Out of Control

Addressing the Rise in Psychiatric and Neurodevelopmental Disorders amongst Children and Young People

Zachary Marsh and Jean André Prager

Foreword by Rt Hon Sir Jeremy Hunt MP

Preface by Alun Francis OBE

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Endorsement

“I am delighted at the publication of this report. It is such a relief that this issue of ‘diagnostic inflation’ is now being taken seriously in policy circles. For too long, those of us who have raised red flags about the exponential rise of a recent cultural trend: the problematic medicalisation of more and more aspects of the human condition – have been dismissed as lacking empathy for suffering. In truth, when ever-greater numbers of young people are being encouraged – often by government-backed policies and a veritable industry of counsellors, therapists and psychotherapeutic practitioners – to pathologise normal, if adverse or perhaps painful, life events through the prism of mental illness and neurodivergence, we risk reducing the time and resources available to those who desperately need professional help.

The report rightly scrutinises the unsustainable financial costs for our welfare and education systems. But what’s even more tragic is the human costs: generations who are incited to see themselves as unable to cope with school, work and life, doomed to a life of dependence on state services. It is catastrophic for individuals’ sense of autonomy and aspiration, and something must indeed be done. We might argue about the specific policy recommendations of the report but well done to Policy Exchange for taking on this sacred cow and ensuring it is debated as a key political issue.”

Baroness Fox of Buckley, Non-affiliated Peer

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Select Abbreviations

AHP	Allied Health Professional
CIC	Community Interest Company
CQC	Care Quality Commission
CYP	Children and Young People
CYPMHS	Children and Young People Mental Health Services
DfE	Department for Education
DHSC	Department of Health and Social Care
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
EHCP	Education, Health, and Care Plans
ICB	Integrated Care Board
ICS	Integrated Care System
LTWP	Long Term Workforce Plan
NDEBIDs	Neurodevelopmental, Emotional, Behavioural and Intellectual Disorders
NHSE	National Health Service England
OT	Occupational Therapist
PIP	Personal Independence Payment
RCOT	Royal College of Occupational Therapists
RCSLT	Royal College of Speech and Language Therapists
SEN(D)	Special Educational Needs (and Disabilities)
SENCO	Special Educational Needs Coordinator
SLT	Speech and Language Therapist
SLCN	Speech, Language and Communication Needs

Foreword

Rt Hon Sir Jeremy Hunt MP, *Chancellor of the Exchequer, 2022-2024 & Secretary of State for Health and Social Care, 2012-2018*

Having served as Secretary of State for Health for over half a decade, I witnessed an alarming escalation in the prevalence and severity of mental ill-health among children and young people – alongside a significant increase in diagnoses of neurodevelopmental conditions.

In Government, we sought to create parity of esteem between mental and physical health and invested significantly in services. This was well-intentioned; it reduced stigma, improved awareness and enabled appropriate intervention for many young people.

But the huge spike in both reported and diagnosed cases of mental ill-health and neurodiversity we have seen in recent years requires us to ask some stretching questions of our policy approach.

This is a societal challenge of the highest order, given the impacts upon educational attainment, social integration, economic productivity and long-term well-being.

Mental ill-health and neurodiversity now accounts for more than half of the post-pandemic increase we have seen in claimants of disability benefit. Spending on SEND provision has sky-rocketed and risks the financial sustainability of Local Government.

Rather than assuming that more money or 'more of the same' is the answer, we need to ask more fundamental questions. Is a cash transfer – or a label that means young people are treated and come to see themselves as different – the right way to help them? What about the importance of good work, physical activity, social connection?

These factors are too often deprioritised in our policy prescription.

Across the political spectrum, and amongst a growing range of practitioners, it is now recognised that there is a level of 'overdiagnosis' our system. We need to cut through the complexity to better understand the drivers of demand we are seeing.

This new report from Policy Exchange is timely and prescient. It calls for nothing less than a fundamental re-evaluation of how we conceive and deliver support for our children and young people.

It is to be welcomed in particular for its exploration of the interplay between NHS mental health services, the Special Educational Needs and Disabilities (SEND) system and the health and disability benefits system. By comparing these distinct yet linked systems, the authors illuminate the connections, incentives – and ultimately, the poor outcomes that too often stem from it.

It shines a light on the emphasis and implications of support which hinges upon a formal diagnosis – and how this drives behaviours. The report also highlights that support can be poorly targeted, with reactive systems and limited and ineffective early intervention.

As a society, we seem to have lost sight of the fundamental reality that child development is a messy and uneven process. Our laudable desire to ensure young people are happy and well-supported is at times manifesting in excessive impulses to medicalise and diagnose the routine, in a manner that can undercut grit and resilience.

I would urge everyone with a stake in the future of our young people – policymakers, practitioners, parents, and indeed, young people themselves – to consider deeply the arguments and proposals put forward in this report.

Preface

***Alun Francis OBE**, Chair of the Social Mobility Commission; and Chief Executive of Blackpool and The Fylde College.*

In recent times, there has been a troubling trajectory in the health and development of our young people.

But the statistics of those reporting – and diagnosed – with mental ill-health and neurodiversity, while stark, only tells part of the story.

Behind every set of figures lie young people too often being let down by the system: either because they cannot access the support they need, or because the state's incentives encourage them to define what holds them back rather than what would help them to move forward, and to dwell on disadvantage.

We need to reorient this to create a more positive approach. Fundamentally, we need to raise our expectations for young people.

There has been a consensus that the spiralling of needs amongst children and young people is inevitable. This narrative has resulted in substantial resources poured into services of support, but which too often does not improve the outcomes or life chances of those the system is designed to help.

This thoughtful new report by Policy Exchange tips that assumption on its head. It demands that we re-evaluate the very foundations of our support structures – across a range of Government departments.

It makes the case that we must ensure that high-quality support is always there for those who need it most – and that this must come sooner and more flexibly to empower professionals to meet individual needs. Yet it also rightly identifies that, as a result of social pressures and poor incentives, too many young people and their families have become diagnosis-seeking, diluting the resources available to support those with the most acute needs – and meaning that the nature of support they are provided with may even be actively harmful.

This report's radical proposals for SEND are particularly noteworthy – and timely.

For too long, SEND has been viewed through a lens of deficit; a system characterised by bureaucratic hurdles, fragmented support, and a focus on what a child cannot do, rather than their potential. It has encouraged families and schools to escalate and entrench needs – rather than empowering the system to meet these more proactively and flexibly. They embark on a journey expecting a positive outcome, but find themselves in a disappointing dead end.

This report makes the compelling case that we must move from a tick-box attitude that solely prioritises 'meeting need' to one which has efficacy and outcomes at its core.

The proposals here are bold, and will undoubtedly provoke debate. That is precisely their intention. They are designed to stimulate a national conversation, to challenge thinking left in a default mode that is clearly not working and which is transparently unsustainable.

As the CEO of an FE college, I believe it is our moral imperative to engage with these ideas, to scrutinise them, and to work collaboratively to implement solutions that will genuinely improve the wellbeing and life chances of the next generation.

It is about ensuring that every child, regardless of their starting point or their challenges, has the opportunity to reach their full potential, to discover their strengths, and to contribute meaningfully to the world around them.

Executive Summary

There has been a significant growth in reported and formally-diagnosed mental ill-health and neurodivergence over the last decade amongst children and young people (CYP), straining our systems of support across health, education and welfare. There was a 48% increase in children and young people accessing NHS mental health services between 2021 and 2025, with an 11% per annum growth rate (since 2016). 1 in 5 children in the UK are now identified as having Special educational needs / disabilities (SEND), with the number of Education, Health and Care Plans (EHCPs) for those with the most severe needs increasing by 83% from 2015/16 to 2023/24. The number of 11-to 15-year-olds receiving Disability Living Allowance (DLA), in which the 'main condition' determining eligibility was a learning difficulty, such as Attention-Deficit/Hyperactivity Disorder (ADHD), increased by 70% between 2018 and 2024. These developments must be seen within a wider context too: there are now almost one million under-25s not in work, further education or training (NEETs), with a link between those with psychiatric or neurodevelopmental disorders and NEET status.[1]

The report considers the reasons behind this growth, examines the current provision of support across healthcare, education and welfare and sets out proposals to improve outcomes for CYP by delivering a more coherent, proactive and sustainable system.

Whilst there are complex reasons for the sizable increases in help-seeking and formal diagnosis of psychiatric and neurodevelopmental conditions, this cannot solely be explained by reduced stigma and growing awareness. Whilst these are factors, there must also be a greater recognition of the widening social definition of mental health and neurodiversity. A 'new normal' has been created which has led to a greater recognition of challenges, but also a greater acceptance of the withdrawal of young people from full participation in schooling, further education and work, owing to poor mental health.

The risks associated with 'overdiagnosis' and 'overtreatment' require far wider recognition and public discussion. The Secretary of State for Health and Social Care, Rt Hon Wes Streeting MP, has recently suggested that '*overdiagnosis*' represents a factor in rising caseloads. Despite the backlash, he is right to pose this issue – and has been joined by a growing number of practitioners. Whilst formal healthcare services clearly have an important role to play in the management and treatment of individuals with psychiatric or neurodevelopmental conditions, there are many instances where interventions (particularly some pharmaceutical

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[1] The Guardian, 'Uk faces youth jobs crisis as number of 'neets' rises to almost 1m', 27 February 2025, link.

interventions) may be inappropriate – and may in fact cause harm.

Each of our systems of support – across education, health and welfare – all have the same bug: each were designed to meet the needs of a small number of specialised cases, rather than the sizeable proportions of the total CYP population they are now expected to support. How we determine eligibility for support – and the nature of support itself – has not sufficiently evolved in-step with the shift in societal expectations and caseloads.

These systems of support can also incentivise *diagnosis-seeking behaviour*, by basing their support upon formal diagnosis. The consequence of this development overall, as Dr Lucy Foulkes has recently put it, is '*we are in a situation where some adolescents are very legitimately experiencing mental health crises, without decent treatment, while others are inaccurately describing typical developmental stress with the language of disorder*'.[2]

Yet there is also an inflexibility and incoherence to these systems of support. Core definitions, defining eligibility for support are subjective and differ across services. For example, assessments for the Disabled Living Allowance (DLA) require assessors to judge which children require '*substantially more care, attention or supervision*', whilst having SEND is defined as needing '*special educational provision to be made*'. A lack of clear criteria means equivalent cases may be handled very differently. Greater coherence across Government in planning the transition from children to adult services is needed.

The consequence of this is a system which has squeezed support for those with the most severe needs but is ineffectively proactive or preventative. Even as spending on EHCPs for those with SEND has ballooned, the expanded gateway has meant funding per head has fallen by a third since 2015/16. We see the prevalence of a larger number of milder cases, resulting in those with the greatest need receiving more delayed and more limited support.

The fact that additional resource and attention is not delivering improved outcomes, coupled with the fact that there are risks associated with overdiagnosis, must necessitate a paradigm shift in our policy approach. In some cases, systems have lost sight of the need to deliver better outcomes for young people, instead delivering provision as an end unto itself. For instance, speech and language therapists have noted the significant rise in statutory work, driven by EHCPs, which has reduced their ability to flexibly deliver support. Moreover, SEND students' education is disrupted by interventions that hamper learning and deny access to a broad and balanced curriculum. 19-year-olds with EHCPs were 6% more likely to achieve Level 2 qualifications in 2015/16 than in 2022/23.

Overall, we have under-weighted the significance of the 'wider determinants' of behaviour or poor mental health – both in terms of the nature of care provided and our overall public policy response: the vital role of a supportive family life and of the role of parenting; of the importance of sleep; of regular physical exercise; of securing

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[2] Lucy Foulkes, 'The Adolescent Mental Health Mess', *Medium*, 4 Jan 2024, link.

good employment or undertaking further education or training and of minimising excessive screen time.

Ultimately, we need to revise our approach and raise our expectations. We need to ask of our young people what they can do – with the right support – rather than what they can't. We also need to ask tough questions – based on our necessarily limited resources – as to whether support for individuals who come forward for support with any psychiatric and/or neurodevelopmental disorder at any level of severity ought to always result in a presumption of additional support at school (such as additional time for examinations) or additional financial support (such as a cash transfer).

So what should be done?

It is crucial that the Government – and key professional groups responsible for our systems of support, including healthcare and teaching professionals – consider the risks of over-diagnosis and how current support may encourage an escalation of need, rather than effectively targeting support where it is needed most. This will be an essential consideration as the Government conducts a wider review into mental health services, as it sets out reforms to the SEND system, as it rolls out other supportive services such as Family Hubs, and as it finalises its National Youth Strategy.

For those requiring support from formalised healthcare services, **far more effective initial triage and coordination of resources (delivered by the NHS and Local Government) is required**. So too will be more effective data collection and reporting of service performance and outcomes. Improvement in these areas should in turn inform improved coordination of professionals working across services. The latest evidence on the impact of 'excessive' screen time – as a risk factor for mental ill-health and upon neurodevelopmental disorders – should be updated in guidance and integrated into clinical practice. This information should also be imparted to parents from as early as their first engagement with neonatal and early years services.

The fundamental principles of England's SEND system must be re-evaluated – and reforms introduced. Current incentives that escalate need through the system need to be repealed. Crucially, the potential for the system to deliver unlimited, personalised support must be ended to restore financial sustainability and empower professionals to make efficient and effective decisions on support. To that end, The Children and Families Act 2014 and 2015 SEND Code of Practice should be repealed and replaced with a new statutory regime. EHCPs should become non-statutory documents and a new national model for SEND in mainstream settings should be introduced, supported by a new National Institute for Special Educational Needs and Disabilities Support (NISENDS) to formulate NICE-style guidance for schools on how to identify and support SEND needs effectively.

Commensurate with reforms being undertaken for Universal Credit and the Personal Independence Payment: the application process

and assessment for the Disability Living Allowance (DLA) should be reformed. Every case should be supported by medical evidence, with the opportunity for video and photo evidence to be supplied; the DWP should meanwhile introduce more frequent review of cases for younger claimants (every 3 years for DLA, rather than 5).

Summary of Recommendations

1. **The Government should ensure greater coherence across mental health and neurodevelopmental services by aligning the age-based eligibility for supportive services.**
    a. This should proceed by using the legal point of adulthood 18.
    b. EHCP provision should finish at the end of the academic year at which a child turns 18.
    c. The age at which the Personal Independence Payment (PIP) can be claimed should be increased incrementally to 18.

2. **Information/Data Sharing Protocols across services, spanning health, education and welfare must be enhanced.**
    a. This will be essential to developing case management systems and to support service integration (where applicable).
    b. Clear protocols should be established for sharing relevant information between different agencies to avoid duplication.

3. **An expansion of Family Hubs should be regarded as an opportunity for improved information sharing, early identification of issues and as an opportunity to boost the role of parents in driving improved outcomes across psychiatric and neurodevelopmental conditions.**
    a. The role of Family Hubs in meeting the needs of families with SEND should be reviewed, with particular attention to the Care Review recommendations for SEND at a locality level.[3]

4. **A full, statutory ban on the possession and use of smartphones in all schools in England – as first proposed in Policy Exchange's report, *Disconnect* – should be announced.**[4]

5. **The Government should introduce a new scheme called 'Active Start' to expand the range of premises for physical activity for CYP in areas of current areas of under-provision.**

Education

6. **The current SEND system and the policies that underpin it should be scrapped. The Children and Families Act 2014 and 2015 SEND Code of Practice should be repealed and replaced with a new statutory regime.**

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[3] Department for Education, 'Family Hubs Innovation Fund Evaluation', November 2023, link.

[4] Policy Exchange, 'The Case for a Smartphone Ban in Schools', 30 April 2024, link.

   a. As part of this process EHCPs should be reformed to become non-statutory documents, and the obligation for local authorities to meet the costs associated with EHCPs should be removed.
   b. No new EHCPs should be issued for mainstream settings from 2026. EHCPs should be reformed to serve as a passporting assessment into specialist settings.

7. **A new national model for SEND in mainstream settings.**
   a. Schools should receive expanded, ringfenced SEND budgets from national government through a new National SEND Funding Formula. Schools should retain discretion over how to spend this budget, including to support high quality teaching by teachers within mainstream classes.
   b. Schools should be expected to commission specialist support for their routine SEND provision, such as Educational Psychologists and Speech and Language Therapists, as part of this expanded offer.
   c. Schools should be encouraged to create and expand specialist unit hubs to support children with SEND needs alongside mainstream settings. These could be delivered across multiple schools, such as within a trust. Schools should fund these unit hubs from within their new SEND budgets.

8. **A new passporting system for special schools.**
   a. Local authorities should hold responsibility for baseline funding for special schools and alternative provision from their Higher Needs Funding block. Where the block is not fully spent local authorities would be obligated to distribute outstanding funds to schools within the local authority.
   b. Local authorities should retain responsibility for conducting EHCP assessments for those deemed to require provision outside of mainstream settings. The assessment criteria should be revised to raise the standard for securing an EHCP, with the grounds for appeal tightened to streamline the system. Sections F, G and H should be removed from the EHCP, with specialist settings given flexibility to meet the needs established in the document.
   c. Local authorities would be authorised to manage passporting into specialist settings based on the resources and capacity available within budgets to support students.
   d. In cases where there are localised spikes in acute SEND need, local authorities may apply directly to a National Emergency Relief Fund for a temporary uplift in their Higher Needs Funding block.

9. **A new National Institute for Special Educational Needs and**

Disabilities Support (NISENDS) should be created to formulate NICE-style guidance for schools on how to identify and support SEND needs effectively.

   a. NISENDS should establish guidance for defining and identifying SEND needs, including clear symptoms identified with specific conditions.
   b. NISENDS should evaluate the efficacy of different forms of SEND provision and establish tariff bands for what may be paid for specific kinds of provision. This should include assessing and recommending effective pedagogy and techniques to support SEND within mainstream lessons.
   c. All schools, regardless of status, should only be allowed to commission or utilise SEND provision and pedagogy approved by NISENDS. Local authorities may only include NISENDS-approved provision in their Local Offer.

Health & Social Care

10. **The Department of Health and Social Care / NHS England should develop a new integrated dataset to measure the changing burden of mental ill-health and neurodevelopmental disorders.**
    a. The Adult Psychiatric Morbidity Survey was last updated in 2014 (although we can expect a new publication later this year), but we lack a similar survey for CYP. One should be developed which publishes on an annual basis. The survey should include the formal publication of diagnoses of neurodevelopmental disorders, including ASD and ADHD.
    b. In addition, national standards for data collection across both children's and adult services for ADHD should be introduced to build a more consistent picture on access and performance.

