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Punishing Children for Their Disabilities

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I. Introduction

One Barbie doll, dressed for the beach, lounged in her Barbie car, while the other one stood by in her bridal gown as Crystal (not child's real name) carefully selected matching accessories. Keeping up a dialogue in special voices for her Barbies, Crystal acted younger than her eleven years. People around her in the courthouse waiting room were surprised by the striking contrast between her seductive appearance and her childish play. Crystal was fully developed, five feet tall and over 120 pounds, and if they had not seen her playing with Barbies they would have assumed she was an older teenager.

At age ten and one-half, Crystal was charged with assault for hitting her fourth grade special education aide who was removing her from the classroom for being unruly. In the state where she lives, children between eight and twelve years of age are presumed incapable of committing crimes, unless the prosecutor overcomes the presumption by providing clear and convincing evidence to the judge that the child understood that his or her behavior in the specific incident was wrong and could form the requisite intent of the crime charged. State statutes vary how to determine a child's capacity. In Washington state, the judge may consider the nature of the offense, the child's age, prior conduct similar to that charged, the consequences of the prior conduct, and any acknowledgment by the child that the behavior is wrong.[1]

Crystal typifies the rapidly increasing number of behavior-disordered children being prosecuted for aggression stemming from early trauma and brain dysfunction. In one urban area, advocates sued the school system on behalf of children with disabilities because children in special education were five times more likely to be referred for prosecution for school behavior problems than children not in special education.[2] The actions of behavior disordered has been treated simplistically as school violence, with little attention to—and apparently little understanding of—the extent to which their acts grow out of their disabilities. They are perceived as dangerous and responsible for their actions instead of being treated as children with disabilities whose behavior is the result of brain dysfunction and trauma.

Punishing children for their disabilities is unfair. The Americans with Disabilities Act prohibits discrimination by state and local government entities on the basis of disability and requires accommodations for individuals with disabilities. Prosecuting behavior disordered children in special education presents courts with capacity questions that cannot be resolved simply by considering the "misconduct" itself. A complex child development framework, including both the effects of trauma and brain dysfunction, and information about effectively managing the behavior of such children are necessary to determine why the child behaved as he or she did. To achieve developmentally sound justice in these increasing number of court cases would require expert testimony on trauma and brain function in children not currently available in most jurisdictions.

II. The Context of Victimization

Crystal is the oldest of three children from a family with a long history of cocaine and alcohol abuse, as well as domestic violence. Her stepfather sexually molested Crystal's mother, she left home when she was twelve, and subsequently began using drugs. Crystal was born when her mother was fifteen. Crystal and her mother moved in and out of her grandmother's home until her mother was sentenced to prison. Crystal and her siblings were placed in foster care after a Child Protective Services investigation based on the school's report of Crystal's sexualized behavior in kindergarten. Crystal and her siblings

described being locked in a closet, whipped with an extension cord, incest, exposure to pornography, and domestic violence. When Crystal's mother was released from prison, she began visiting with Crystal to prepare for reunification; she participated in drug treatment programs, but returned to substance abuse. Her parental rights were terminated when Crystal was seven with the finding that "while the children love their mother, and their mother loves them, they cannot wait any longer to move into a safe, secure, and truly stable placement of a long-term nature"as noted in the child welfare case record. Crystal's younger siblings were adopted by their original foster parents who found Crystal's continuing sexualized behavior, bed-wetting, temper tantrums, and hitting too unmanageable. Six years after being removed from her family, 11-year old Crystal is now in her tenth placement: a therapeutic home after five foster homes, a shelter, a residential program, and a psychiatric hospital.

III. The School Setting

In first grade, a special education evaluation indicated that Crystal, who had normal intelligence, was easily frustrated. Her teachers reported that sometimes her anger seemed to erupt for no apparent reason. When her emotions took control of her, she was described as being "out of it." When there was any change in routine she had difficulty for the remainder of the day. At age 10 she was classified as Seriously Behaviorally Disabled. Her Individualized Education Plan gave five simplistic goals: (1) increase reading to a fourth grade level; (2) increase math to a third grade level; (3) increase written language skills to a third grade level; (4) improve following directions; and (5) improve problem solving skills.

