informed but as "zero relationship" policies).

407 *See* GINWRIGHT, *supra* note 273, at 20 (noting how zero-tolerance "result[s] in accumulated trauma and ultimately erode[s] young people's sense of hope").

408 *See id.* at 28, 30–31, 96–98 (describing restorative justice and the practice of forgiveness).

409 *Id.* at 30.

410 *Id.* at 31.

411 *Id.* at 30.

412 *See* 20 U.S.C. § 1415(k)(1)(E) (2018) (requiring that a manifestation determination review be held "within 10 school days of any decision to change the placement of a child with a disability because of a violation of a code of student conduct"). During this review, the IEP team must generally determine whether the conduct was caused by the child's disability or failure of the LEA to implement the child's IEP. If the answer is yes, then the school may not change the child's placement and instead must conduct an FBA and implement a BIP; review an existing BIP; or remediate the failure to implement the child's IEP. *See* 1415(k)(1)(F); *see also* 34 C.F.R. § 300.536 (defining change of placement).

413 *Cf.* 20 U.S.C. § 1415(k)(1)(E) (stating that any relevant information in the student file or provided by the parent must be considered in a manifestation determination).

414 *See* 34 C.F.R. § 300.530(e)–(f) (describing steps IEP teams must take when a child's problematic behavior is deemed a manifestation of their disability, including returning the child to the child's placement before the behavior occurred, remedying any failure to implement an IEP, conducting an FBA, and/or modifying a BIP for the child).

7. *Trauma-Responsive Whole-School Approach*

Many trauma-responsive interventions could be provided through a whole-school approach rather than through the IEPs or 504 plans of individual children. In fact, promoting trust, relationship, and emotional and physical safety throughout entire schools would be an ideal, if not necessary, approach to providing educational access to children with traumatic stress. The reason is that a school environment cannot truly become trauma-responsive unless every person in that environment, including janitorial, transportation, and cafeteria staff, behaves in a manner that promotes relationship, trust, and physical and emotional safety for all students.[415] To illustrate, a school cannot effectively implement a trauma-responsive BIP if school administrators who discipline a child do not understand or adhere to the BIP and thereby use harsh disciplinary tactics.[416] A student's sense of safety at school can be severely undermined by a single experience with a staff member or student who treats that student in a threatening, emotionally reactive, or coercive manner.[417]

Further, making entire schools or communities trauma-responsive would give many traumatized children access to their education, thereby minimizing the need for schools to create 504 plans and IEPs to provide such access. Studies have shown that shifting an entire school's culture towards trauma-responsiveness improves overall student educational progress, behavior, and relationships with educators.[418] Making entire schools trauma-responsive can reduce costs in identifying and providing special education or disability accommodations to children whose disabilities arise from trauma.[419] Further, making entire schools trauma-responsive reduces the need to

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[415] *See, e.g.*, Gregory & Nichols, *supra* note 35, at 245 (arguing that the lack of a safe and supportive school environment "thwarted the efficacy of" the critical educational supports provided by IEP plans for two students with traumatic stress).

[416] *See id.* at 244–45.

[417] *See id.* at 243–44 (describing how a student's educational progress stalled, even though her devoted special education teachers worked hard to teach her the skills she was lacking, because she was severely triggered by the threats she perceived in the larger school community).

[418] SPORLEDER & FORBES, *supra* note 28, at 6–10; *see* WEHMAH JONES ET AL., AM. INSTS. FOR RESEARCH, TRAUMA AND LEARNING POLICY INITIATIVE (TLPI): TRAUMA-SENSITIVE SCHOOLS DESCRIPTIVE STUDY FINAL REPORT 61 (2018), https://traumasensitiveschools.org/wp-content/uploads/2019/02/TLPI-Final-Report_Full-Report-002-2.pdf (describing how implementing a trauma-responsive whole-school approach at three schools resulted in "reports of fewer crises, the school feeling 'safer' and 'calmer,' decreased office referrals and fewer disciplinary incidents").

[419] *Cf.* Gregory & Nichols, *supra* note 35, at 247 ("Trauma sensitivity is not about identifying and labeling those students with traumatic backgrounds; rather it is more like a universal design approach, taking for granted that all students stand to gain from school environments that help them feel safe and supported." (emphasis omitted)).

place children with traumatic stress in costly, more restrictive settings in order to protect them from triggers and potentially harsh interactions with school staff who do not engage with them in a trauma-responsive manner.

Conclusion

The recent research on trauma has revolutionized our understanding of its significant effects on learning and behavior, and it is time for educational disability law to evolve appropriately in response to these breakthroughs.[420] Many children are struggling academically or behaviorally in school because they have unaddressed needs resulting from traumatic experiences. Even though we now have evidence-based approaches to giving educational access to these children, school administrators do not typically recognize trauma's disabling effects, and they generally do not know how to provide instruction and support in ways that restore the educational progress of these children. As a result, many traumatized children fail academically or fall into the school-to-prison pipeline, even while having an IEP or 504 plan, and their educational failures compound the traumas that they have already endured.

IDEA and Section 504, however, can and should help children like Rondell make meaningful educational progress. If—through changes to the design and implementation of IDEA and Section 504—schools become better at detecting trauma's effects in children and providing trauma-responsive education, then it is reasonable to expect that fewer children will drop out of schools, misbehave, and fail academically. It is also likely that as educational interventions for children impacted by trauma become more effective, the massive economic toll of childhood adversity upon multiple public systems, especially the criminal justice, welfare, and public benefits systems, will decrease. Schools can and should be places of solace and empowerment for children who suffer from trauma.

Schools must be proactive in making their systems for serving children with disabilities trauma-responsive. The imperative to do so is moral as well as legal. If schools do not act quickly, parents and advocates will likely push them to do so through enforcement actions, as suggested by the *Peter P.* and *Stephen C.* cases.[421]

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[420] *See, e.g.*, Blodgett & Lanigan, *supra* note 146 (examining the correlation between trauma and behavioral problems in school children).

[421] *See* Peter P. v. Compton Unified Sch. Dist., 135 F. Supp. 3d 1098 (C.D. Cal. 2015) (denying a motion to dismiss for an action claiming that exposure to a traumatic event is a disability under the Rehabilitation Act or the ADA); Stephen C. v. Bureau of Indian Educ., No. CV-17-08004-PCT-SPL 1, 2019 U.S. Dist. LEXIS (D. Ariz. Dec. 16, 2019)

However, it is clear that making special education, related services, and accommodations trauma-responsive will not be easy. It requires genuine commitment by educators and policymakers to understand the effects of trauma and apply evidence-based approaches in schools, even if doing so means changing the culture of schools. It requires training school staff, hiring personnel with skills in providing trauma-responsive education, addressing misbehavior in non-traditional ways, supporting staff in dealing with vicarious trauma, and harnessing resources outside of school to address the root causes of trauma. Educators and policymakers need the support of the public to make this commitment possible and sustainable. Making special education trauma-responsive will demand much from our schools and communities, but the benefits of effectively addressing a root cause of school failure are worth it.

(granting summary judgment to defendants and rejecting plaintiffs' claim that defendant schools were required, and failed, to provide plaintiff students with a system to help those impacted by trauma).