11. **Every Integrated Care System (ICS) in England should commission a single point of access (SPA) model.**
    a. The aim should be to streamline referrals into NHS child and adolescent mental health services to improve triage and to reduce waiting times for suitable assessment.
    b. There is an opportunity for GIRFT to identify best practice in relation to screening processes – with a view to reducing current unwarranted variation. As a minimum, standard referral forms should be introduced to streamline referral processes.

12. **'Mutual aid' should become commonplace across every integrated care system (ICS) footprint in England to maximise the use of the existing multi-disciplinary workforce across settings.**

   a. The aim should be to maximise capacity and expertise across a given geography & as a means of providing additional opportunity for professionals to retain credentials to perform assessments – particularly for ASD.

13. **Mental health interventions in schools should shift to becoming targeted interventions, rather than uniform offers.**
   a. This is essential where there is growing evidence of the ineffectiveness, even potential for 'negative effects' emerging from some universal offers.[5]

14. **The Department of Health and Social Care (DHSC) should announce a set of measures to boost clinician and parental understanding of the 'digital determinants' of mental health and child development.**
   a. NICE should update guidance relating to the plausible impacts of excessive screen time upon CYP development and mental health to support clinical practice.
   b. The Chief Medical Officer – as part of ongoing work to update guidance – should ensure there is sufficient focus upon the 'first 1000 days' and early years as part of his ongoing review of the impact of screens and CYP.

Welfare

15. **The Department for Work and Pensions (DWP) should review the role of the child DLA over the next twelve months, to dovetail with their planned review of the Personal Independence Payment (PIP) (Timms Review).**
   a. The review into Child DLA should closely replicate the Timms Review. It should examine the full assessment process, including the assessment criteria, eligibility criteria (specifically, the duration of time a child must have lived in England, Scotland, or Wales), and the interrelationship between DLA and other support for young disabled people, as well as the transition from DLA to PIP**.**

16. **The DWP should move to reviewing DLA awards every three years to provide more effective ongoing monitoring and assessment of development.**
   a. The latest data suggests that almost 60% of current awards are for more than 5 years.

17. **Medical evidence should be provided to support every claim for the DLA, with each claimant offered the opportunity to attend an in-person assessment.**
   a. To modernise the provision of evidence, parents (or carers)

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[5] Child and Adolescent Mental Health, 'Debate: Where to next for universal school-based mental health interventions? Time to move towards more effective alternatives', 7 December 2024, link.

should be able to upload photo or video evidence to support their claim through an updated portal.

18. **The Prospective Test for PIP should be expanded to eighteen months.**
    a. The Prospective Test for PIP is currently nine months in duration. While we recognize that this aligns with the definition in the Equality Act and its guidance, we think there should be a re-evaluation as to whether nine months constitutes 'long-term'.
    b. While recognising that this is arbitrary, we believe that a medical panel should undertake a review of whether the length of time for the Prospective Test is correct, and we would suggest that the Prospective Test should be set at 18 months.

19. **For those aged 16 to 30, all health and disability benefits – including the Personal Independence Payment (PIP) as previously recommended by Policy Exchange – should become 'conditional', with exceptions in only limited circumstances.**

An Overview of Psychiatric, Neurodevelopmental and Behavioural Disorders

This report examines the growth in reported and diagnosed psychiatric conditions amongst children and young people (CYP) alongside neurodevelopmental, emotional, behavioural and intellectual disorders (NDEBIDs). It considers how the state supports individuals and families with their diagnosis, management, and – where applicable – treatment.

Figure 1 below provides a categorisation of this heterogenous range of disorders, complete with examples and a brief overview of their onset and characteristics. It is important to note that some disorders included here, such as Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) are sometimes described as being 'mental health' conditions. They are neurodevelopmental, rather than psychiatric conditions, however. By way of illustration, **ADHD can be viewed as lying along a spectrum (neurodivergence) as well as being a clinical diagnosis (disorder).**[6]

Yet there can be (and often is) considerable co-occurrence between psychiatric and neurodevelopmental disorders. This is one of the primary justifications for examining them side-by-side. As one study puts it, the '*co-existence of a number of NDEBIDs within the same [child or young person] and sharing of symptoms across other disorders (co-morbidity) is the rule rather than the exception*'.[7]

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[6] NHS England, 'Report of the Independent ADHD Taskforce', 20 June 2025, link.

[7] Common Pediatric Diseases, 'The Role of Integrated Services in the Care of Children and Young People with Neurodevelopmental Disorders and Co-Morbid Mental Health Difficulties: An International Perspective', October 2023, link.

Figure 1: Psychiatric, Neurodevelopmental and Behavioural Conditions

Category	Relevant Conditions and / or Disorders	Onset	Features
Psychiatric	• Depressive or anxiety disorders • Bipolar Disorder • Schizophrenia • Eating Disorders • Personality Disorders. These can be divided into: • **Common mental disorders (CMDs):** comprising different types of depression and anxiety causing 'marked emotional distress and interfere with daily function, but do not usually affect insight or cognition'.[8] And; • **Severe mental illness (SMI):** psychological problems that are 'often so debilitating that the ability to engage in functional and occupational activities is severely impaired'.[9] SMI can also include anxiety disorders, eating disorders, and personality disorders, if the degree of functional impairment is severe.[10]	Often arise from a complex interplay: genetic predisposition, brain chemistry, environmental factors (like stress or trauma), and psychological experiences. While there may be biological underpinnings, the focus is often on changes in mood, thinking, and behaviour that develop over time. While some psychiatric conditions can emerge in childhood or adolescence, many can also develop in adulthood. The onset can be gradual or sudden, and the course of the condition can vary (episodic, chronic, etc.)	Primarily involve disturbances in a person's thoughts, feelings, perceptions, and behaviour. While neurobiological factors can play a role, the clinical focus is often on the subjective experience and observable symptoms as they relate to a person's mental and emotional well-being.

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[8] University College London, 'Adult Psychiatric Morbidity Survey 2014 Chapter 2:', 2014, link.

[9] Public Health England, 'Severe Mental Illness (SMI) and Physical Health Inequalities: Briefing', 27 September 2018, link.

[10] National Library of Medicine, 'Disparities with Serious Mental Illness', May 2016, link.

Neuro-developmental	• Autism Spectrum Disorder (ASD) • Attention-Deficit/Hyperactivity Disorder (ADHD) • Learning Disorders (e.g. dyslexia and dyscalculia), Communication Disorders • Motor Disorders (e.g. Developmental Coordination Disorder).	Conditions arise from differences in brain development in early development, often before or during birth, or in early childhood. These developmental variations can be influenced by genetic factors, environmental factors (such as exposure to toxins during pregnancy), or a combination of both.	Primarily affect the development of the nervous system, impacting learning, behaviour, communication, motor skills, and social interaction.
Behavioural	• Oppositional Defiant Disorder (ODD) • Conduct Behavioural Disorder (CD)	Characterised by patterns of behaviour that deviate from accepted social norms and expectations, causing distress or impairment in various life domains (e.g., school or home). Origins are often multifaceted, involving a combination of genetic predispositions, environmental influences (such as family dynamics, upbringing, and exposure to trauma), learned behaviours or co-occurring psychiatric conditions. Can emerge at any age, from childhood through adulthood. Some, like Oppositional Defiant Disorder or Conduct Disorder, typically manifest in childhood or adolescence.	A central feature is the presence of persistent and problematic patterns of action and response to situations. These behaviours can be directed towards oneself (e.g., self-harm), others (e.g., aggression, rule-breaking), or both. They often involve difficulties with self-control, impulsivity, regulation of emotions (leading to behavioural outbursts), and adherence to social rules and norms.

Introduction

> *'Mental wellbeing, illness, it's a spectrum and I think definitely there's an overdiagnosis but there's too many people being written off.'*[11]
>
> **Rt Hon Wes Streeting MP**, Secretary of State for Health and Social Care

In recent years, a lively debate has taken place about why the prevalence of psychiatric, neurodevelopmental and behavioural disorders appear to have grown so considerably amongst children and young people (CYP).[12] This has been a phenomenon observed not just across the UK, but also across many Western countries. The rise has been particularly notable since the COVID-19 pandemic, but predates it.[13]

A recently published survey suggests that more than one million 18 to 24-year-olds are struggling with their mental health, accounting for 22% of the 'Gen Z' age group. (Compared to an average of 8% across the entire population).[14] Sir Charlie Mayfield's recently-published interim 'Keep Britain Working' review notes that '*those reporting mental health conditions as their primary challenge has increased by over 70% since 2015, with the younger population contributing over 60% of this rise*'.[15] In 2023, it was reported that 1 in 5 CYP between the ages of 8 and 25 in England were diagnosed as having a 'probable mental disorder', with notable rises in the diagnosis of common mental disorders, such as anxiety and depression.[16] Alarmingly, we have also seen an increase in levels of self-harm (both with and without suicidal intent).[17]

The total number of referrals to specialist NHS Children and Young People's Mental Health Services (CYPMHS) tripled from 40,000 in 2016 to almost 120,000 in 2024.[18] The rate of referrals has increased by 11.7 per cent a year from 2016 to 2024.[19] CYP now wait three times as long on average for specialist services, compared to a decade ago. There is a 170 day wait (on average) for accessing mental health services for CYP across the NHS (compared to 57 days in 2017/18).[20]

The increase has been particularly striking for neurodevelopmental disorders. Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) doubled amongst boys in England between 2000 and 2018, with the rise particularly sharp over the past five years.[21] In October 2019, the total number of people waiting for an assessment of Autistic Spectrum Disorder (ASD) was 28,480. By December 2023, that total had grown to 172,022 people, a 504% increase in less than five years. The vast majority of those assessed were CYP.[22]

Diagnoses of Special Educational Needs (SEN) in English schools have

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[11] BBC, 'Mental health conditions are overdiagnosed, Streeting says', 16th March 2025, link.

[12] Please see Table 1 for a breakdown of the conditions which are encompassed by these terms.

[13] On the impact of the COVID-19 pandemic, see: link.

[14] The Telegraph, 'Quarter of Gen Z suffer long-term mental health issues in blow to Reeves's growth plans', 7th August 2024, link.

[15] Gov.uk, 'Keep Britain Working Review', March 2025, link.

[16] NHS England, 'Mental Health of Children and Young People in England...', 21st November 2023, link.

[17] NHS, 'Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4', 26th June 2025, link.

[18] NHS, 'Independent Investigation of the National Health Service in England', September 2024, link.

[19] Ibid.,

[20] The King's Fund, 'Mental health 360', 21 February 2024, link.

[21] UCL, 'Significant rise in ADHD diagnoses in the UK', 17 July 2023, link.

[22] Nuffield Trust, 'The rapidly growing waiting lists for autism and ADHD assessments', link.

risen rapidly. After a drop in overall SEN numbers between 2010 and 2016, the number of SEN students has grown significantly.[23] Just under one in five pupils in England are now identified as having a SEN need.[24] Those with the most severe needs who qualify for an Education, Health and Care Plan (EHCP) have risen almost threefold, with 72% of those with EHCPs being male.[25] 29.1% of all ECHPs are now for children identified as having Autistic Spectrum Disorder (ASD).[26]

SEN demand has placed huge pressures on the funding of schools and local government**.** In 2024, the National Audit Office estimated SEN provision cost a total of £10.7bn – a rise of 58% over the course of a decade.[27] This has had an extreme effect on local authority budgets from which SEN funding is drawn. Nationwide council deficits as a result of SEN now stand at £2 billion a year.[28]

We have also seen a significant uptick in claims for health and disability benefits from those under the age of 25. There are now 1.2 million people under 25 claiming health and disability benefits, representing a rise of two-thirds in just five years.[29] Over the last decade, the number of under-16s in receipt of Disability Living Allowance (DLA) in England and Wales has doubled, reaching 682,000 in 2023. This is equivalent to one-in-sixteen children. In real terms, spending on children's disability benefits more than doubled from £1.9 billion in 2013-14 to £4.0 billion in 2023-24 (all figures in 2024-25 prices), equivalent to an average rise of 6.2 per cent a year.[30]

This growing caseload has been driven almost entirely by awards made to children whose main condition is either a learning difficulty, neurodevelopmental or behavioural disorder(s): in 2023, four-fifths of all DLA awards were for children whose main condition was included within these categories, including ADHD and ASD.[31]

What is clear from this overview is that the changing pace and scale of demand has overwhelmed our systems of support.

There has also been widespread conversation about the wider prevalence of dissatisfaction amongst CYP. The 2022 Programme for International Student Assessment (Pisa) survey, for 2022 showed that across the UK, 30.9 per cent of girls aged 15 reported low life satisfaction — more than the 19.8 per cent of boys, and higher than the European average for girls, which was 21 per cent. The Children's Society have called this a 'happiness recession'.[32]

These developments must be seen within the wider context – and challenge – that there are now almost one million under-25s not in work, further education or training (and are, so-called NEETs).[33] It is estimated that around a third of young people who are NEET have ADHD and that around 40% of children in youth offending institutions have ADHD.[34]

The report considers the reasons behind this growth; examines the current provision of support and/or treatment across a range of Government services, namely in education, healthcare and welfare; and makes a series of policy recommendations to deliver improved outcomes for CYP in a more joined-up, proactive and sustainable system.

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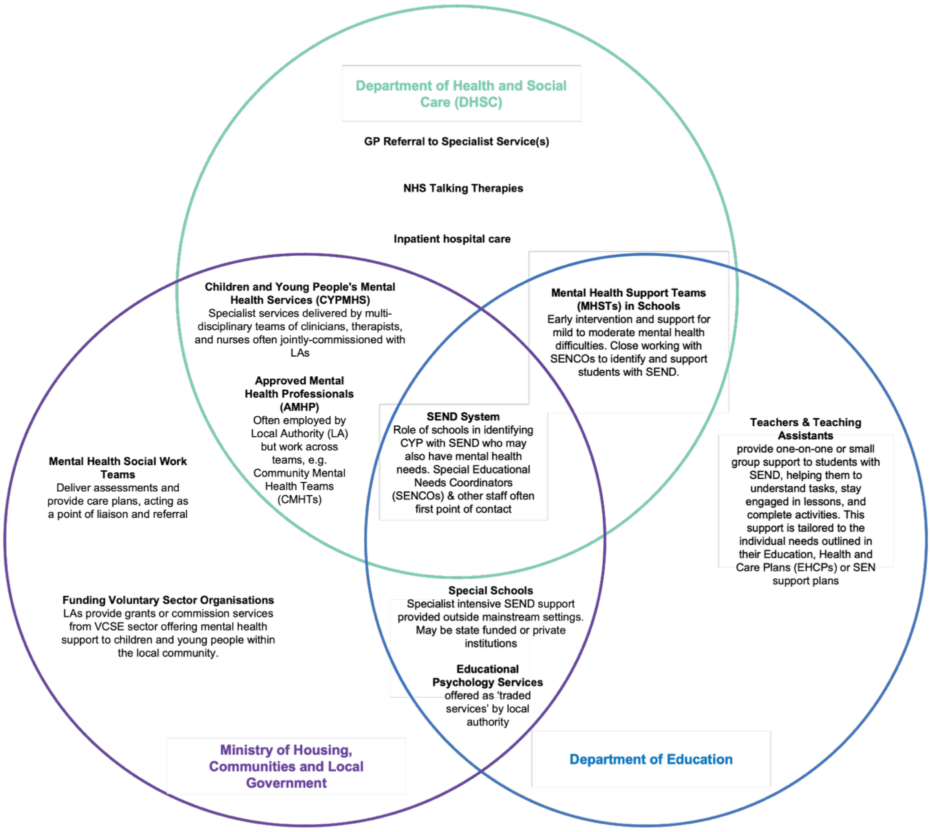
23. IFS, 'Spending on special education needs in England: something has to change', December 2024, link.
24. House of Commons Library, 'Special Education Needs: Support in England', 11 July 2025, link.
25. National Audit Office, 'Support for children and young people with special educational needs', 24 October 2024, link.
26. DBV, 'Delivering Better Value in SEND', link.
27. National Audit Offices, 'Special Education Needs system is financially 'unsustainable'', 24 October 2024, link.
28. County Councils Network, 'SEND deficits risk bankrupting almost three quarters of England's largest councils by 2027, with government urged to take action', 21 October 2024, link.
29. The Times, 'One in ten working-age adults now claiming sickness benefits', 17 March 2025, link.
30. Resolution Foundation, 'Growing Pressures: Exploring trends in children's disability benefits', 17 August 2024, link.
31. Ibid.
32. The Times, 'Teenagers in the UK face 'happiness recession', 29 August 2024, link.
33. The Guardian, 'UK faces youth jobs crisis as number of 'neets' rises to almost 1m', 27 February 2025, link
34. National Library of Medicine, 'Young-Adult Social Outcomes of Attention-Deficit/Hyperactivity Disorder', 25 January 2023, link.

There are a complex set of overlapping services which are involved in identifying, referring, diagnosing, supporting or treating CYP, which encompass a similarly large and diverse range of professionals (both clinical and non-clinical). Figure 2, below depicts this ecosystem and is illustrative, rather than exhaustive.

Figure 2: Mapping the Ecosystem of Support for CYP with Psychiatric, Neurodevelopmental and Behavioural Conditions



What this mapping reveals is not just a complex web of organisations and services with responsibility for supporting individuals, families or in delivering care, but also a large range of professionals who are involved in identifying, referring, diagnosing or supporting CYP, who often work across a variety of settings.

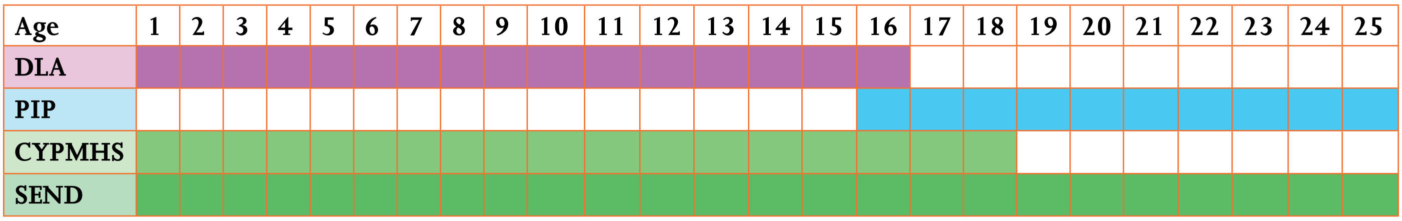
This includes teachers and school nurses, youth and social workers, staff working in NHS general practice or in Children and Young People's Mental Health Services (CYPMHS), including paediatricians.