Crystal's special education program, a self-contained classroom with seven severely behaviorally disabled children, used a behavior modification system based on earning points (if certain points were accumulated rewards would be given) and a time out room. She was described as "craving adult attention" and having at least one incident report a week for behavior problems. In the month before she was charged, she experienced daily physical restraint.

IV. Aggression toward School Staff

Crystal's teacher and her aide often forcible removed Crystal from the classroom. The aide dragged Crystal to the quiet room "because she was running around and threw things. She hit me, kicked me and yelled at me repeatedly. I decided to take her down to keep her from hitting me more." The aide testified that Crystal knew the difference between right and wrong: "During our problem solving sessions, Crystal must answer questions about what happened and why. She has to work through the problem to be removed from isolation. She acts out when the staff corrects or disciplines her. Crystal does show some remorse and apologizes for her behavior. That doesn't stop her from acting up when she wants to. We have had to restrain her more than twenty times in the past eight weeks."

Crystal explained that she felt persecuted in her classroom, and she repeatedly described her teachers as "mean." In contrast to the staff descriptions, she felt that restraint and "take- downs" were cruel, that physically forcing students into the time out room was harmful, and that neither restraint nor the time out room helped students. What staff reports called a "basket hold" according to Crystal was painfully pinning her arms behind the back of the chair she was sitting in, sometimes for long periods. What staff called a "floor hold" according to Crystal was painfully pinning one arm behind her back while she was face down on the floor. She said staff hurt her when they picked her up by the arms and dragged her to the quiet room, giving her scrapes on her knees. Crystal emphasized that the most important thing about a teacher is to be nice, which she defined as treating her "politely" and being "gentle." She saw the teachers as threatening and unfair. While staff intentions may have been to keep the situation under control, Crystal's perceptions determined how she reacted.

V. Understanding Trauma and Prenatal Substance Exposure

A. The developmental challenges facing girls

Intervening successfully in Crystal's behavior requires understanding female development and the impact of sex abuse, loss and prenatal substance exposure on children.[3] Girls develop differently than boys; designing interventions to meet their special needs is crucial. Connection with others is the central organizing feature of development in girls. Often, girls feel conflicted about

being selfish versus selfless. The struggle to be loyal, including worries about abandonment and disconnection, dominates girls' thinking from elementary through high school.[4] Girls who feel abandoned by their mothers become especially vulnerable–they have difficulty trusting others, but they are hungry for attention and affection.[5] Half of all girls report being depressed and many more girls than boys attempt suicide.[6] Girls are more upset than boys by stressful life events, are prone to see themselves as helpless, fear abandonment by others, and express a greater need for closeness and nurturing.[7] Girls report substantially less satisfaction with themselves than boys in areas including perceived self-worth, physical appearance, and social, academic and athletic competence.[8] Anecdotal evidence suggests that girls often mask their learning disabilities, resulting in delayed intervention. The transition to middle school is especially stressful for girls. Girls who experience early physical maturing have particular difficulty feeling accepted and liking themselves.[9] Crystal's fear of abandonment, need for attention, helplessness and self-dislike are not surprising. Sufficiently intensive assistance to address her individual needs should have been designed.

Trauma has delayed Crystal's emotional development and caused her to be untrusting, angry, sexualized and easily triggered. Abuse and loss typically slow down development in children and can interfere with all aspects of the child's functioning.[10] Children who were sexually abused or lost an important person in their lives may continue to function emotionally at the age when the trauma occurred. These children have trouble concentrating in school, are fearful and have disturbing nightmares.[11] Children who have been abused or disappointed by parents who did not protect them typically dislike themselves and have trouble trusting others. Aggression can be a defense against the helplessness common among traumatized children. Children who have been abused often react like younger children when they feel threatened. Traumatized children tend to misconstrue and be offended by what others say and do. Depression is a common reaction to trauma, but usually the child's behavior problems are focused on at home and school rather than this underlying sadness.