Across three distinct chapters (1,2 and 3 respectively), this paper focuses on the operation and interaction of the following services:

Figure 3: Services and programmes relevant to CYP mental health and neurodivergence

Department	Service(s)	Description	Eligible Cohort	Comparative
Department for Education (DfE)	**Special Educational Needs and Disabilities (SEND)**	Statutory support provided by schools (e.g. speech and language therapy); often set out via education, health and care (EHC) plan.	Up to 25 years of age	MHSTs commissioned with NHS CYPMHS – cross-over in workforce
Department of Health and Social Care (DHSC)	**NHS children's and young adult's mental health services**	Clinical service provision, delivered by NHS providers (often jointly commissioned with local authorities)	Between 5-18 years of age	Each ICB has both leadership and statutory responsibilities for SEN provision
Department of Work and Pensions (DWP)	**The Disability Living Allowance (DLA)** **Personal Independence Payment (PIP)**	Benefit(s) designed to meet the additional costs associated with a disability or development.	Up to 16 years of age From 16 years of age	EHCP can be used as evidence for eligibility for DLA

Figure 4: Comparison of Age-Based Eligibility for SEND, NHS CYPMHS and DLA/PIP



Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
DLA	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪	🟪									
PIP																🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦
CYPMHS	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩							
SEND	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩

Time to Challenge Orthodoxy?

The reasons underlying these developments have been largely assumed to be driven by what we might call the 'orthodox' perspective: that the growth in diagnoses with these conditions is real. CYP are just more anxious and stressed today than in the past; that there is simply greater incidence of behavioural and neurodevelopmental challenges in the population. Coupled with an improvement in diagnostic techniques and our overall understanding (alongside a reduction in stigma), the growth in demand can be understood.

As such, the public policy response has been to boost awareness and to increase the provision of support – both in clinical contexts, but increasingly across a wider range of settings too, from schools to other local authority-funded services, such as Family Hubs. For instance, the two largest parties at Westminster both pledged to put a 'mental health professional in every school' during the 2024 General Election and we have seen the creation of new roles to deliver these services.

Yet we have begun to see more people challenge this perspective. A wider range of 'iconoclastic' perspectives have gained purchase across the political spectrum. On the Left, the case has been made that the development of the 'wellness industry', of the growth in counselling services driven by corporations and 'big pharma' bear responsibility. The Government has recently announced that it seeks to crack down on what it has described as an 'unregulated private sector' in counselling.[35] On the Right, commentators have begun to query whether such a growth in demand is genuine, or whether a wider set of societal factors and 'social contagion' bear greater responsibility for this growth.

Whilst these 'iconoclastic' perspectives have been described by some as an attempt at stoking new frontiers in the 'culture wars', such a conclusion would now be to neglect the widespread commentary – and concern – in these developments reflected by a far wider range of healthcare professionals, who reflect that diagnosing young people's '*differences or distress as disorders, from depression and ADHD to autism…are medicalising ordinary or understandable reactions and behaviours*'.[36] Professor Sir Simon Wessely for instance, Regius Professor of Psychiatry at the Institute of Psychiatry, King's College London and former President of the Royal College of Psychiatrists, has warned of the dangers of '*overprofessionalising or medicalising*' conditions that are '*not really the business of doctors and GPs*'.[37] These are, therefore, entirely legitimate questions to ask.

A Case of 'Overdiagnosis'?

For a number of the disorders explored in this paper, diagnostic criteria have been relaxed in recent years which has allowed them to be diagnosed in milder forms. For example, the NHS website describes how symptoms of depression in children may include: '*sadness, or a low mood that does not go away*' and '*being irritable or grumpy all the time*' yet these descriptions will inevitably cause confusion for parents trying to distinguish between what is 'normal' teenage behaviour and more serious mental illness.[38]

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35. Pulse, 'Minister announces crackdown on private sector therapists at Pulse conference', 19 March 2025, link.
36. The Telegraph, 'Diagnosing a child with autism or ADHD? There's a lot of money to be made', 18 March 2025, link.
37. The Times, 'Mental health awareness 'creating demand NHS was not set up to meet', 19 August 2024, link.
38. NHS, 'Depression in children and young people', link.

Some commentators have raised challenges with what is called the 'prevalence inflation hypothesis' and 'overinterpretation' to explain these changes.[39] As Dr Suzanne O'Sullivan has recently put it, *'overdiagnosis is when a diagnosis may well be entirely correct but, crucially, isn't benefiting the patient'*.[40] *'Overdiagnosis is not only something done to us but something we do to ourselves, usually unwittingly. People want answers. Healthcare professionals want to provide answers for their patients, making this a natural impulse, albeit with knock-on consequences'*.[41]

Fifty years ago, just one in 2,500 people was said to have Autism; today that has risen to one in 36 children in the UK (including one in 20 children in Northern Ireland).[42] Indeed, there is an ongoing debate amongst healthcare professionals about whether we ought to regard some of the conditions here under review as 'disorders' at all.[43] Many more are asking whether medical intervention is in fact the most appropriate vehicle or focus to support individuals' needs and to improve outcomes. For this can mean that the problems we encounter in everyday life are reinterpreted as medical ones.

This development has begun to be recognised and acted upon by policymakers. Consider the most recent statutory Relationships, Education, Relationships and Sex Education (RSE) and Health Education guidance, which now reflects *'that worrying and feeling down are normal, can affect everyone at different times and are not in themselves a sign of a mental-health condition'*.[44]

There is little doubt that public policy development has been significantly impacted by societal shifts in expectations. It is not uncommon to now hear of patients 'waiting for their child to get an ADHD diagnosis'. This is a form of 'diagnosis creep', in which the number of people with a diagnosis grows not through scientific advancement or discovery but through a change in what society is willing to consider as normal.[45]

The combination of shifting societal expectations and the development of systems of support which require formal diagnosis for eligibility – are factors which have encouraged the growth in *diagnosis-seeking behaviour* across our systems of support.

The Case for a Paradigm Shift

These developments raise more fundamental questions about the lives and experience of our children and young people and how the underlying incentives in our system, coupled with new challenges such as the 'digital determinants' of health, or of a 'phone-based childhood', persuasively argued by Professor Jonathan Haidt, with evidence increasingly suggesting a series of dramatic impacts upon CYP during critical stages in both their cognitive and physical development.[46]

In policy terms, the aim of this report is to set out how a more joined up, rationalised system, can be developed which is able to effectively differentiate between the most severe cases where the need is greatest. This is vital to balancing appropriate levels of support and fiscal sustainability.

In doing so, we build on previous Policy Exchange interventions on this subject matter.

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39. Science Direct, 'Are mental health awareness efforts contributing to the rise in reported mental health problems? A call to test the prevalence inflation hypothesis', April 2023, link. It should be noted that further studies seek to test this thesis: link.
40. The Times, 'Our new health crisis — we're diagnosing too much, too early', 14 March 2025, link.
41. Ibid.
42. The Times, 'Diagnosing a child with autism or ADHD? There's a lot of money to be made', 18 March 2025, link.
43. The Economist, 'Researchers are questioning if ADHD should be seen as a disorder', 30 October 2024, link.
44. DfE, 'Relationships, Education, Relationships and Sex Education (RSE) and Health Education', 25 June 2019, link.
45. The Times, 'Our new health crisis', 14 March 2025, link.
46. The Atlantic, 'End the phone-based childhood now', 13 March 2024, link.

- *Disconnect* appraised the link between smartphone use in schools, academic attainment and mental health, calling for an 'Effective' smartphone ban in schools.[47]
- *Not Fit for Purpose* explored current approaches to certifying fitness to work (including use of the 'fit note' and health-related benefit assessments), considering the social, medical and fiscal implications of the rise in individuals being signed-off work for mental ill-health or being in receipt of health-related benefits.[48]
- *For Whose Benefit?* proposed a package of reforms to the health and disability benefit system.[49]

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[47] Policy Exchange, 'Disconnect', 30 April 2024, link.

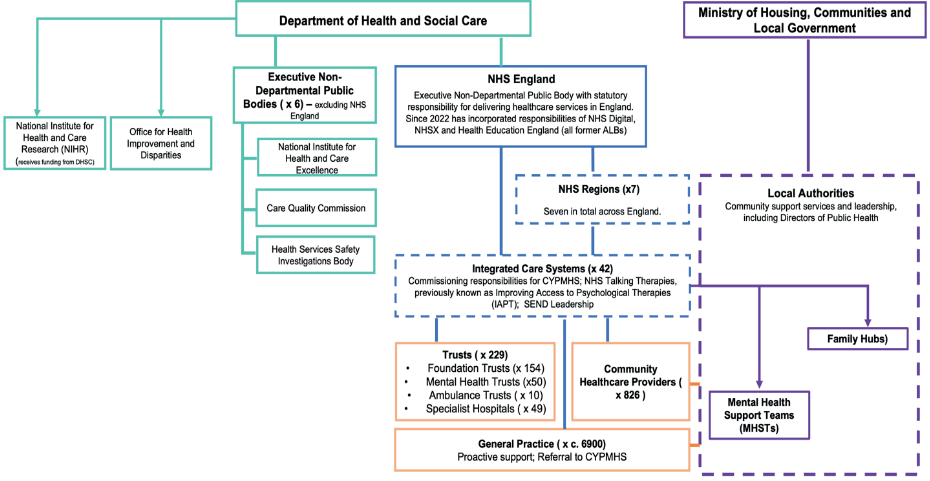
[48] Policy Exchange, 'Not Fit For Purpose', 13 April 2024, link.

[49] Policy Exchange, 'For Whose Benefit?', 6 March 2025, link.

Chapter 1 – Health & Social Care

This chapter examines the impact that the growing number of children and young people seeking advice, support and treatment for mental ill-health, behavioural and neurodevelopmental conditions is having upon the provision of formal healthcare services – mostly delivered by NHS providers.

Figure 5: Mapping the Commissioning Arrangements and Responsibilities for CYP Mental Health Services Across the NHS Today



Today, the NHS either directly provides, or supports, a range of services to support children and young people with mental ill health, behavioural or neurodevelopmental issues (in addition to services which cover the entire population, such as general practice and accident and emergency (A&E)). See Fig. 5 above. This includes:

1. Children and Young People's Mental Health Services (CYPMHS) [*also known as Child and Adolescent Mental Health Services* (*CAMHS*)], services designed and commissioned at 'System' level, i.e. by Integrated Care Systems (ICSs) to '*help children and young people up to 18 who are finding it hard to cope with everyday life because of difficult feelings, behaviour or relationships*.'
2. Services commissioned at a national-level by NHS England, but

delivered by NHS-led 'provider collaboratives', i.e. most often with an NHS Trust the 'lead provider', but working in partnership with local authorities, independent sector providers etc.

3. The NHS Talking Therapies for Anxiety and Depression programme (TTAD), formerly 'Improving Access to Psychological Therapies' (IAPT), programme which focuses on cognitive behavioural therapy, counselling and self-help support – collectively known as 'talking therapies'. People can be referred by their GP, or can self-refer.
4. Mental health support teams (MHSTs), developed in recent years and operating in schools and colleges.
5. Services commissioned and/or funded by local authorities and delivered by the VCSE sector, such as charities and social enterprises.
6. Services commissioned locally, but delivered by independent sector providers (both remote and in-person services).

Most of these services are focused upon individuals under 18 years of age, with individuals then supported by adult mental health services (AMHS). But some services across the country will support individuals up to the age of 25, dependent on personal circumstances and local availability.[50]

Context

Early years, childhood and adolescence represent an important period which significantly affects predisposition to mental ill-health.[51] It has been suggested that half of all mental health disorders start before the age of fourteen.[52] Three quarters of mental health problems start before the age of twenty-five.[53] As such, identifying early-life risk factors, developing preventative interventions and ensuring effective provision of care are vital to improving lifelong mental health trajectories.[54]

Mental ill-health in childhood or adolescence has significant knock-on effects. Individuals who have a 'probable mental disorder' are more likely to take longer periods of absence from education and they are far more likely to be unemployed. Between 2018 and 2022, 21 per cent of 18-24-year-olds with mental disorders were unemployed, compared to 13 per cent of those without mental health problems.[55]

The most recent population survey of mental health among children and young people in England was carried out in 2017 (with the next publication due in Autumn 2025).[56] That study showed a significant rise in 'emotional disorders', such as anxiety, depression and obsessive-compulsive disorders (OCD), which had increased in prevalence from 4.3% to 5.8% among respondents between 1999 to 2017. Slightly more girls than boys had emotional disorders in 2017 (6.1% compared to 5.6%), but an increasing trend was observed in both boys and girls.[57]

Further analysis from NHS Digital (since 2017) has suggested further significant increases in the prevalence of emotional disorders. In 2023, about 1 in 5 children and young people aged 8 to 25 years had a 'probable

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[50] NHS, 'Moving on to adult mental health services', link.

[51] Department of Health and Social Care, 'Improving the mental health of babies, children and young people: a framework of modifiable factors', 8 January 2024, link.

[52] National Library of Medicine, 'Age of onset of mental disorders: A review of recent literature', 2007, link.

[53] The Lancet Psychiatry, 'Age of onset and cumulative risk of mental disorders: a cross-national analysis of population surveys from 29 countries', September 2023, link.

[54] Jama Network, 'Air and Noise Pollution Exposure in Early Life and Mental Health From Adolescence to Young Adulthood', 28 May 2024, link.

[55] Resolution Foundation, 'We've only just begun: Action to improve young people's mental **health, education and employment**', link.

[56] Major surveys of the mental health of children and young people in England were carried out in 1999, 2004, and 2017. The 2017 Mental Health of Children and Young People (MHCYP) survey (published in November 2018) "provides England's best source of data on trends in child mental health". As the preamble to the survey results explain, "while surveys use brief tools to screen for nonspecific psychiatric distress or dissatisfaction, this series applied rigorous, detailed and consistent methods to assess for a range of different types of disorder according to International Classification of Disease (ICD-10) diagnostic criteria. All cases were reviewed by clinically-trained raters", For an overview of the 'Trends and Characteristic', see: link More recently however, NHS Digital has conducted follow up 'waves' to the 2017 study (in 2020, 2021, 2022 and 2023) which enable changes to be monitored against the 2017 study.

[57] Ibid. The 2017 study found that all other types of disorder, including behavioural disorders, hyperactivity and less common disorders have remained similar in prevalence to the previous studies in 1999 and 2004. See also: link.

mental disorder' (compared with 12.1% in 2017). In 2023, this included 20.3% of 8- to 16-year-olds and 23.3% of 17- to 19-year-olds.[58] A systematic review by Racine et al., found that the prevalence of anxiety and depression in CYP almost doubled in 2020 compared to pre-pandemic levels.[59]

Figure 6: Mental health of child or young person by age and sex, 2023 – % of those with a 'probable mental disorder'.[60]

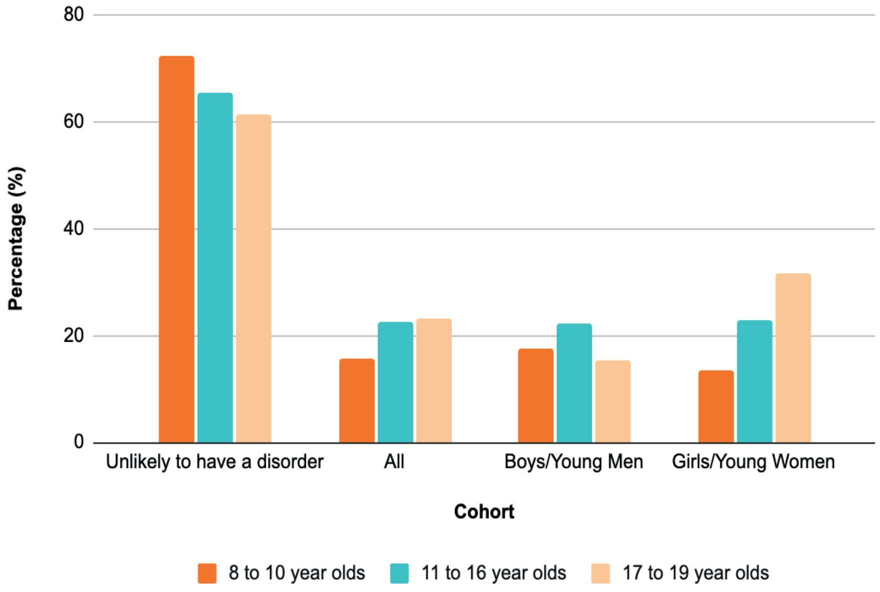
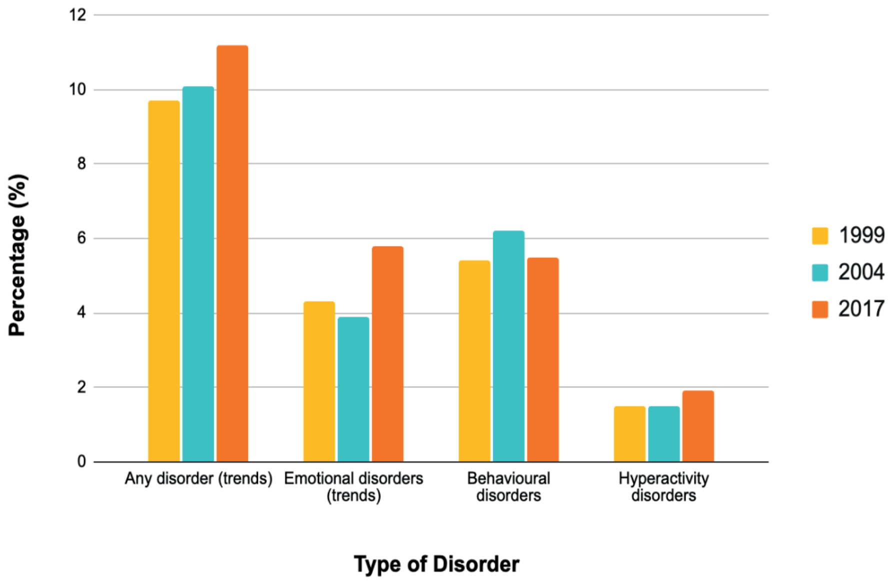


Figure 7: Prevalence of mental disorders, 5- to 15-year-olds, 1999-2017[61]



As such, we now see more children of school-age reporting a mental health condition or seeking support. Fig. 8, below reveals there has been

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[58] NHS Digital, 'Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey', 21 November 2023, link.

[59] Science Direct, 'Child and adolescent mental illness during COVID-19: A rapid review', October 2020, link.

[60] NHS Digital, 'Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey', 21 November 2023, link.

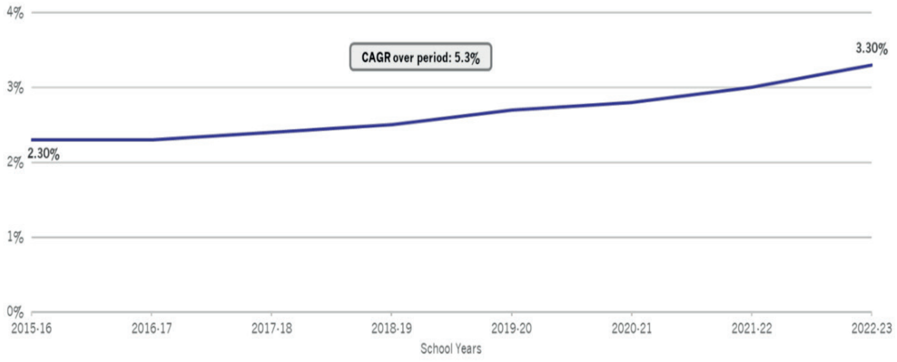
[61] NHS, 'Mental Health of Children and Young People in England, 2017', 22 November 2018, link.

a compound annual growth rate of 5.3% each year since 2015/16. We have also seen a significant growth in the proportion of 'home students' at UK universities who disclose and seek support for a mental health condition whilst they are at university (from under 1% in 2010/11 to 5.7% in 2021/22).[62]

There are notable differences between the backgrounds and upbringing of children and their likelihood of mental healthcare provision. In 2021, 45% of children and young people who were looked after in England had emotional and mental health problems. This compares to a rate of 10% among 5- to 15-year-old children in the general population.[63]

These findings, however, stand in contrast to intellectual disabilities or other childhood disabling conditions.[64] Higher socio-economic status can be associated with later-age childbearing, with older maternal and paternal age important risk factors for Autism Spectrum Disorder (ASD).[65] Parents with higher socio-economic status may also be more knowledgeable about ASD or have improved access to supportive services.[66]

Figure 8: Percentage (%) of school pupils who have educational support for social, emotional and mental health needs (school age).[67]



Notes: This data shows the percentage of pupils in schools who have been formally identified in schools as having Special Educational Needs (i.e. requiring/eligible for additional in school support) and whose primary type of need is recorded as social, emotional and/or mental health. Schools have different practices for recording pupils as SEN and for which type of need is recorded as primary, and many pupils also have multiple needs.

Referrals made to NHS Children and Young People's Mental Health Services (CYPMHS) meanwhile have tripled from 40,000 in 2016 to almost 120,000 in 2024.[68] The rate of referrals has increased by 11.7 per cent a year from around 40,000 a month in 2016 to almost 120,000 a month in 2024.[69] There is now a 170 day wait (on average) for accessing mental health services for CYP across the NHS (compared to 57 days in 2017/18).[70] Some 343,000 CYP under the age of 18 are waiting for mental health services, with 109,000 of those referred waiting for more than a year.

62. House of Commons library, 'Student mental health in England: Statistics, policy, and guidance', 25 April 2025, link.
63. NHS, Transforming mental health services for children, young people (0-25) and their families across South West London', 2023, link.
64. BMJ Open, 'Disabling chronic conditions in childhood and socioeconomic disadvantage: a systematic review and meta-analyses of observational studies', 3 September 2015, link.
65. Molecular Psychiatry, 'Autism risk associated with parental age and with increasing difference in age between the parents', 9 June 2015, link.
66. Science Direct, 'Parental concerns, socio-economic status, and the risk of autism spectrum conditions in a population-based study', December 2014, link.
67. UK Government, 'Independent Investigation of the National Health Service in England: Technical Annex', September 2024, link.
68. NHS, 'Independent Investigation of the National Health Service in England', September 2024, link.
69. Ibid.
70. The King's Fund, 'Mental health 360', 21 February 2024, link.

Figure 9: Children and young people (CYP) accessing mental health services, Mental Health Services Dashboard, NHS England, 2021-2025[71]

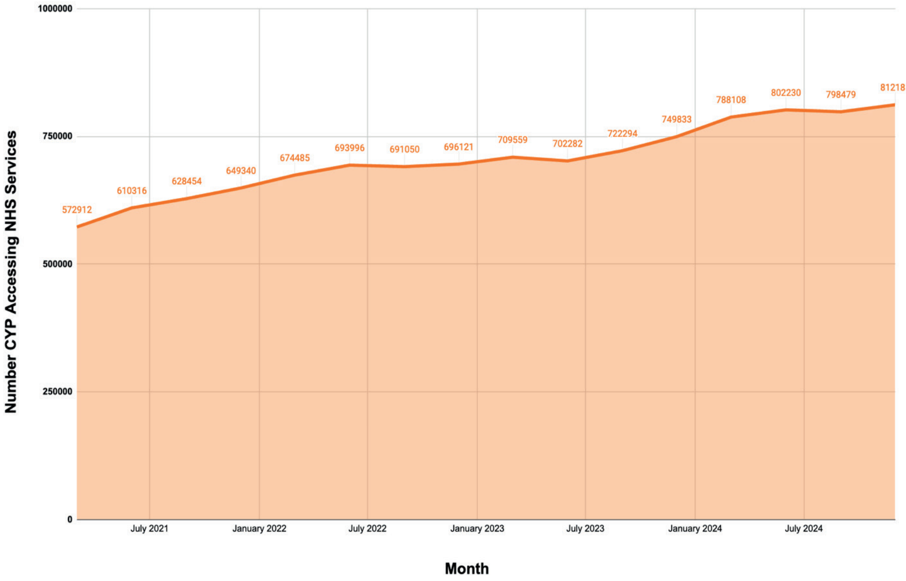
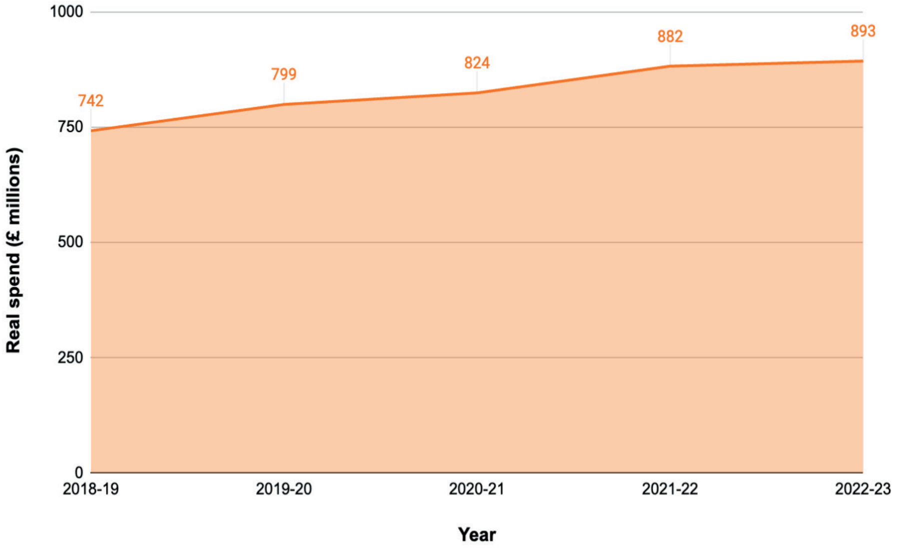


Figure 10: Real terms spending on NHS children's mental health services, 2018-19 to 2022-23[72]



There has been a significant rise in real spending on CYPMHS over time, see Fig. 10 above.

There is significant discrepancy between spending across the country, however. See for instance the data on the different Integrated Care System (ICS) footprints and the amount they have recently spent per referral. By way of example, NHS North Central London ICB spent £43m in 2022/23, at £2,236 per child referred. NHS Greater Manchester ICB meanwhile, whilst spending £56m in all, spent £875 per child referred.[73]

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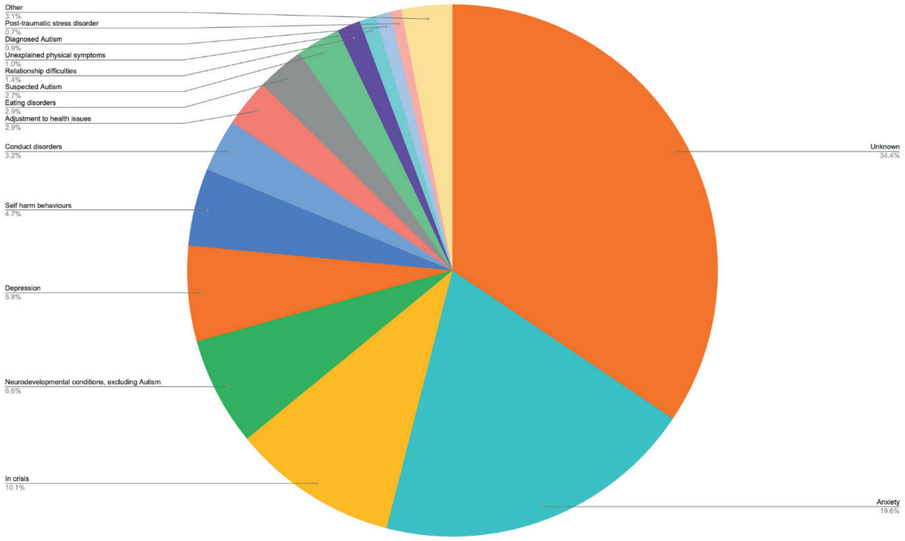
[71] NHS England, 'Mental Health Services Monthly Statistics Dashboard', link.

[72] Children's Commissioner, 'Children's mental health services 2022-23', 14 March 2024, link.

[73] Ibid.

A Getting It Right First Time (GIRFT) report notes that the average cost of a single admission to inpatient care '*would support almost 100 young people within the community for one year*'. Despite this, admission into an adolescent inpatient care can be driven by a lack of appropriate community services, '*rather than the belief that it is the best-known treatment*'.[74]

Figure 11: Primary referral reasons to CYPMHS, 2022-23[75]



Of the known 'primary' referral reasons to NHS CYPMHS, 'anxiety' is currently the most common reason (20%), with children 'in crisis' the second most common referral reason (10%). This reflects a wider trend, with the number of children referred for emergency treatment increasing by 53% between 2019-20 and 2022-23 (from 21,242 referrals in 2019-20, to 32,521 referrals in 2022-23). This includes young people who are suicidal, severely depressed and who have an eating disorder.[76]

The aforementioned GIRFT report which examined (former) Clinical Commissioning Group (CCG) spend on community CYP mental health services found that the provision of '*effective intensive community support services, such as early intervention in psychosis services, eating disorder services, personality disorder services and neuro-disability services, lead to better outcomes for young people*'. However, it also reflected that there is inconsistent provision and quality of these services.[77]

The next most common primary referral reasons are for neurodevelopmental conditions. Whilst Autism and other neurodevelopmental conditions are not mental health conditions, diagnostic assessments for these conditions can take place in the context of NHS CYPMHS, and some children may be in contact with CYPMHS because of the overlap between neurodiversity and mental ill-health.

Demand for assessments for ADHD and Autism have also grown considerably in recent years. As the Chief Executive of the Nuffield Trust has recently put it, '*the unprecedented rise in demand for NHS autism and ADHD services*

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74. NHS, 'CYP Mental Health National Report', December 2021, link.
75. Children's Commissioner, 'Children's mental health services 2022-23', 14 March 2024, link.
76. NHS, 'Mental Health Services Monthly Statistics, Performance November 2023', link
77. NHS, 'CYP Mental Health National Report', December 2021, link.

has completely overtaken the system's capacity to meet people's needs'.[78] Since 2019, the number of children waiting at least thirteen weeks for an assessment for ASD increased at a rate of 65% a year, while for adults the increase has been 77% a year. Activity has risen too, with services now seeing 33,000 people a month. But as of March 2024, there were still more than 70,000 children and young people under 18 and more than 50,000 adults waiting at least 13 weeks for an assessment for Autism.

Today, the incidence and prevalence of ADHD diagnoses and medication are highest among children, with new diagnosis rates between 2000 and 2018 highest between those of 6 to 9 years of age, and in adults, new diagnosis rates highest between those of 18 and 29 years of age. Proportionally, rates increased most among adults from 2000–2018.[79] As it stands, however, there is no definitive national data on the prevalence of ADHD, but it is suspected to affect 3–4% of adults in the UK.[80] A recent systematic review of the data at a global level suggests some stability in diagnoses since 2020, but is clear on the need for further research and for improved data reporting to inform the debate.[81]

Figure 12: New referrals for people aged 0 to 17 at the time of referral to Mental Health, Learning Disability and Autism and Dementia Services, England[82]

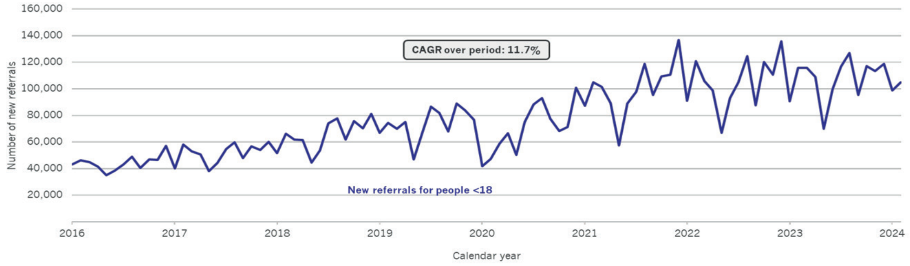
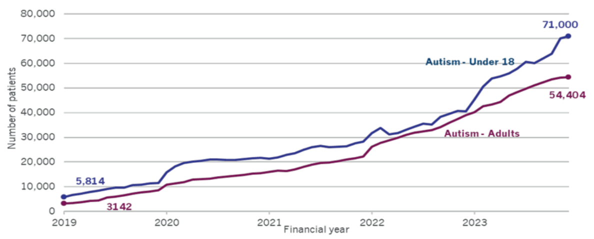


Figure 13: Number of patients with a referral for suspected autism, open for at least 13 weeks, who were still waiting for a first contact, April 2019 to March 2024[83]



CAGR	Under 18	Adults
Apr 2019 – Mar 2024	65%	77%
Apr 2019 – Mar 2022	70%	92%
Mar 2022 – Mar 2024	58%	57%

Notes: Only children and young people referred to CAMHS services are in scope of the MHSDS and included in the autism data. Referrals and diagnoses of autism in child development services, which comprise the majority of autism referrals for young children in the UK, are out of scope of the MHSDS and excluded in these statistics. NHS England does not have a full list of in-scope providers of autism diagnostic services, and it is therefore very likely that some providers of autism services may not be submitting autism data to MHSDS even though they are providing these services.

We have seen notable increases in the dispensing of medication to manage psychiatric and neurodevelopmental disorders – and this is a particularly helpful marker of the growth of help-seeking behaviour.[84] Antidepressants – particularly selective serotonin reuptake inhibitors

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78. Nuffield Trust, 'Autism and ADHD: a Q&A with Thea Stein', 13 February 2025, link.
79. BJPysch Open, 'Attention-deficit hyperactivity disorder diagnoses and prescriptions in UK primary care, 2000–2018: population-based cohort study', 2023, link.
80. National Institute for Health and Care Excellence, 'ADHD: How common is it?', February 2025, link. A good overview on the current state of adult ADHD services is: link.
81. Science Direct, 'The changing prevalence of ADHD? A systematic review', 1 November 2025, link.
82. UK Government, 'Independent Investigation of the National Health Service in England: Technical Annex', link
83. Ibid.
84. BMC Psychiatry, 'ADHD medicine consumption in Europe after COVID-19', 9 February 2024, link.

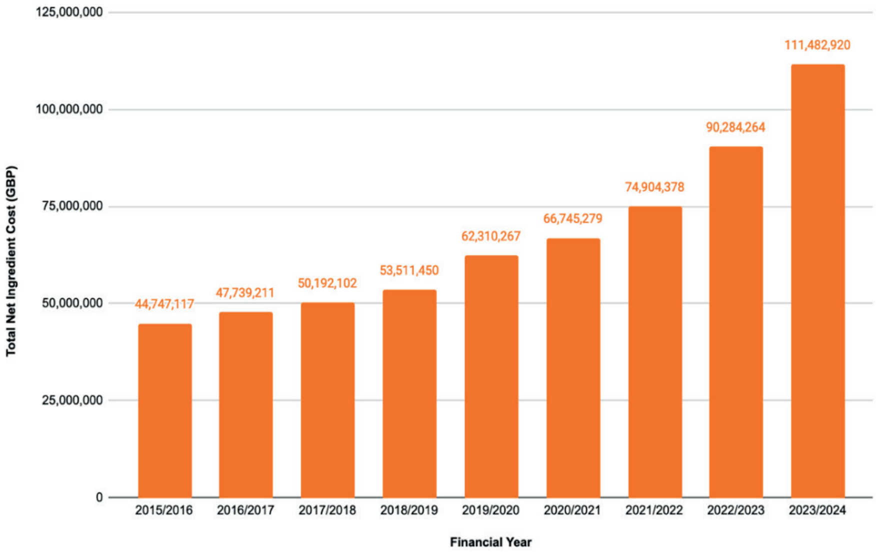
(SSRIs) – are now widely used not just for depressive disorders, but also for anxiety disorders, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and chronic pain. This expanded range of indications has been a significant factor in their increased use in recent decades.[85] The proportion of individuals prescribed ADHD medication increased between 2000 and 2018 in children (quadrupling in boys and increased almost nine-fold in girls).[86]

The percentage of patients with a learning disability who were prescribed antidepressants has increased each year from 20.8% in 2020-21 to 21.7% in 2022-23 and 22.1% in 2023-24.[87]

People with a learning disability are thought to be sixteen times more likely, and those with Autism seven times more likely, to be prescribed an antipsychotic than the general population.[88]

As a consequence**,** stopping the over-medication of people with a learning disability and autistic people (STOMP) has been developed by NHS England as part of the NHS Long Term Plan (2019) alongside the national supporting treatment and appropriate medication in paediatrics (STAMP) programme (which has aimed to ensure children and young people with Autism or with a learning disability get medication for the right reason, in the right dose and for as short a time as possible).[89]

Figure 14: Medicines Used in Mental Health - England - 2015/16 to 2023/24 - Financial year totals split by identified patients, CNS stimulants and drugs used for ADHD



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[85] Azeem Majeed, X, link.