In addition, trauma affects brain development, with a reactive alarm response becoming the child's coping method for even small stressors. The brains of traumatized children develop uniquely, resulting in "a persisting fear-response . . . [with] profound cognitive distortions that accompany this neurodevelopmental state."[12] Because the experience of traumatized children is one of fear, unpredictability and frustration, they do not grow out of primitive reactions such as dissociation or aggression.[13] Traumatized children do not learn to soothe themselves and instead manage their fears with combative self-preservation.[14]

The trauma of sexual abuse caused Crystal to be both sexually precocious and ashamed of her mature-looking body.[15] Because she did not like herself, she felt appreciated as a sexual object for her brothers at the same time that counselors and foster parents disapproved of her sexualized behavior. In addition, the trauma of loss significantly affected Crystal. She remained angry with her mother and untrusting of others, expecting and sometimes contributing to repeated abandonment. She was always on the alert for rejection and aggressively self-protective at the slightest provocation because of the losses she has endured. Multiple placements may have been as harmful as the original abuse. Repeated losses caused her to feel unlovable and contributed to the increasing pool of anger inside her. Crystal blamed herself for not being adopted; the loss of her siblings was also significant. Her moodiness was treated as an annoying behavior problem, but irritability is the most common symptom of depression in children. Her only methods of soothing her chronic sadness about these losses appeared to be overeating and masturbation. Although Crystal's angry outbursts and 'spacing out' might have been secondary to seizure activity, more likely periods of dissociation, which provide traumatized children safe distance from their upsetting feelings and memories, caused these behaviors.

Prenatal substance exposure has limited Crystal's ability to anticipate the consequences of actions. Because the brain of the fetus develops throughout pregnancy, many brain changes result from prenatal drug, alcohol and tobacco use.[16] Typically, the child looks normal, but his or her thinking and self-regulation are different. From infancy, the prenatally substance-exposed child may have noticeable difficulty with arousal and attention regulation, getting easily over-stimulated, having limited self-calming skills, being disorganized in play and on tasks, and being quickly frustrated.[17] Their abilities to comprehend instructions and express themselves may be delayed. The child may be repeatedly surprised by obvious consequences of actions, sometimes developing what appears to be a habit of lying to avoid responsibility.[18] The prenatally substance-exposed child may be treated for Attention Deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder with no effect, because the child has brain damage requiring different interventions.[19] Frustrated families and teachers understandably get increasingly controlling, particularly when behavior modification does not produce improvement.[20] "Time outs" may result in the escalation of behavior rather than helping the prenatally substance exposed child calm down.

Crystal showed three classic symptoms of prenatal substance exposure: she did not learn from experience, repeating the same mistake over and over; she seemed unaffected by simple rules that other children routinely obey; and she had difficulty explaining or following normal sequencing of events.

Her behavior quickly escalated when she felt threatened, in part because of her past victimization, but also because her compromised brain limited her ability to regulate her own behavior.

Instead of a conscious delinquent act, at age ten and one-half Crystal's reaction to being dragged to the quiet room was a trauma reflex by a brain on alert for danger, limited in sequencing functions, and quickly flooded by anger from hurt in the past. These were her disabilities, and punishment would not change her behaviors. What help do traumatized and prenatally substance-exposed children like Crystal need that will accommodate their disabilities and enable them to change their behavior?