[86] BJPysch Open, 'Attention-deficit hyperactivity disorder diagnoses and prescriptions in UK primary care, 2000–2018: population-based cohort study', 2023, link.

[87] NHS, 'Health and Care of People with Learning Disabilities, Experimental Statistics 2023 to 2024', 12 December 2024, link.

[88] NHS, 'Stopping over medication of people with a learning disability and autistic people (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP)', link.

[89] Ibid.

Figure 15: Medicines Used in Mental Health - England - 2015/16 to 2023/24 - Financial year totals split by identified patients, CNS stimulants and drugs used for ADHD

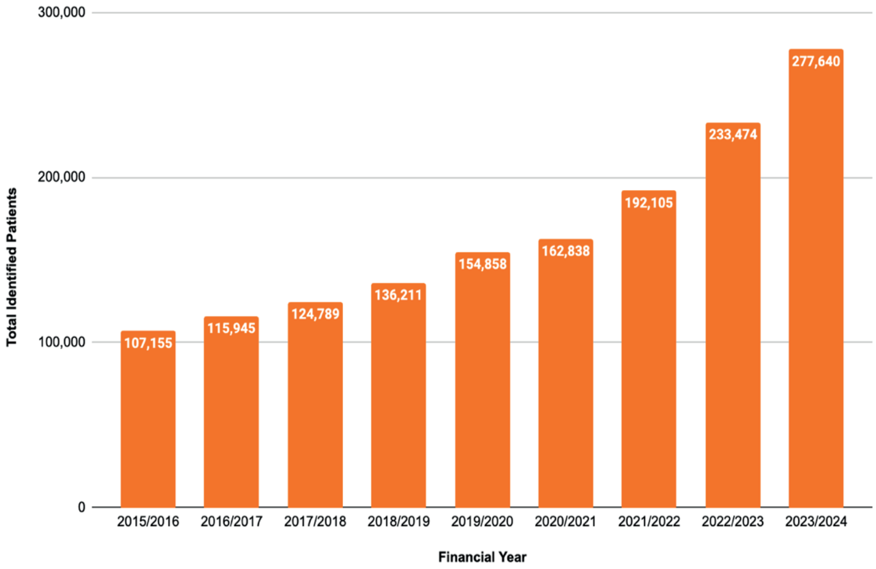
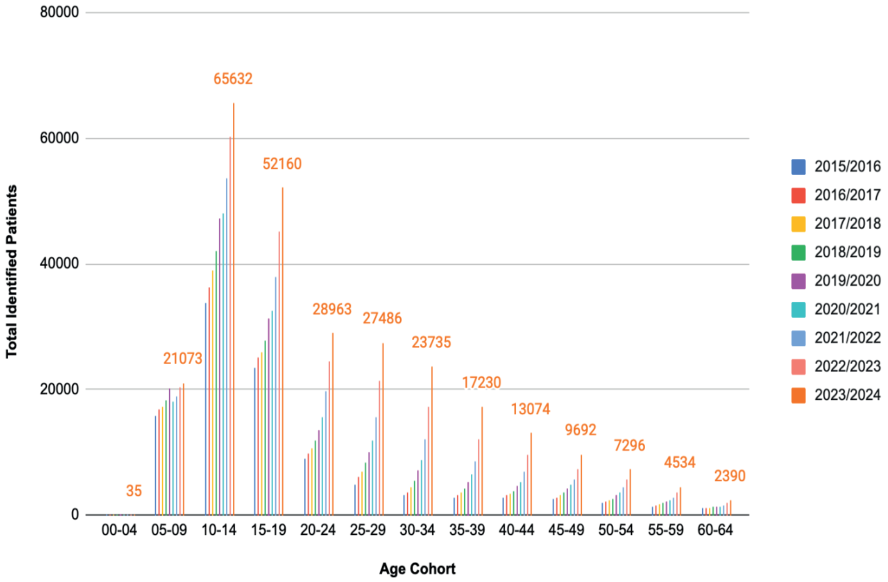


Figure 16: Medicines Used in Mental Health - England - 2015/16 to 2023/24 - Financial year totals split by identified patients, CNS stimulants and drugs used for ADHD



What's Behind the Growth?

This is one of the most challenging, but compelling questions in health and care today, with the debate constantly evolving and practitioners themselves not settled on the most appropriate means of distinguishing (for instance) between disorders – e.g. bipolar mood disorder, cyclothymic temperament, and borderline personality disorder.[90]

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90. Psychology Today, 'Distinguishing Borderline From Bipolar Spectrum Disorders', 3 May 2025, link.

Below however, we set out the theses which have been put forward to explain the rising prevalence (and diagnosis) of both mental-ill health and neurodevelopmental disorders amongst CYP.

Increased Awareness and Diagnostic Practices:

- **Improved Recognition and Reduced Stigma:** Greater public awareness and reduced stigma surrounding mental health leading to greater help-seeking.
- **Evolving Diagnostic Criteria:** Evolutions in diagnostic manuals (like the Diagnostic and Statistical Manual of Mental Disorders or DSM and ICD) and assessment tools capturing a broader range of presentations.
- **Improved Screening:** In both clinical and non-clinical setting, e.g. schools.
- **Diagnostic Thresholds:** Changes to diagnostic criteria, lowering thresholds for a diagnosis.

Environmental Factors:

- **Prenatal and Perinatal Exposures:** Factors during pregnancy and birth, such as maternal stress, infections, exposure to certain substances (e.g., alcohol, drugs, pollutants), and birth complications, can influence neurodevelopment.
- **Adversity in Early Life:** Exposure to trauma, abuse, neglect etc. in early childhood linked to an increased risk for both psychiatric and neurodevelopmental disorders.
- **Social and Economic Factors:** Socioeconomic disadvantage, poverty, food insecurity, and lack of access to quality education and healthcare can increase vulnerability to mental health challenges.
- **Social Isolation:** Changes in social structures and increased reliance on digital communication may contribute to feelings of isolation, which can impact mental well-being.

Genetic and Biological Factors:

- **Genetic Predisposition:** Research has identified numerous genes and genetic variations that contribute to the risk of psychiatric and neurodevelopmental disorders.
- **Epigenetic Mechanisms:** Environmental factors can interact with an individual's genetic makeup through epigenetic mechanisms, influencing gene expression and potentially increasing the likelihood of developing a disorder.
- **Changes in Brain Development:** Various factors influencing brain development, as a contributing factor to neurodevelopmental disorders.

Lifestyle and Behavioural Factors:

- **Changes in Diet and Nutrition:** Shifts in dietary patterns, including increased consumption of processed foods and reduced intake of essential nutrients, have been hypothesized to impact brain health and mental well-being.
- **Reduced Physical Activity:** Lower levels of physical activity have been linked to increased risk for some psychiatric disorders.
- **Digital determinants, such as 'excessive' screen time:** Excessive screen time and exposure to certain types of digital content have been linked to impacts upon attention, social development, and poor mental health.
- **Sleep Disruption:** Chronic sleep problems are common in both psychiatric and neurodevelopmental disorders and may also contribute to their development or exacerbation.

Provision

The Development of Children and Young People's Mental Health Services (CYPMHS)

History

The development of Children and Young People's Mental Health Services (CYPMHS) in England has been an evolving process, marked by increasing recognition of the importance of early intervention and specialist support for CYP. Key policy drivers over the past decade include the Government's *Future in Mind* report (2015) and the NHS *Long Term Plan* (2019), which set out ambitions to widen access, reduce waiting times, and improve the quality and integration of services.[91]

Prior to this, CYPMHS provision lacked consistent commissioning and delivery frameworks. The 2019 NHS Long Term Plan set out a ten-year vision for expanding CYPMHS to enable an additional 345,000 children and young people aged 0-25 to access NHS-funded mental health services by 2023/24, including through schools and colleges via Mental Health Support Teams (MHSTs). The plan emphasised a joined-up approach, integrating services from early intervention to crisis care, and fostering collaboration between commissioners, providers, young people and their families. The development of Integrated Care Boards (ICBs) (placed on a statutory footing in July 2022) marked a further shift in the commissioning landscape. ICBs currently hold the responsibility for planning and funding the majority of NHS services, including CYPMHS, within their geography. However, there is uncertainty over the role that ICBs will continue to play for some of the key elements of CYPMHS, including safeguarding and SEND, with ICBs recently instructed to '*test and explore options to streamline and transfer some activities out of ICBs*'.[92]

In 2022-23, nearly one million children and young people were referred to CYPMHS, equating to 8% of the child population in England.

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[91] Department of Health, 'Future in mind', 2015, link.

[92] HSJ, 'ICB functions radically reduced in national 'blueprint', 6 May 2025, link.

Despite this increase in referrals, a substantial number of children are still waiting for support. In the same year, over a quarter of a million children referred were still waiting for support, and nearly 40% had their referral closed before accessing treatment. Waiting times for those who do access support also vary considerably. In 2022-23, the average waiting time for those who received support was 35 days, but some children experienced waits of over two years.

There has been a reported increase in the CYPMHS workforce, with a 5% growth in whole-time equivalent (WTE) staff overall since 2021, with roles such as Education Mental Health Practitioners witnessing significant growth. However, in November 2024, nearly one in five consultant psychiatrist posts in CAMHS were vacant. When including posts covered by locums, the total vacancy rate was over one in three.[93] Mental health nursing also has high vacancy rates within CYP mental health services.

Outcomes

Current outcomes in CYPMHS are mixed, with waiting times demonstrating significant geographical variation. For example, in 2022-23, average waiting times ranged from 147 days in one ICB to just four days in another.

Services that are designed to support CYP remain rather fragmented with care coordination remaining a significant challenge.[94] Some ICBs have focused on expanding community-based services and early intervention through MHSTs, while others have prioritised specialist services or crisis care pathways. The increasing demand for service provision in this patient population, together with infrastructural, financial and staff limitations in child and adolescent mental health services has led to calls for an adaptation/advancement of current models of service provision.

As a consequence of these pressures upon services, the threshold to receive higher levels of support is frequently very high indeed. People have to be – as one individual we spoke to for this report reflected – '*at breaking point*' (i.e. the point at which a patient may be considered for inpatient services, or which triggers a home visit). There are natural gaps in the system as a result – with a sense that services to support those with significant, but not the most severe needs, are lacking.

This has led to the development of new service models, such as the Intensive Community Care Service (ICCS) in East London which provides treatment and interventions to young people with the most intensive needs (and where they would traditionally have been treated in inpatient settings). This service focuses on intensive interventions for up to twelve weeks, whilst liaising with their families / support network and offers an instructive model to be scaled more widely.[95]

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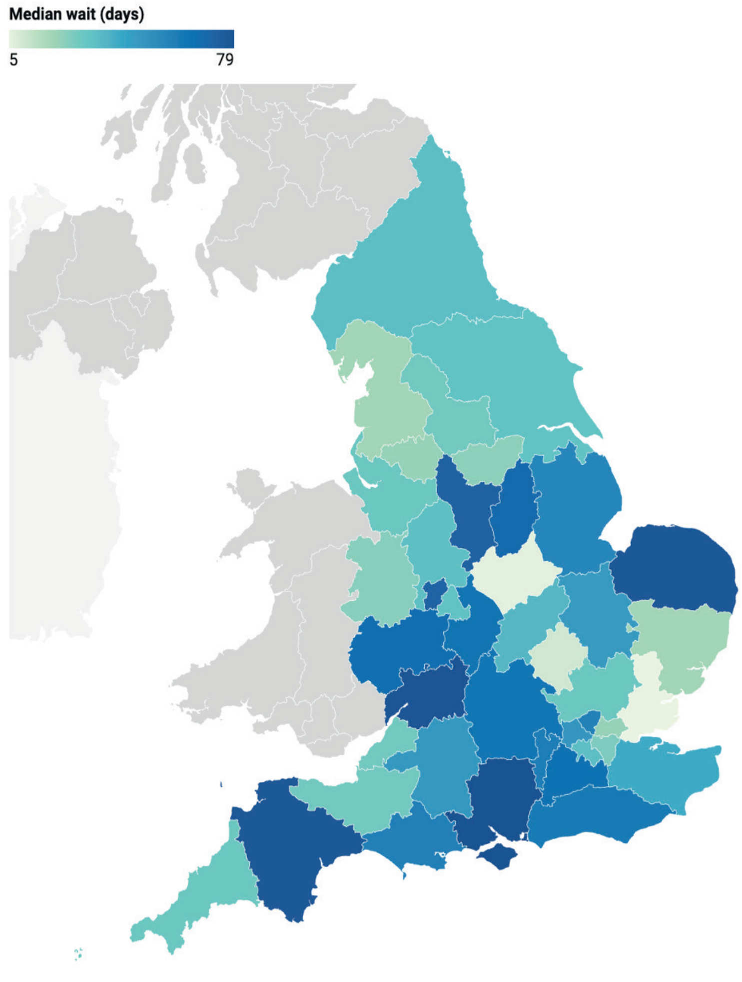
[93] Royal College of Psychiatrists, 'Children's mental health crisis deepens: severe shortage of psychiatrists to meet growing demand', 28 November 2024, link

[94] National Library of Medicine, 'The Impact of Covid-19 pandemic on services for children and adolescents with ADHD: results from a survey of paediatricians in the United Kingdom', 21 June 2022, link.

[95] Child and Adolescent Mental Health Services, 'East London CAMHS ICCS (Intensive Community Care Service)', link.

Figure 17: Median wait (days) for CYPMH Services by Integrated Care System (ICS), England, 2022/23[96]



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[96] 96. Children's Commissioner, 'Children's mental health services 2022-23', 14 March 2024, link.

NHS
South West London

Case Study: South West London ICB – An Example of Governance Arrangements Across a 'System'

- A **Partnership Delivery Group** oversees the implementation of an 'All-Ages Mental Health Strategy' and provides updates to the SW London ICB and Integrated Care Partnership (ICP). It is made up of partners from across adult and children's mental health including Mental Health Trusts, Local Authorities and 7 GP Clinical Leads.
- The **Children and Young People's Mental Health Steering Group** is a collaborative meeting of place-based CYP 'Transformation Managers', Mental Health Trusts, Local Authority Leads, SW London Mental Health Programme team, service-user representatives, Public Health, the GP Clinical Leads and VCS representatives.
- The **Mental Health in Schools Team Steering Group** is a collaborative meeting of education leads from schools with Mental Health Support Teams (MHST), Local Authority Education and Public Health Leads, SW London CYP MH Partnership Boards representatives, CAMHS Managers, MHST Providers, SW London Mental Health Programme team and GP Clinical Leads.

Mental Health Support Teams (MHSTs) in England

History

The development of Mental Health Support Teams (MHSTs) in England have been a key recent component of the Government's strategy to improve mental health support for CYP. The genesis of MHSTs can be traced to the Transforming Children and Young People's Mental Health Provision Green Paper (published December 2017).[97] The Green Paper proposed incentivising and supporting all schools and colleges to identify and train a Designated Senior Lead for mental health; proposed funding for Mental Health Support Teams (MHSTs) supervised by NHS CYP mental health staff and piloting a four-week waiting time for access to specialist NHS children and young people's mental health services. The NHS Long Term Plan (2019), solidified the commitment to MHSTs, stating an ambition for at least 345,000 additional CYP to access mental health support through NHS services or school/college-based MHSTs by 2023/24. MHSTs have been designed to deliver three core functions:

1. **Delivering evidence-based interventions** for mild to moderate

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[97] UK Government, 'Transforming children and young people's mental health provision: a green paper', 4 December 2017, link.

mental health problems.

2. **Supporting the senior mental health lead** in each school or college to develop a 'whole school' approach to mental health and wellbeing.
3. **Giving timely advice to school and college staff** and liaising with external specialist services to help CYP get the right support.

Outcomes

A key feature of MHSTs has been the introduction of Education Mental Health Practitioners (EMHPs). These new professionals receive training in delivering interventions based on Cognitive Behavioural Therapy (CBT) for common issues like anxiety and low mood, whilst under supervision from more experienced therapists within MHSTs.

Significant progress has been made in the implementation of MHSTs across England. As of the 2023-24 academic year, 44% of pupils and learners in England were covered by an MHST representing 34% of all educational settings in the country. Coverage varies by setting type, with secondary schools having the highest proportion of pupils/learners covered (59%) compared to special schools (33%) in 2023-24.

The MHST program is early stages of national implementation, initial evaluations and data are beginning to provide insights into its outcomes.

- Early evaluations of the 'Trailblazer' sites indicated general satisfaction with the program. Schools valued the additional mental health support and reported increased staff confidence in discussing mental health with pupils.
- A study analysing the impact of MHSTs on young people's wellbeing outcomes using the #BeeWell survey data found no overall difference in wellbeing outcomes between students in MHST and non-MHST schools.[98] However, Barnardo's, a major provider of MHSTs, suggests that their presence improves children's mental health and wellbeing and is cost-effective, estimating a saving of £1.90 for every £1 invested.[99]
- There is some evidence to suggest MHSTs can lead to earlier identification and quicker access to support for mild to moderate mental health issues, as well as increased mental health literacy among students where the teams are well-embedded.[100]
- But the latest evidence suggests a need to move away from '*universal prevention*' and that we should '*instead invest our limited resources in the refinement and dissemination of interventions with a stronger evidence base, such as one-to-one, targeted and indirect approaches*'.[101]
- Reasons for this include the fact that '*universal prevention is not possible because too many young people are already symptomatic*'– and with the risk that some symptoms may be exacerbated.[102]

Further measures are needed to improve the join up of services. Single Point of Assessment (SPA) should be developed across every ICB footprint.

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[98] #BeeWell, 'Do Mental Health Support Teams make a difference to young people's wellbeing?', link.

[99] Barnardo's, 'It's hard to talk: Expanding Mental Health Support Teams in education', 1 January 2023, link.

[100] National Library of Medicine, 'Early evaluation of the Children and Young People's Mental Health Trailblazer programme, Chapter 10: Programme progress and impact', June 2023, link.

[101] ACAMH, 'Debate: Where to next for universal school-based mental health interventions? Time to move towards more effective alternatives', 7 December 2024, link. Another useful evaluation is: link.

[102] Ibid.

Services which operate a single point of access have demonstrated an ability to handle referral process more swiftly and effectively. We, however, still find Child and Adolescent Mental Health Services and paediatric services completing childhood autism assessment and diagnosis work independently of one another.[103]

There are wider opportunities to improve the gathering and sharing of pre-appointment information, developing single practitioner assessments and providing more effective better coordination of health and education pathways.

After all, a recent Royal College of Psychiatry guideline on assessing adults with ADHD suggests that a *'good quality assessment takes time and is ideally multidisciplinary … longitudinal assessment is also advised'*, and should include a mental state examination, a developmental history, collateral information from other sources and consideration of features of other neurodevelopmental disorders.[104]

NHS
Leicestershire Partnership
NHS Trust

Developing a Dynamic Support Pathway (DSP) – Leicestershire Partnership NHS Trust

- Leicestershire have developed an 'all-age early intervention pathway' for people with Learning Disabilities, Autism or both for people living in Leicester, Leicestershire and Rutland (LLR). Its aim is to ensure they can continue to stay well at home in the community.
- The goal is to identify concerns early and provide additional support that will prevent further deterioration or escalation that could lead to a crisis. Referrals to the DSP can be made by any professionals supporting the person. Alternatively, the person themselves (or a family member, advocate etc.) can now make a referral to the DSP using the online referral forms.[105]

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[103] National Library of Medicine, 'A national research survey of childhood autism assessment services in the UK: empirical evidence of diagnostic practice, challenges and improvement opportunities', 18 June 2024, link.

[104] Royal College of Psychiatrists, 'Attention deficit hyperactivity disorder (ADHD) in adults: Good practice guidelines', January 2023, link.

[105] NHS, 'Leicestershire Partnership Trust - Dynamic Support Pathway', link.

Developing a Single Point of Assessment (SPA) for CYPMHS

- The SPA encourages prompt referral and access to services through the promotion of an online referral form, but also welcomes self-referrals from CYP or parents by phone.
- Around 40% of referrals to service come from GPs/primary care for common mental health challenges, such as anxiety and/or low mood problems, mixed emotional and/or behaviour problems as well as querying neurodevelopmental problems.
- Between 15% and 20% of referrals are received from education staff, i.e., Head Teachers, teachers, special educational needs coordinators (SENCos), school nurses or educational psychologists,
- 5-10% come from specialist child health professionals such as paediatricians, speech and language therapists, occupational therapists or physiotherapists.
- Self-referrals from young people and parents/families are welcome but make up only a relatively small proportion of referrals (below 10%).[106]
- SPA teams will screen all referrals and offer an appointment either face-to-face, online or via a telephone interview to determine the most suitable treatment options to address issues presented at the point of referral.
- When the SPA team have carried out the initial screening and assessment, the young person will be offered a relevant intervention option or signposted to the most useful service.

Most disorders do not have objective biomarkers, so self-reported symptoms weigh far more heavily in the diagnostic process.

A formal diagnosis requires symptoms which can be identified over a period of time and linked to impairment.[107] *'We didn't used to do diagnosis in child psychiatry,'* Dr Sami Timimi has recently stated. Rather, presentations were evaluated *'in developmental terms — in other words, children change'*. It remains the case that for children in particular, psychiatrists are less inclined to give a formal diagnosis on the basis of changing development and symptoms. In other words, the 'stability' of a diagnosis can often be less strong. Mental health professionals will also emphasise the relational element in each case. This is particularly important *'with children because a lot of the decisions in their life are made by the adults around them.'*.[108]

One of the most notable challenges with the formal diagnosis of some of the disorders being considered in this report – particularly neurodevelopmental disorders, such as ADHD and Autism is that there are no objective biomarkers that can be used to reach an objective conclusion. A recent scoping paper is clear that to advance research on adult ADHD, *'the quality of the diagnostic assessment must be prioritised, requiring comprehensive differential diagnosis by a skilled psychiatrist or psychologist.'*[109]

That same review notes that recent updates to the DSM [10–15], diagnostic criteria for ADHD *'have been diluted and become more inclusive'*. *'Unlike*

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[107] National Library of Medicine, 'What is "functional impairment"? Disentangling disability from clinical significance', June 2009, link.

[108] The Times, 'Diagnosing a child with autism or ADHD? There's a lot of money to be made' , 18 March 2018, link.

[109] European Psychiatry, 'Diagnosing ADHD in adults in randomized controlled studies: a scoping review', 14 April 2025, link.

[106] NHS, 'Transforming Mental Health Services for Children and Young People 0-25 and their families across South West London', 2023, link.

most other…mental disorders, which are defined by a combination of diagnostic criteria targeting behavioral and experiential anomalies, i.e., signs and symptoms, the diagnosis of ADHD is based on behavioral features (signs).'[110]

NICE guidelines state that a diagnosis of ADHD should only be made by a healthcare professional with training and expertise, based on a full clinical, psychosocial, developmental, psychiatric history alongside corroborative reports and assessments. The discrepancy between disorders is clear however, with ADHD lacking the same levels of training and tools that exist for ASD. International studies, such as a recent example from Norway are also revealing variation in clinician and clinic behaviour when it comes to diagnosis.[111]

The recently published report of the independent ADHD Taskforce has suggested that rather than a reliance on formal diagnosis, early support for ADHD should be '*needs-based*' with support offered to all those with suspected ADHD to include '*quiet rooms*' in classrooms, parenting lessons and flexible working hours.[112] Some have suggested the development of ADHD as a specialism within primary care, with the '*relegation of adult ADHD diagnosis to specialist services*', '*at odds with its high prevalence and chronic course*'.[113]

The impact of the 'digital determinants' upon child development and mental health have been under-weighted in both the public policy response and clinical practice thus far.[114]

There has been significant alignment between increased ownership in smartphones, access to social media and a notable decline in the psychological wellbeing of CYP.[115] A study from Jonathan Haidt and Jean Twenge found that loneliness increased between 2012–2018 in adolescents from 36 of the 37 countries studied. [116] These findings have applicability not just for the UK, but many other advanced economies. A 2019 study found the proportion of adolescents (aged 12 to 19) in the Republic of Ireland reporting severe anxiety doubled from 11% to 22% since 2012.[117] Similar findings have been found in countries including Canada, Australia and Japan.[118]

But the impacts can be felt more widely – and far earlier – in a child's development too. A recent study in the *Journal of the American Medical Association (JAMA) Pediatrics* has shown the impact of excessive screen time and reduced parent-child interaction (such as vocalisations and conversational turns).[119] This is highly significant because of the long-term impacts of delay to speech and language skills. Low language levels can be a predictor of academic attainment and even earnings in adulthood.[120]

We have under-weighted the significance of technological change or the 'digital determinants' of health (e.g. increased screen time, and smartphone ownership and engagement) upon the prevalence of mental ill-health and neurodevelopmental disorders. Organisations such as Health Professionals for Safer Screens have persuasively made the case for greater consideration of screen-time and smartphone use as a risk factor for mental ill-health and neurodevelopmental disorders and have advocated a more comprehensive public health campaign around the risks. They have also brought together much of the recent evidence on the impacts to inform

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110. Ibid.
111. National Library of Medicine, 'Geographical variation in ADHD: do diagnoses reflect symptom levels?', 18 May 2022, link.
112. NHS, 'Report of the independent ADHD taskforce', 20 June 2025, link.
113. National Library of Medicine, 'Attention deficit hyperactivity disorder in adults: common in primary care, misdiagnosed, and impairing, but highly responsive to treatment', 19 August 2020, link.
114. This link is examined in J. Twenge, *Generations: The Real Differences Between Gen Z, Millenials, Gen x, boomers and Silents and What They Mean for the Future* (New York, 2023), pp. 392-416. See also: link; link. We also recommend the following resources: J. Haidt, Z. Rausch & J. Twenge, (ongoing) 'Adolescent mood disorders since 2010: A collaborative review'. Unpublished manuscript, accessible at: link.
115. Ibid.
116. Science Direct, 'Worldwide increases in adolescent loneliness', December 2021, link.
117. My World, 'My World Survey 2', link.
118. For Canada, see: link. For Australian evidence, see: link. For Japanese evidence, see: link.
119. JAMA Paediatrics, 'Screen Time and Parent-Child Talk When Children Are Aged 12 to 36 Months', 4 March 2024, link.
120. National Library of Medicine, 'Beyond the 30-Million-Word Gap: Children's Conversational Exposure Is Associated With Language-Related Brain Function', 14 February 2018, link.

the debate.[121].

Accordingly, we should encourage CYP and their families to seek a wider range of services to support improved mood, esteem and good heath, including physical exercise.

Almost one-third of children and young people (30.2%) in 2023 were inactive, doing less than 30 minutes of activity per day.[122] Children and young people from the least affluent families are the least likely to be active, with only 44% meeting the Chief Medical Officers' guidelines - compared to 55% of those from the most affluent families.[123]

Recommendations

The Department of Health and Social Care / NHS England should develop a new integrated dataset to measure the changing burden of mental ill-health and neurodevelopmental disorders.

a. The Adult Psychiatric Morbidity Survey was last updated in 2014 (although we can expect a new publication later this year), but we lack a similar survey for CYP. One should be developed which publishes on an annual basis. The survey should include the formal publication of diagnoses of neurodevelopmental disorders, including ASD and ADHD.

b. In addition, national standards for data collection across both children's and adult services for ADHD should be introduced to build a more consistent picture on access and performance.

Every Integrated Care System (ICS) in England should commission a single point of access (SPA) model.

a. The aim should be to streamline referrals into NHS child and adolescent mental health services to improve triage and to reduce waiting times for suitable assessment.

b. There is an opportunity for GIRFT to identify best practice in relation to screening processes – with a view to reducing current unwarranted variation. As a minimum, standard referral forms should be introduced to streamline referral processes.

'Mutual aid' should become commonplace across every integrated care system (ICS) footprint in England to maximise the use of the existing multi-disciplinary workforce across settings.

a. The aim should be to maximise capacity and expertise across a given geography & as a means of providing additional opportunity for professionals to retain credentials to perform assessments – particularly for ASD.

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[121] Health Professionals for Safer Screens, 'Resources', link.

[122] Sport England, 'Active Lives Children and Young People Survey – academic year 2022-23', December 2023, link.

[123] Sport England, 'Active Lives Children and Young People Survey – academic year 2022-23', December 2023, link.

Mental health interventions in schools should shift to becoming targeted interventions, rather than uniform offers.

b. This is essential where there is growing evidence of the ineffectiveness, even potential for ‘negative effects’ emerging from some universal offers.[124]

The Department of Health and Social Care (DHSC) should announce a set of measures to boost clinician and parental understanding of the ‘digital determinants’ of mental health and child development.

c. NICE should update guidance relating to the plausible impacts of excessive screen time upon CYP development and mental health to support clinical practice.

d. The Chief Medical Officer – as part of ongoing work to update guidance – should ensure there is sufficient focus upon the ‘first 1000 days’ and early years as part of his ongoing review of the impact of screens and CYP.

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[124] Association for Child and Adolescent Mental Health, ‘Debate: Where to next for universal school-based mental health interventions? Time to move towards more effective alternatives’, 7 December 2024, link.

Chapter 2 – Education

This chapter examines Special Educational Needs (SEN) spending and provision across primary and secondary schools in England.

What is SEND?

The 2015 Special Educational Needs and Disability Code of Practice defines Special Educational Needs and Disability (SEND) in the following way:

> *'A child or young person has SEND if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.*
>
> *A child of compulsory school age or a young person has a learning difficulty or disability if he or she:*
>
> - *has a significantly greater difficulty in learning than the majority of others of the same age, or;*
> - *has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions'*[125]

Types of SEND Need

The SEN Code of Practice identifies four broad areas or types of SEN need.

1. **Communication and Interaction**
   These children are said to have speech, language and communication needs (SLCN) and '*have difficulty in communicating with others*'.[126] Many children with Autism Spectrum Disorder (ASD) may be classed as having SLCN needs.

2. **Cognition and Learning**
   These children learn at a slower rate than their peers. Children with this need can have mild, moderate or profound learning difficulties. Dyslexia, dyscalculia and dyspraxia are examples of this need.[127]

3. **Social, Emotional and Mental Health Difficulties**
   These children may suffer from a range of mental health issues. Their behaviour '*may include becoming withdrawn or isolated, as well as displaying challenging, disruptive or disturbing behaviour*'.[128]

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[125] UK Government, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

[126] Ibid.

[127] Waltham Forest, 'Local Offer: Special Educational Needs and Disability', link.

[128] UK Gov, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

Attention Deficit Disorder (ADD) and Attachment Disorder are examples of this need.

4. **Sensory and/or Physical Needs**

This category of need covers children who '*have a disability which prevents or hinders them from making use of the educational facilities generally provided*'.[129] Children with visual or multi-sensory impairments would be classed as having this kind of need.

SEND Policy in England, 1944 – Present

Prior to 1944, the process of reform to ensure children with special needs received a proper education had been sluggish. The 1944 Education Act was the first sustained effort to bring large numbers of children with special needs into formal education. The Act identified 11 categories of need with different levels of severity, provision for which ranged from mainstream classrooms to special schools.[130] The Act further brought special education within the wider mandate of local education authorities. Although the Act abolished the certification of '*defective*' children, the most extreme category of need continued to be '*ineducable*'.

Support for children with special needs continued to evolve over the next few decades. The Chronically Sick and Disabled Persons Act 1970 required local education authorities to make education provision for blind, deaf, autistic and dyslexic children, with the onus on provision in mainstream schools. The Education Act 1976 featured a major push towards inclusion, requiring local authorities to provide for 'handicapped' pupils in mainstream schools '*except where this was impractical, incompatible with the efficient instruction in the schools or involved unreasonable public expenditure*'.[131] The then Secretary of State for Education, Margaret Thatcher, announced a consultation on the implementation of this principle.

The resulting Warnock Report of 1978 and the subsequent Education Act of 1981 '*radically changed the conceptualisation of special needs*'.[132] Schools of all kinds were now to have the same educational objectives for all children, differing only in the support provided. The categories established by the 1944 Education Act were deemed unhelpful and replaced by detailed assessments of individual needs. The principle that special needs should wherever possible be met in mainstream schools was further entrenched. The central role of parents, both as stakeholders and partners in shaping SEND provision, was also established by the report. The 1981 Act established the definition of SEND which is effectively in use today, tying SEND to the necessity of special educational provision. It also created Statements of SEND for those with more severe needs, which detailed a child's needs and obligated local authorities to provide the resulting provision needed.

Reform continued in the 1990s and early 2000s. The Education Act 1993 created the SEND Tribunal, to which parents could appeal the decisions of local education authorities if they felt their child's needs

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[130] Frontiers in Education, 'Warnock 40 Years on', 29 January 2020, link.

[131] UK Gov, 'Education Act 1976', link.

[132] UK Parliament, 'Select Committee on Education and Skills: Third Report', link.

[129] Ibid.

were going unmet.[133] It also established the first SEND Code of Practice, which was released the following year. The revised 2001 Code of Practice reinforced the central role to be given to parents, including in identifying their children's needs. The increased focus on familial empowerment in the system coincided with growing adversarialism in the SEND process, with the number of appeals to the SEND Tribunal rising from 1170 in 1994/5 to 3772 in 2002/3.[134] From the 1970s to the early 2000s the number of students with SEND in special schools fell sharply, from 131,000 in 1979 to 90,290 in 2005.[135]

The Children and Families Act 2014 and the 2015 SEND Code of Practice

Ongoing concerns about the health of the SEND system prompted the 2009 Lamb Review, which argued for an expanded role for parents to address low familial confidence in the system.[136] This resulted in major SEND reform in 2014/15 in the form of the Children and Families Act 2014 and the 2015 SEND Code of Practice.

The Children and Family Act 2014 and the SEND Code of Practice 2015

England's current SEND system is established in Part 3 of the 2014 Act and the subsequent 2015 Code of Practice. The Act and Code were shaped by a number of core objectives:

- To strengthen the '*rights*' children and families had to SEN services and to expand their influence within the SEND system.[137]
- To '*provide more tailored support to families*' with a greater focus on individual need and provision.[138]
- A more joined up approach that integrated education, health and social care services to support children with SEND with the most complex needs.

The Act and Code implicitly focused on those children with the most severe SEND needs. It sought to establish legal protections for these children by placing statutory duties on local authorities to provide support and empowering parents to navigate the SEND system.

Many elements of the pre-existing SEND system were retained by the Act. For example, the definition of SEND remained relatively unchanged from the Warnock Report. However several key reforms were made by the Act, including:

- Statements of SEND were replaced by Education, Health and Care Plans (EHCPs) designed to draw together support from all three services. EHCPs would now cover young people

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[133] Policy Exchange, Special Educational Needs, 26 November 2010, link.

[134] Frontiers in Education, 'Warnock 40 Years on', 29 January 2020, link.

[135] UK Parliament, 'Select Committee on Education and Skills: Third Report', link.

[136] 'Lamb Inquiry Review of SEN and Disability Information' link.

[137] UK Gov, 'Reforms for children with SEN and disabilities come into effect', 1 September 2014, link.

[138] Ibid.

up until the age of 25, or until they left full-time education.

- The Act enabled parents to express a preference for any kind of setting, including special and independent schools.[139] Pre-2014 the presumption had been that children with statements would be accommodated in mainstream schools unless parents specifically requested a specialist placement.
- Local authorities were required to publish a Local Offer, setting out what SEND support was available.

Crucially Section 42 of the Act confirmed that local authorities had a statutory duty to '*secure the specified special educational provision for the child or young person*' '*where a local authority maintains an EHC plan*'.[140] No budget constraints were placed upon this duty. This meant that, in effect, local authorities were legally compelled to meet the costs of any provision set out in an EHCP.

The 2015 Code of Practice offered guidance to local authorities and schools on how the new SEND system should operate in practice. The Code of Practice established in detail the rights of children and parents and the points within the SEND system at which they must be consulted. It also set relatively low thresholds for families to apply for an EHCP assessment and for the issuance of an EHCP.

As this Chapter will highlight, the SEND system designed by the Children and Families Act 2014 and 2015 SEND Code of Practice has resulted in significant policy failure that has undermined the sustainability of England's SEND system.

Changes to SEND since 2014

In 2022 the Government published a significant review of England's SEND system entitled Right Support, Right Place, Right Time. It concluded that '*a vicious cycle of late intervention, low confidence and inefficient resource allocation*' was driving problems in the English SEND system established in 2014.[141]

The subsequent 2023 SEND and AP Improvement Plan established a blueprint for reforming the 2014 SEND regime, including a move towards '*a less adversarial system*'.[142] Its action points included new National SEND and Alternative Provision Standards to clarify how to identify and provide for SEND needs and a new National Funding Formula to deliver school notional SEND budgets. Controversially, it also recommended the creation of a new national system of '*bands and tariffs*' to specify the support and funding available to meet different kinds of SEND need. Furthermore, it called for the introduction of a '*tailored list*' of suitable educational settings for parents and children to consider when indicating a preference for a particular setting as part of the EHCP process.