VI. Generally Accepted Responses to Traumatized and Prenatally-Substance Exposed Children

Teachers, foster parents and others who care for angry or depressed children who have been abused and suffered loss and children who have difficulty learning from experience because of prenatal brain damage must use substantially different approaches than with other children. They must have training in preventing and managing behavior problems specifically designed for these children. This training should emphasize that (1) these children react reflexively to threat; (2) these children overreact to perceived hostility; (3) adult actions can prevent most of the children's behavior problems; and (4) praise is much more effective than punishment in changing the children's behavior. Training for school staff, foster parents and child care staff should include techniques for: avoiding confrontation and power struggles which may be misperceived as hostile, de-escalating situations before children get out of control, teaching children not to be rejection-sensitive, giving children practice in self-regulation of anger, teaching children how to be cooperative, not taking children's behavior personally, and building on children's strengths.[21]

It is widely known that verbal confrontation and unwanted physical contact cause reactive behavior in children, especially abused children, which escalates until they lose control. While children benefit from predictability in an organized environment, the structure cannot be confrontational.[22] Furthermore, because abused children often assume adults will misuse their power, considerable effort must be made to reassure them that rules, consequences, and other decision-making (at school, home and during activities) are fair and also to teach them how to appeal perceived unfairness without becoming outraged.

In their description of Crystal, school staff blamed her for the reactions caused by prenatal substance exposure, early abuse and repeated losses, which led to her classification as severely behaviorally, disordered. Educators, clinicians and therapeutic foster parents have the responsibility of designing learning that is successful for Crystal and other children like her. Caretakers should be aware that Crystal's behavior will escalate when her feels unfairly treated, given her combination of abuse, loss and prenatal substance exposure. The discipline records indicate that several times a week Crystal was physically restrained in her chair or on the floor for five to fifteen minutes, which is contra-indicated in abused children and could precipitate abuse flashbacks and self-protective reactions in children with posttraumatic stress disorder.

Because of the effects of trauma on her developing brain, a reflexive-aggressive response remained Crystal's primary method of coping when she felt threatened or worried. Even with minor provocations, Crystal's hurt and anger from cruelty and loss in the past overwhelmed her. Crystal's description of what happened with her teachers showed that she was oversensitive, perceived others as hostile, lacked the ability to self-soothe, and could not think before she reacted to protect herself. Well-trained caregivers do not expect traumatized and prenatally substance exposed children to function like other children because traumatized children's brains have not matured normally and their emotional development has been delayed. Professionals who understand traumatized and prenatally substance exposed children arrange an environment where a youngster like Crystal does not feel threatened and believes she is fairly treated and where adult de-escalation and avoidance of power struggles prevent behavior problems. In such a setting, it is possible to teach children whose brains reflexively react to perceived threat or do not anticipate consequences how to sequence events and explain what makes things happen. As Perry pointed out, "Interventions which are based simply upon a cognitive, problem-solving approach to conflict resolution cannot be easily generalized to a perceived-threat situation. When a child or adolescent sits quietly in a room with peers and thinks though a situation, non-violent resolution comes more easily. The same child, however, when threatened will be in a different internal state. The fearful child's cognition and behavior is being mediated by more primitive parts of the brain—she will be more reactive, reflexive and will have a very difficult time pulling cognitive solutions from her cortex."

VII. Conclusion

Traumatized behavior disordered children may not be able to stop reacting to school staff and other caregivers because: (1) they see these adults as mean and unfair, which past abuse has made the acutely sensitive to; (2) when adults hurt them, they reflexively protect themselves (even if the adults think the restraint will control the situation, the child automatically reacts as if back in the position of being victimized); (3) when their feelings are hurt they are flooded with anger from the past which they are unaware is out of proportion to the present provocation; (4) they lack the ability to calm themselves; and (5) they cannot anticipate the consequences of their actions which surprise them (because of immature cognitive processing normal for their age and/or sequencing problems associated with fetal substance exposure).

At the time, these children react to feeling unfairly treated without being able to think about their response as being wrong. Afterwards when they are not being hurt, they can see that what they did was wrong—nevertheless, unless their teachers and others arrange an environment with effective accommodations, this predictable reaction will be provoked over and over. In Respondent's Brief on Capacity, Crystal's lawyer argued:

> While children are taught it is wrong to hit and kick others, we have recognized at common law and by statute that a person may use force in defense of self or to fend off an aggressor. Crystal's description of what happens when school staff restrain her shows that in her mind, she is reacting defensively to physical abuse. Crystal suffered prenatal substance exposure, which typically results in brain damage and developmental delays, which interfere with the ability of a child to learn from experience and anticipate consequences. Crystal has also suffered abuse and ongoing loss, which typically result in delays in emotional development, including reacting to stress like a much younger child. Her special education program used behavior modification techniques and physical restraint, which were contra-indicated for abused children and would be expected to result in the behavior observed. While the state argues that Crystal behaved similarly and had been punished for that behavior in the past, that is not clear and convincing evidence that she would then know at the time of the "assault" that her behavior was wrong . . . Despite the ability of such children to recognize the wrongfulness of their behavior after the fact, or at least say whatever it takes to get out of the quiet room or readmitted to class, these children do not recognize what they are doing is wrong at the time they lash out. These children are delayed in the development of the ability to understand consequences and are oversensitive and reactive to perceived threats. Therefore, at the time of the "assaultive" behaviors, they are acting reflexively and do not see that they are acting wrongly.[23]

Prosecution of children for their disabilities sets up an unacceptable conflict between their delayed development versus the appearance of dangerousness because of their size and aggressive reactions. For a child as traumatized as Crystal to be able to take responsibility for her actions would require (1) being able to separate her own victimization from provocative situations encountered at school and home and (2) learning new skills, and developing higher brain functions, to stop, think and calm herself before responding. The prenatally substance exposed child cannot help being unable to regulate her behavior, so the emphasis should be on what the child can do to use her competencies more effectively to reduce brain limitations with the environment providing effective support for desired behavior. Because trauma and brain dysfunction slow down many aspects of development, all the adults involved with the traumatized and prenatally substance-exposed child must respond as if she were younger than her chronological age.

A combination of interventions are necessary for these children to recover from early trauma and compensate for compromised brain function: emotional nurturance to make sure she feels safe and loved, predictability to reduce her anxiety, instruction in self-soothing, sequencing, logical consequences, and verbal expression of her frustration, and developmentally-sequenced trauma treatment to help her make peace with loss and abuse. Tragically, with daily power struggles and physical restraint, Crystal's school was not a nurturing environment. Behavior modification has not offered her the kind of teaching she can digest about how to be less sensitive, to calm herself, and to anticipate so she can stop before acting. Her multiple placements have caused increased loss and anxiety. Residential placement would likely make her behavior worse because of the provocation from other children and the lack of instruction in self-soothing and anticipating consequences. She must be protected from any school or living environment that continues to call on her reflexive fear response, reinforces her sensitivity to hostility, rejection and unfairness from adults, or punishes her for being unable to sequence normally.

Under the Individuals with Disabilities Education Act of 1997 (IDEA), students with disabilities have a right to an appropriate public education that meets their special needs.[23] As envisioned by the IDEA and ADA, these traumatized and prenatally substance exposed children are entitled to the coordinated effort of teachers, parents, and therapists in providing effective instruction and nurturance. When Crystal defended herself against perceived victimization by the teacher aide who was hurting her, she was reacting reflexively due to trauma and brain damage and did not have criminal intent even though

when not under stress she could say that hitting and kicking are wrong. Because of her disabilities, she cannot function like other children at her chronological age. Criminalizing the disabilities of traumatized and prenatally substance exposed children is harmful and will not change their behavior. They cannot be accountable because of brain dysfunction and delayed development. Instead of prosecution, the ADA and IDEA provide guidelines for services to meet their needs and develop the ability to regulate their own behavior.