However, implementation of the Improvement Plan has been stagnant and constrained to a small number of pilot schools. As of September 2024, only £39.2 million of the £70 million made available by the Department of Education as part of the Plan had been allocated and of this, very little

[141] UK Government, 'SEND review: right support, right place, right time', 29 March 2022, link.

[142] UK Government, 'Special Educational Needs and Disabilities (SEND) and Alternative Provision (AP) Improvement Plan', March 2023, link.

[139] ISOS Partnership, 'Towards an effective and financially sustainable approach to SEND in England', July 2024, link.

[140] UK Gov, 'Children and Families Act 2014', link.

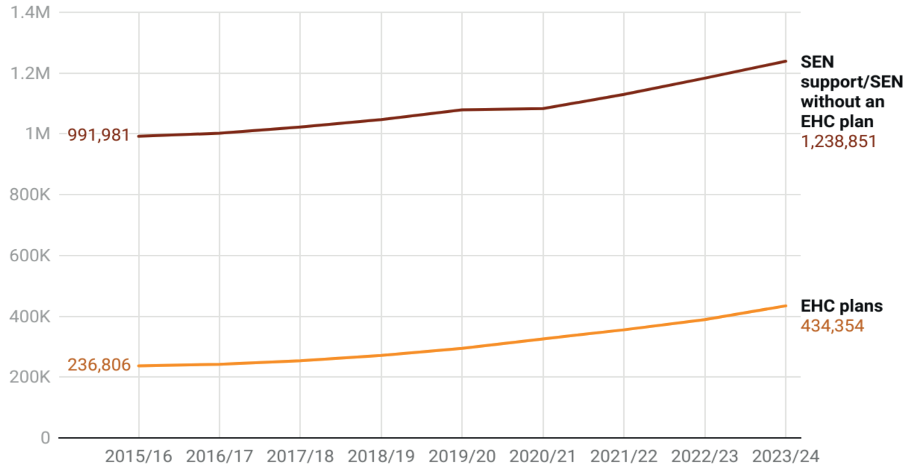
has been spent.[143]

England's SEND Crisis

In recent years England's SEND system has been described by many observers as being in crisis.[144] This stems primarily from the rapid increase in the number of children with SEND, particularly those with more complex SEND needs who have Education, Health and Care Plans (EHCPs), and the rising costs of meeting these needs, which appear increasingly unsustainable.

Since 2015 the number of children with SEND has increased significantly. The number of children defined as requiring SEND Support increased by almost 25% over this nine-year period. In the same period the number of children with SEND who have EHCPs has increased by 83%. Over 1.6 million pupils in England are now diagnosed as having SEND, equivalent to almost one in five children in English schools. The growing level of SEND diagnosis, the increased proportion of English students diagnosed with SEND and the increasing severity of SEND needs (those with EHCPs) has created significant pressure on the education and wider SEND system.

Figure 18: Number of SEND students in England with SEND Support needs and EHCPs over time[145]



Increased SEND need is primarily being driven by a small number of conditions. As Figure 19 shows, there have been significant increases in the last fifteen years in the number of EHCPs given to children diagnosed with Autistic Spectrum Disorder; Speech, Language and Communication Skills; and Social Emotional and Mental Health needs.

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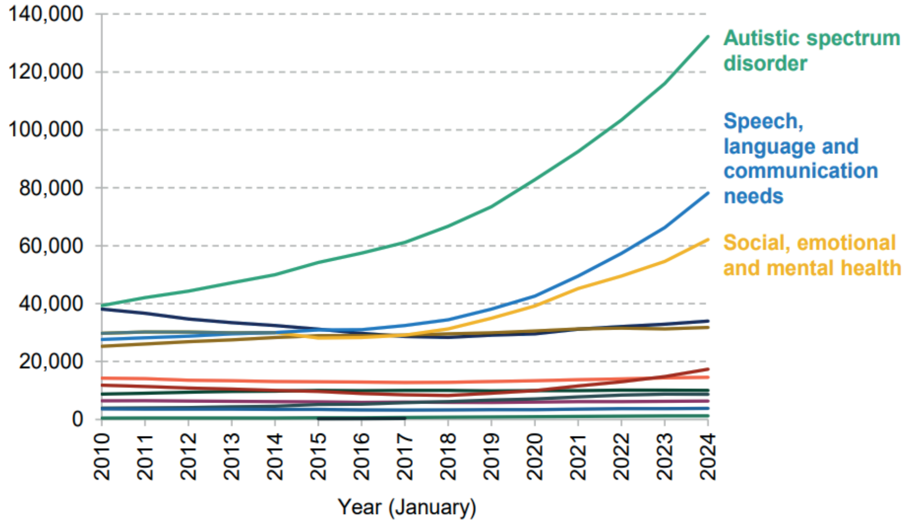
[143] Special Needs Jungle, 'What's happening with the SEND & AP Change Programme – November 2024 update', 19 November 2024, link.

[144] UK Parliament, link ; UK Parliament, 'Solving the SEND Crisis', link ; Schools Week, 'The Special Educational Needs Crisis Goes Mainstream', 9 September 2024, link.

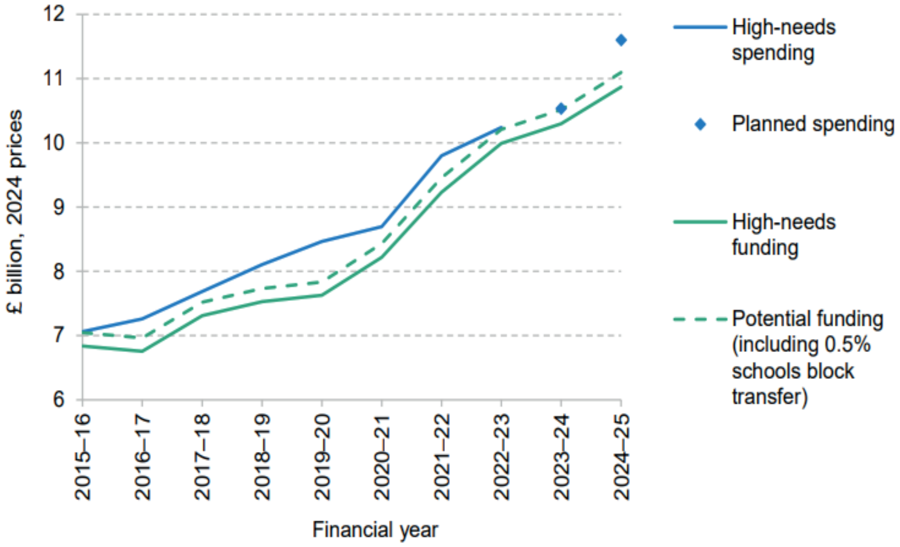
[145] UK Gov, 'Academic year 2023/24: Special educational needs in England', 20 June 2024, link.

Figure 19: Pupils with statements of SEND or EHCPs by primary type of need[146]



The costs of supporting these children and young people have rapidly increased in recent years, driven largely by the increase in the number of EHCPs. Roughly half of the increased school spending since 2015 has been spent on England's SEND system.[147] Local authority high-needs spending is projected to have increased in real terms by 64% from 2015/16 to 2024/25.[148] This equates to an increase in annual SEND spending of £4.5 billion for a total of £11 billion. Actual spending is likely to be even higher, as the costs of meeting SEND commitments routinely exceed budget allocations by local authorities. This pattern of rising SEND expenditure appears increasingly unsustainable.

Figure 20 – High needs funding and spending over time[149]



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[146] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

[147] Institute for Fiscal Studies, 'System for funding special educational needs is broken', 10 December 2024, link.

[148] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

[149] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

The SEND System in England

Funding for SEND

Funding given to schools in England to support children with SEND needs is primarily drawn from two sources. Schools receive a basic entitlement of per-pupil funding for all students to fund their education, regardless of SEND need, some of which could be used to support the school's SEND provision. In addition to this, schools receive a notional SEND budget from the local authority.[150] This is based on an algorithm that calculates notional SEND need, based on factors including the proportion of the school's pupils eligible for Free School Meals and student's prior attainment. It is not directly linked to the number of children identified as having SEND within a school. The budget is notional because, although it is provided to schools to support SEND students, the funding sits within the school's general budget. As a result, school leadership can choose to use this funding in any way, including on items which may not relate to SEND support.

Schools are expected to fund the first £6000 of SEND support for any child in their care from these two funding sources. If schools anticipate a child's SEND provision will cost more than this, they may apply for additional funding from their local authority. This funding comes from the 'higher needs block', part of the Designated Schools Grant given to local authorities by central government. Some local authorities use this money to provide additional support to schools where the notional SEND budget does not accurately reflect the level of SEND need.[151] In practice, however, the vast majority of this funding is committed to funding support set out in Education, Health and Care Plans (EHCPs) for children with SEND who qualify for this support. As the Institute for Fiscal Studies has noted:

> *'The demand-led nature of the SEND system means that councils are obligated to provide the support set out in EHCPs. This means that, in practice, councils have a limited say in the minimum they must spend on high needs.'*[152]

As a result, high needs spending by local authorities has routinely exceeded high needs funding over the last decade, resulting in many local authorities accumulating deficits due to the costs of providing SEND support, particularly for those with EHCPs.

SEND Support

SEND Support is the term used for the first of two levels of support available to children and young people with SEND needs.[153] It refers to children and young people who receive support for their SEND needs within their mainstream setting, whether this is in early years, schools or post-16 institutions. Children and young people receiving this support will generally be included on an internal list of others in that setting who have SEND needs, known as the SEND Register.

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[150] UK Government, 'The notional SEN budget for mainstream schools: operational guide 2024 to 2025', 1 August 2024, link.

[151] UK Government, 'High needs funding: 2025 to 2026 operational guide', 30 June 2025, link.

[152] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

[153] House of Commons Library, 'Special Education Needs: Support in England', 11 July 2025, link.

Identifying SEND Needs

SEND needs are almost always initially identified whilst a child is attending a mainstream setting, be that early years, school or further education (FE). The key indicator established by the SEND Code of Practice for a child potentially having SEND needs is '*making less than expected progress given their age and individual circumstances*'.[154] Providers, whether early years or school settings, are expected to monitor the development of children to ensure they are making appropriate progress. Schools are also required to benchmark '*each pupil's current skills and attainment on entry*' and will also use this information to assess any prospective SEND needs.[155] Concerns that a child may have SEND are typically initially flagged by either an individual classroom teacher or early years care provider, or by a parent.

Where there are concerns that a child may not be making progress as expected, settings are expected to gather wider evidence to investigate potential SEND need. This may include analysing the standard of the child's work and assessment outcomes and talking to teachers or early years carers. Settings are also expected to speak with the child and their parents and incorporate their views on the nature of their needs. In schools, the identification process will often involve an assessment by the Special Educational Needs Coordinator (SENDCO). The SENDCO is a specific role in a school that is responsible for supporting children with SEND needs and organising provision and is a legal requirement for all schools under the Children and Families Act 2014.[156] This may either be a full-time role or completed alongside a classroom teacher's other duties. In some cases, an assessment may instead by conducted by an external professional such as an educational psychologist, although this is unusual at the initial diagnosis stage. If a child is found to have SEND needs, support will then be put in place to address these.

SEND Support Provision in Mainstream Settings

The Local Offer

Under the SEND Code of Practice 2014, local authorities are required to publish a Local Offer, '*setting out in one place information about provision they expect to be available*'.[157] The Local Offer must include information about what is available for all SEND children, including those who do not have EHCPs. As part of the Local Offer, information should be provided on the full range of settings in which SEND students may be educated, including special schools and alternative provision.[158] It should indicate generally what provision mainstream schools should be making and set out support for SEND children transitioning between schools and into work. The Local Offer also includes information about support for SEND children's travel to school, and wider social services and family support.

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[154] Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

[155] Ibid.

[156] UK Government, 'Children and Families Act 2014', link.

[157] Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

[158] Council for Disabled Children, 'The local offer explained', link.

SEND Provision in Mainstream Schools

Most SEND students are supported through provision within mainstream settings, with 99% of non-EHCP SEND students and 55% of EHCP SEND students attending such schools.[159] Owing to the range of conditions classified as SEND, there is wide variety in the kinds of provision made for these SEND pupils. Sometimes this provision is made in mainstream lessons, whilst in other cases it is provided in 'SEND units', discrete facilities within larger mainstream schools. Certain forms of provision are typically linked to one of the four broad areas of need, whilst some are more universally employed to support students. Children identified as requiring SEND Support may also be eligible for free school transport if their SEND need means they '*could not reasonably be expected to walk*'.[160]

There is a lack of nationally available data on what SEND provision is offered by mainstream settings, including FE colleges. This lack of data makes it difficult to generalise the SEND support offered. To address this, Policy Exchange systematically reviewed the statutory SEND Policies and SEND Information Reports of a random sample of 100 English secondary schools. The sample included schools from a wide range of local authorities across England. Special schools were excluded from the sample.

Our review identified a wide variety of different forms of SEND provision. These included:

- Teaching Assistants
- Speech and Language Therapy
- Specialist equipment – wedges, desk slopes, pencil grips etc
- Maths and Literacy provision
- Social Stories

Most schools have, whether explicitly or implicitly, adopted a 'wave' approach to SEND Support. Each successive 'wave' represents more extensive support, generally in response to more acute need or the failure of other, less intrusive interventions. Wave 1 involves teaching practice referred to as Quality First Teaching. As the SEND Code of Practice states '*high quality teaching, differentiated for individual pupils, is the first step in responding to pupils who have or may have SEND*'.[161] This intervention involves high-quality teaching directed at the full class, with the understanding that SEND pupils benefit disproportionally from carefully planned, taught and assessed lessons that are underpinned by cognitive science techniques. For example, teachers may scaffold student's learning with word banks or exemplars or use questioning to test student knowledge before progressing. Teachers may also use differentiation – an approach where SEND children are given additional support (such as more structured worksheets) to help them access the same content as their peers. This approach intends to minimise disruption to the child's mainstream participation and does not involve additional provision.

Subsequent 'waves' may see a child with SEN receive additional support beyond mainstream lessons, known as an 'intervention'. This will often

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[159] National Audit Office, 'Support for children and young people with special educational needs', 24 October 2024, link.

[160] County Councils Network, 'Spiralling SEND transport budgets threaten financial sustainability of England's largest councils, report reveals', 18 November 2023, link.

[161] Department for Education, 'Special education needs and disability code of practice: 0 to 25 years', January 2015, link.

involve students being put on a time-limited course during which they are withdrawn from normal lessons for separate provision, such as booster literacy and maths courses. Initial interventions are normally provided directly by the school, often with the support of Teaching Assistants. Later waves may see children with SEND receive more and longer interventions, including the introduction of support by external specialists such as Educational Psychologists and Speech and Language Therapists.

When assessing how best to support students, the SEND Code of Practice requires schools to use what is referred to as the '*graduated approach*'.[162] The graduated approach is a four-stage process: '*assess, plan, do, review*'. In this process, which will typically be orchestrated by the SENDCO, students' needs are assessed, appropriate provision is planned and implemented, and the effectiveness of the approach then reviewed. If initial interventions are unsuccessful more intensive support may then be put in place, moving a child up through successive 'waves' of support.

Mainstream schools have broad discretion over the SEND provision they provide to children without EHCPs. Unlike in healthcare, there is no equivalent of the guidance produced by NICE on the impact and cost-effectiveness of different forms of SEND provision. Schools can therefore choose freely what evidence to base their SEND provision on and what support to commission. Decisions around the provision offered will generally be made by the SENDCO in conjunction with the school's leadership team and will be shaped by the broad expectations established by the local authority's Local Offer.

This means that SEND provision at the granular level varies significantly setting-to-setting and across different areas of the country. This has also produced a fractured landscape of SEND provision, where students with the same needs in different schools may receive very different levels of support. Research has found that '*more than half of the differences in identification [can be] explained by the school attended*' as a result of this variation.[163] Although schools are required to publish a SEND Policy and SEND Information Report, this information is rarely detailed enough to provide families with a comprehensive sense of what support each school can offer. This has created widespread inequality of SEND provision between different schools and local authorities.

Education, Health and Care Plans

Roughly three quarters of students in England have their needs met at the level of SEND Support as set out above. In these cases SEND need is diagnosed and supported internally within a mainstream educational setting. However, in a minority of cases a child's SEND needs may be assessed as being too severe to be met by the provision ordinarily available in mainstream settings. In these circumstances an application for an Education, Health and Care Plan (EHCP) may be made. An EHCP is a statutory document, which '*is for children and young people aged up to 25 who need more support than is available through special educational needs support*'.[164]

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[162] Department for Education, 'Special education needs and disability code of practice: 0 to 25 years', January 2015, link.

[163] Education Policy Institute, 'Identifying pupils with special educational needs and disabilities', March 2021, link.

[164] UK Government, 'Children with special educational needs and disabilities (SEND)', link.

The Process of Acquiring an EHCP

Under the Children and Families Act 2014 any parent, school or post-16 institution or child between 16-25 has the right to request an EHCP assessment from their local authority.[165] Whilst there is no requirement for parents and schools to act in consort, schools will often actively support parent's applications for an EHCP assessment. The number of applications for EHCP assessments has risen rapidly in recent years, from 55,235 in 2016 to 154,489 in 2024 – an increase of almost 180%.[166]

The Children and Families Act 2014 sets out that an EHCP assessment must be granted if:[167]

> *(a) the child or young person has or may have special educational needs, and*
>
> *(b) it may be necessary for special educational provision to be made for the child or young person in accordance with an EHC plan.*

This 'test' presents a relatively low bar for assessment. There need only be a suspicion that a child may have SEND needs, and the possibility that those needs require support beyond what a mainstream setting could provide. As such 65% of requests for EHCP assessments are initially successful.[168]

If a local authority denies a request for an EHCP assessment there is a clearly defined appeals process that the applicant can follow. Local authorities must notify applicants of their decision within 6 weeks of their request.[169] Applicants are then required to secure a mediation certificate before they can register an appeal with the Special Educational Needs and Disabilities Tribunal.

The Special Educational Needs and Disabilities Tribunal (SEND Tribunal)

The then-called SEN Tribunal was established as part of the Education Act 1993.[170] The SEND Tribunal hears appeals against local authority decisions regarding SEND, including refusals to:[171]

- assess a child or young person's educational, health and care (EHC) needs
- reassess their EHC needs
- issue an EHC plan
- change what is in a child or young person's EHC plan
- maintain the EHC plan

Tribunal panels consist of a judge '*and 1 or 2 specialist members who have relevant specialism and experience*'.[172] Tribunals have the power under the law to direct local authorities to reverse or make changes to their decisions.