Endnotes

*"Marty" Beyer received her doctorate in clinical/community psychology from Yale University and is an independent child welfare and juvenile justice consultant. Marty focuses on adolescent development: where each young person is in cognitive, moral and identity development and recovery from trauma and designing strengths/needs-based services to meet their needs.

1. WASH. REV. CODE § 9A.04.050 (2001)

2. In Shoemaker v. School Board of Palm Beach County, the judge granted summary judgment in favor of the school district, saying the court lacked authority under the disability discrimination laws to examine the adequacy to children with disabilities of behavioral supports offered by a school district as long as the district offered the same menu of services to children with disabilities that it offered to all children. Shoemaker v. School Board of Palm Beach Co., 97-8036-Civ-Moreno (1999).

3. Marty Beyer, *Delinquent Girls: A Developmental Perspective*, KY. CHILD. RTS. J., in press.

4. CAROL GILLIGAN ET AL., MAPPING THE MORAL DOMAIN (1988).

5. Scott Henggeler et al., *The Family Relations of Female Juvenile Delinquents*, 15 J. ABNORMAL CHILD PSYCHOL. 199-209 (1987). *See also* Sally Powers & Deborah Walsh, *Mother-daughter interactions and adolescent girls' depression, in* CONFLICT & COHESION IN FAMILIES (Martha Cox et al. eds., 1999).

6. A. Peterson et al., *Depression in Adolescence*, 48 AM. PSYCHOL. 155, 168 (1993). *See also,* Dawn Obeidallah & Felton Earls, *Adolescent Girls: The Role of Depression in the Development of Delinquency*, NAT'L INST. OF JUST. RES. PREVIEW (1999).

7. Margit Wangby et al., *Development of Adjustment Problems in Girls*, 70 CHILD DEV. 678, 699 (1999).

8. Christine Ohannessian et al., *Does self-competence predict gender differences in adolescent depression and anxiety?* 22 J. ADOLESCENCE 397, 411 (1999).

9. DAVID ELKIND, ALL GROWN UP AND NO PLACE TO GO (1984).

10. POST-TRAUMATIC THERAPY AND VICTIMS OF VIOLENCE (F. Ochberg ed., 1988).

11. R.S. Pynoos, *Posttraumatic Stress Disorder in Children & Adolescents in* PSYCHIATRIC DISORDERS IN CHILD. & ADOLESCENTS (B. Garfinkel et al. eds., 1990).

12. "As the brain develops sequentially during childhood from the brain stem to the cortex, complex areas organize to modulate more primitive, reactive lower portions of the brain cortically-mediated, inhibitory capabilities over arousal, impulsivity, motor hyperactivity and aggression . . . Any factors which increase the activity or reactivity of the brainstem (e.g., chronic traumatic stress) or decrease the moderating capacity of the limbic or cortical areas (e.g, neglect, alcohol) will increase an individual's aggressivity [and] impulsivity . . . The clear implication of this immutable neurophysiological chain of development is that early life experiences have disproportionate importance in organizing the mature brain . . . If during development, [the] stress response apparatus is required to be persistently active, a commensurate stress response apparatus in the central nervous system will develop in response to constant threat. These stress-response neural systems (and all functions they mediate) will be overactive and hypersensitive. It is highly adaptive for a child growing up in a violent, chaotic environment to be hypersensitive to external stimuli, to be hypervigilant, and to be in a persistent stress- response state . . . the very neurobiological adaptations which allow the child to survive violence may, as the child grows older, result in an increased tendency to be violent." Bruce Perry, *Incubated in Terror: Neurodevelopmental Factors in the Cycle of Violence, in* CHID., YOUTH & VIOLENCE (Joy Osofsky ed., 1996).

13. *See id.*

14. BRUCE PERRY, MALTREATED CHILDREN (1996).

15. Learning Disabilities: National Institute of Mental Health (1990). Sexually abused girls are more likely to mature earlier than non-abused girls and feel older than their peers. P.K. Turner et al., *Sexual Abuse, Pubertal Timing, and Subjective Age in Adolescent Girls* 17 J. REPRODUCTIVE & INFANT PSYCHOL. 111, 118 (1999).

16. Learning Disabilities: National Institute of Mental Health (1993). Maternal alcohol use during pregnancy is the leading cause of mental retardation and drug-induced birth defects. The human brain develops rapidly from the third to sixteenth week of pregnancy and is particularly vulnerable to the effects of alcohol. Alcohol exposure appears to affect the timing and pattern of nerve cell generation. MRI brain scans have found that the corpus collosum (connecting the brain's hemispheres) is smaller or entirely missing in children exposed to alcohol during pregnancy. These physical changes in the structure of the brain have been linked to impaired metacognitive social skills such as the ability to regulate impulses, define problems, generate solutions, evaluate consequences and monitor performance. ANN STREISSGUTH, FETAL ALCOHOL SYNDROME (1997). *See also* E. ABEL, FETAL ALCOHOL ABUSE SYNDROM (1998), H. Steinhausen et al., *Long-Term Psychopathological and Cognitive Outcome of Children with Fetal Alcohol Syndrome*, 32 J. AM. ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY 990, 994 (1993).

17. T. Greene et al., *Prenatal Alcohol Exposure & Cognitive Development in the Preschool Years*, 13 NEUROTOXICOLOGY & TERATOLOGY57, 68 (1991).

18. K. Larson, *A Research Review & Alternative Hypothesis Explaining the Link Between Learning Disability & Delinquency*, 21 J. LEARNING DISABILITIES 357, 363 (1988).

19. Diane Malbin. *FAS/FAE: Trying Differently Rather Than Harder*, OREGON STATE OFFICE FOR SERVICES TO CHILD. & FAMILIES (1999), Susan Rich & Charles Dean, *A Previously Unexamined Source of Delinquency* AJFCJ J.(1999).

20. IRA CHASNOFF ET AL., UNDERSTANDING THE DRUG EXPOSED CHILD (1998).

21. This philosophy fits with methods for schools to become safer without harsh punishments by focusing teacher training on positive classroom management, conflict resolution, cultural differences, and helping them understand the causes of disruptive behavior. Nationally, in 1997–1998, more than three million students were suspended and 87,000 were expelled; students of color are disproportionately suspended (typically for disobedience and disrespect of authority). African-American children represent 17% of public school enrollment but 33% of out-of-school suspensions. HARVARD UNIVERSITY ADVANCEMENT PROJECT: THE CIVIL RIGHTS PROJECT, OPPORTUNITIES SUSPENDED: THE DEVASTATING CONSEQUENCES OF ZERO TOLERANCE AND SCHOOL DISCIPLINE (2000).

22. R. Loeber et al., *Developmental Pathways in Disruptive Child Behavior*, 5 DEV. & PSYCHOPATHOLOGY 103, 133 (1993). *See also* J.M. Halperin et al., *Impulsivity and the Initiation of Fights in Children with Disruptive Behavior Disorders*, 36 J. PSYCHOL. PSYCHIATRY 1199, 1211 (1995).

23. Lois D. Trickey, Attorney for Society of Counsel Representing Accused Persons, Respondent's Brief on Capacity (December 4, 2000).

24. Students with disabilities who are disciplined may not be suspended for more than ten consecutive school days. A student with disabilities who has been removed from school for more than ten days in the same school year must receive educational services that will enable him/her to achieve the goals in the student's IEP. Students with disabilities removed from school for more than ten school days are entitled to a functional behavioral assessment and a behavioral intervention plan so that the IEP team (with the student's parents) can put into place the extra supports needed by the child. A student has a right to a review if there is a change in placement due to discipline to determine whether the behavior that led to the disciplinary action is related to the child's disability. If the team finds that the student's behavior is related to the disability, the student must be readmitted to school and his/her IEP should be changed to include services that address the behavioral problem.