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[165] Department for Education, 'Special education needs and disability code of practice: 0 to 25 years', January 2015, link.

[166] UK Government, 'Education, health and care plans', 26 June 2025, link.

[167] UK Government, 'Children and Families Act 2014', link.

[168] UK Government, 'Education, health and care plans', 26 June 2025, link.

[169] IPSEA, 'Refusal to assess pack', February 2025, link.

[170] UK Government, 'Education Act 1993', link.

[171] UK Government, 'First-tier Tribunal (Special Educational Needs and Disability)', link.

[172] Courts and Tribunals Judiciary, 'Special Educational Needs and Disability', link.

The low bar set by the Children and Families Act 2014 means that it is very difficult for local authorities to conclusively prove a child may not have SEND or that a mainstream setting may struggle to meet their needs. As a result, the overwhelming majority of assessment refusals are overturned by the SEND Tribunal. Although official statistics do not break down tribunal rulings by the nature of appeal, 99% of all SEND Tribunal rulings were in favour of the appellant in 2023/24.[173]

The EHCP Assessment

Once a request for an EHCP assessment has been granted the assessment can be undertaken. As the SEND Code of Practice sets out, for the assessment *'the local authority must gather advice from relevant professionals about the child or young person's education, health and care needs, desired outcomes and special educational, health and care provision that may be required to meet identified needs and achieve desired outcomes.'*[174] The Code of Practice requires local authorities to consult with the child and their parents, the child's educational setting, healthcare professionals, an educational psychologist and social care as part of the assessment. They are also required to consult with any other professionals that the child's family requests are included if this is reasonable.[175] For the assessment, all parties consulted with are provided with evidence submitted by the child or their parents regarding their needs.

One of the key figures involved in the EHCP assessment process is the educational psychologist. According to the SEND Code of Practice they *'should normally be employed or commissioned by the local authority'*.[176] However, parents can attempt to use their right to request advice from certain kinds of professional to specify that a particular educational psychologist should be consulted. Many SEND support organisations and groups strongly advise families to commission independent psychologist advice if they can afford to do so to support their own submissions, often claiming that these are likely to be more specific or detailed, or that local authority-commissioned educational psychologists may be compromised.[177] In specific circumstances, where an up-to-date independent educational psychologist's report exists, it may be possible for the family to request the local authority uses this instead for the assessment.[178]

To prove an EHCP is needed it must be demonstrated that the child's SEND needs have been properly identified prior to the assessment and that effective provision at the level of SEND Support has already been employed to attempt to meet these needs. If this has taken place and the child's needs remain unmet, the assessment must determine whether the school, through different support, could reasonably meet these needs. If not the standard for issuing an EHCP is met.[179] Crucially, the key standard is demonstrating that the child's existing setting will not be able to meet the child's SEND needs without the requirements and funding accompanying an EHCP – in other words, to demonstrate the inadequacy of existing support.

The vast majority of EHCP assessments result in an EHCP being issued. In 2024, 93.6% of EHCP assessments saw an EHCP issued, with just 6.1%

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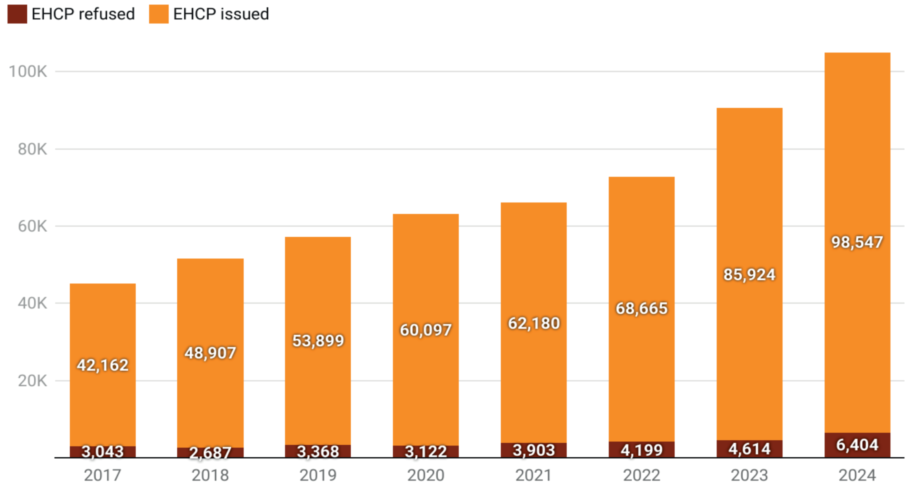
173. Ministry of Justice, 'Tribunal Statistics Quarterly: July to September 2024', 12 December 2024, link.
174. Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.
175. Ibid.
176. Ibid.
177. IPSEA, 'What happens in an EHC needs assessment', link ; Education Advocacy, 'Educational Psychologist Assessments', 18 March 2024, link ; Empowering Families of Children with SEND, 'Educational Psychology Reports', 17 January 2025, link.
178. IPSEA, 'What happens in an EHC needs assessment', link
179. Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

refused.[180] The number of EHCPs issued annual has increased markedly, from 42,162 in 2017 to 98,547 in 2024 – an increase of 134%.

Figure 21: Outcomes of EHCP assessments by year, 2017-2023[181]



In the small minority of cases where EHCP assessments determine not to issue an EHCP, the local authority must inform relevant parties within 16 weeks of the initial request, and the appellant may again appeal the decision to the SEND Tribunal. As previously stated, only 1% of local authority refusals of any kind were upheld by the Tribunal in 2023/24, meaning that in the vast majority of cases the refusal was overturned and the local authority was directed to produce an EHCP. However, as when appealing the refusal for an assessment, this can be an intensive and stressful process for those involved.

Preparing an EHCP

Once the assessment has been conducted and the decision has been made to issue an EHCP the document itself must be drafted. According to the SEND Code of Practice, EHCPs '*must specify the outcomes sought for the child or young person*' and '*must specify the special educational provision required to meet each of the child or young person's special educational needs*'.[182] Under the Code an EHCP must include 12 sections. These include the views of the child and/or their parents, the child's SEND, health and social care needs, the outcomes sought, the education, health or social care provision to be made and a named educational setting to provide this support.

Significant focus is placed on the specificity of provision required. In a 1998 Tribunal ruling, L vs Clarke and Somerset County Council, it was ruled that the support required should be:

> '*So specific and so clear as to leave no room for doubt as to what has been decided is necessary in the individual case. Very often specification of hour per week will no doubt be necessary and there will be a need for that to be done*'.[183]

As such, as Figure 22 demonstrates, EHCPs are typically highly detailed, particularly in setting out the precise SEND support required. However,

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[180] UK Government, 'Education, health and care plans', 26 June 2025, link.

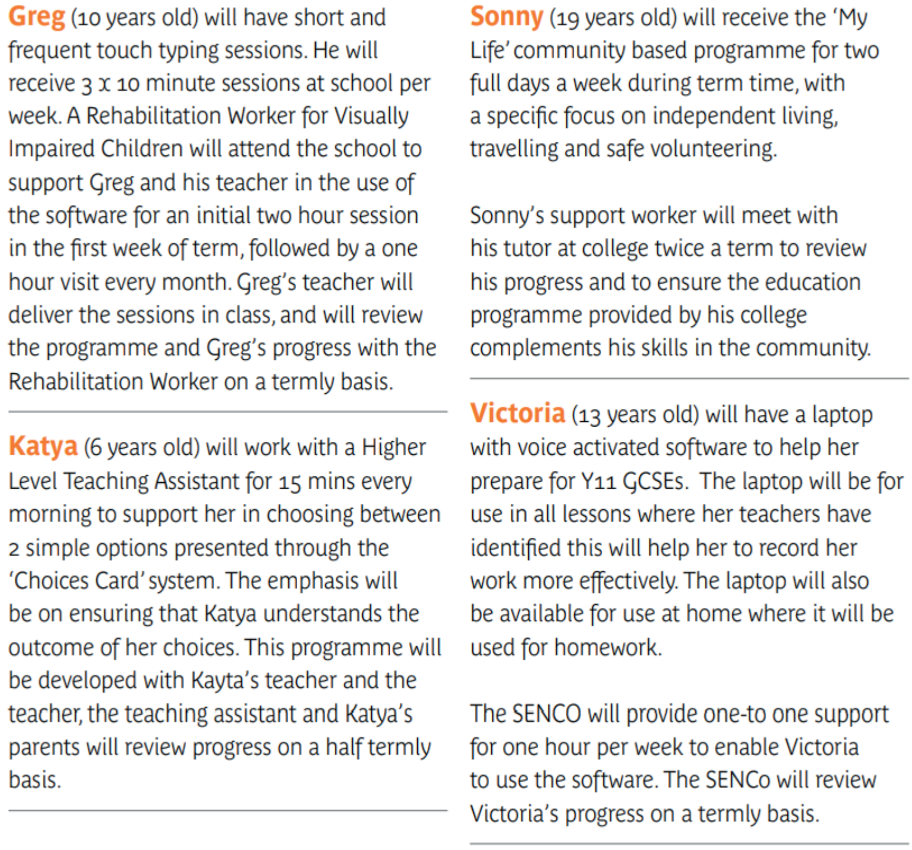
[181] Ibid.

[182] Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

[183] IPSEA, 'L v Clarke and Somerset County Council [1998] ELR 129', link.

the length and therefore specificity of these documents can vary, ranging from 8 to 40 pages in length.[184] As statutory documents, the child is then legally entitled to this support.

Figure 22: Exemplar Section F EHCP paragraphs produced as 'examples of good practice' for those writing EHCPs by the Council for Disabled Children. The Council represents over 300 voluntary and community organisations and partnered with the Department for Education[185]



Greg (10 years old) will have short and frequent touch typing sessions. He will receive 3 x 10 minute sessions at school per week. A Rehabilitation Worker for Visually Impaired Children will attend the school to support Greg and his teacher in the use of the software for an initial two hour session in the first week of term, followed by a one hour visit every month. Greg's teacher will deliver the sessions in class, and will review the programme and Greg's progress with the Rehabilitation Worker on a termly basis.

Katya (6 years old) will work with a Higher Level Teaching Assistant for 15 mins every morning to support her in choosing between 2 simple options presented through the 'Choices Card' system. The emphasis will be on ensuring that Katya understands the outcome of her choices. This programme will be developed with Kayta's teacher and the teacher, the teaching assistant and Katya's parents will review progress on a half termly basis.

Sonny (19 years old) will receive the 'My Life' community based programme for two full days a week during term time, with a specific focus on independent living, travelling and safe volunteering.

Sonny's support worker will meet with his tutor at college twice a term to review his progress and to ensure the education programme provided by his college complements his skills in the community.

Victoria (13 years old) will have a laptop with voice activated software to help her prepare for Y11 GCSEs. The laptop will be for use in all lessons where her teachers have identified this will help her to record her work more effectively. The laptop will also be available for use at home where it will be used for homework.

The SENCO will provide one-to one support for one hour per week to enable Victoria to use the software. The SENCo will review Victoria's progress on a termly basis.

The child and their parents must be involved in producing the EHCP. The local authority must also share a draft of the EHCP with the parents or young person and allow 15 days in which they can provide feedback on the draft. As previously noted, EHCPs also name a setting to be responsible for delivering the child's EHCP and the child or parent has the right to request a named institution as part of this. This preference '*must*' be honoured unless the local authority can demonstrate that the care the setting provides is '*unsuitable*' or that '*the attendance of the child or young person there would be incompatible with the efficient education of others, or the efficient use of resources*'.[186] The setting named in an EHCP is required by law to admit the child. Once again, if a child or parent is unhappy with the final EHCP they may appeal to the SEND Tribunal after securing a mediation certificate. As previously noted, the appellant's appeal is overwhelmingly upheld at these Tribunals. If the nearest '*suitable*' setting identified is more than 2 or

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[184] UK Government, 'SEND Review: right support, right place, right time', March 2022, link.

[185] Council For Disabled Children, 'Education, Health and Care plans: examples of good practice', link.

[186] Department for Education, 'Special education needs and disability code of practice: 0 to 25 years', January 2015, link.

3 miles from the child's home, depending on their age, the local authority is required to provide free transport for the child to their named setting.[187]

Maintaining and Revising an EHCP

When a final ECHP is issued, the local authority has a statutory obligation to '*maintain*' the plan. This involves ensuring all support set out in the EHCP is provided to the child, including meeting any costs associated with this. There are no limits on the costs local authorities can incur in meeting the needs established in EHCPs.

All EHCPs are subject, at minimum, to an annual review. This is an opportunity to review the child's progress and whether the support currently in the EHCP needs to be revised to better meet the child's needs. This enables the EHCP to adapt as a child becomes older and their needs evolve. To this end EHCPs can be transferred between educational settings and local authorities. The child and their parents must be involved in the review process and their views must be accounted for under the SEND Code of Practice. If a local authority decides to modify an EHCP, for instance adapting the support offered, or proposing ceasing it all together, the child and family must be given notice. As in other parts of the system the child and their parents may then appeal this to the SEND Tribunal.

EHCPs post-16

Under the Children and Families Act 2014 EHCPs last until 25, or until the young person either enters Higher Education, a job or, post-18, no longer wishes to engage in education or training. Post-16 schools are required to support the transition into further education or training. Young people with EHCPs are expected to receive consistent week-long support, with a focus on '*work-based learning*' opportunities and careers.[188] When moving off an EHCP, either into Higher Education or because the 25 threshold has been reached, local authorities have an obligation to perform a handover with other relevant institutions, such as supporting a young person to transition into adult social care.

Provision for children with EHCPs

Children and young people with EHCPs receive the provision set out within their EHCP document. As such this is individualised to the specific needs of the child. The educational setting that child is part of is required by law to provide the support, regardless of cost, although it will likely receive additional funding from the local authority to meet these expenses.

Where EHCP provision is delivered by mainstream schools, the kinds of intervention used may be similar to those that the school offers to children with less severe needs. For example, it may include catch-up interventions in core subjects or social skills classes. However, due to the severity of the needs of children with EHCPs a greater proportion of their support is likely to be provided in very small groups or one-on-one and to be delivered by external professionals.

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187. County Councils Network, 'Spiralling SEND transport budgets threaten financial sustainability of England's largest councils, report reveals', 18 November 2023, link.

188. Department for Education, 'Special education needs and disability code of practice: 0 to 25 years', January 2015, link.

Special Schools and Alternative Provision

Some SEND students are registered to and receive SEND provision from specialist settings. Under half of SEND children with EHCPs attend such settings, with 36% registered at state special schools, 9% at independent schools and 1% in alternative provision.[189] In 2024 there were 1050 state funded and non-maintained special schools in England, educating over 160,000 SEND students.[190] Demand for special schools is high, with two thirds over their stated capacity.[191] Special schools have specialist SEND teaching staff and often have a greater range of specialist SEND provision and equipment than is available in mainstream schools. Class sizes tend to be smaller, with a higher student-teacher ratio. The curriculum of special schools may also be adapted to place a greater focus on life skills, such as money management.[192] State funded special schools receive an initial grant of £10,000 per place, which may then be topped up by funding for individual EHCPs.

A small proportion of SEND students attend Alternative Provision (AP). AP refers to the statutory obligation of local authorities under the Education Act 1996 to '*arrange suitable and (normally) full-time education*' for children who, for a variety of reasons, cannot attend mainstream schools.[193] AP can either be delivered in state funded settings, or in private settings funded by the local authority.[194] Roughly half of students in state-funded AP have an EHCP, whilst over 90% in local authority funded AP do so.[195] Alternative Provision includes Pupil Referral Units (PRUs) and online learning, with the aim to keep children engaged in education and ultimately reintegrate them into a full-time educational setting. SEND students will often end up in such settings as a result of school refusal.

England's SEND System: A Perfect Storm?

The SEND system established by the Children and Families Act 2014 and the 2015 SEND Code of Practice is inefficient, ineffective and has failed to deliver improved outcomes for children with SEND. Fundamental flaws have created perverse incentives for actors in the system. The current SEND regime was designed to support a much smaller number of acute cases. It has failed to adapt to changing social definitions of SEND that have widened demand. Instead, the concentration of resources and bespoke support at the top end of the spectrum has prompted an escalation of needs which has overwhelmed the system and undermined its long term sustainability.

A Lack of Evidence, Quality and Efficiency in the System

The amount of research and the quality of evidence around SEND has improved markedly over the last twenty years. However, this remains an emergent field of cognitive research and one in which understanding and advice is constantly evolving. This obviously presents a challenge for professionals supporting children with SEND. Despite the best of intentions, it is not clear that many of these professionals, particularly in mainstream settings, have the knowledge or expertise to consistently

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[189] National Audit Office, 'Support for children and young people with special educational needs', 24 October 2024, link.

[190] House of Lords Library, 'Special education schools and colleges in England: Policy and challenges in the special educational needs sector', 16 October 2024, link.

[191] UK Government, 'School capacity', 27 March 2025, link.

[192] House of Lords Library, 'Special education schools and colleges in England: Policy and challenges in the special educational needs sector', 16 October 2024, link.

[193] Department for Education, 'Arranging Alternative Provision: A Guide for Local Authorities and Schools', February 2025, link.

[194] FFT Education Datalab, 'Who are alternative provision schools for?', 23 November 2023, link.

[195] Ibid.

identify or support SEND needs effectively. As a result, there is too much misdiagnosis and poor-quality provision, with too many children having their needs met ineffectively despite huge costs to the taxpayer.

Mainstream settings lack the consistent ability to accurately identify SEND needs

Almost all SEND need is initially diagnosed by early years providers and schools. Indeed, as explained above, demonstrating engagement with SEND Support is a core prerequisite for obtaining an EHCP. However, how schools identify SEND needs is highly varied and decentralised, differing school to school.

Evidence suggests the SEND diagnosis process is often ineffective. In 2018 a study by academics at Cambridge University found that of 550 children referred by their schools for having learning difficulties, 25% were in fact age-typical with no obvious SEND needs.[196] The study further found very low accuracy in diagnosis, with many children with identical symptoms being diagnosed with different conditions.

This issue may stem from the relatively limited training that school SENDCOs receive. All SENDCOs are now expected to have or be working towards the SENDCO National Professional Qualification (NPQ). This is an 18-month course, which, according to the Department for Education, will '*involve an average of 1 to 2 hours of study each week*'.[197] At a maximum, this effectively corresponds to 19 and a half working days in total. By contrast, it takes a minimum of six years of study to become an educational psychologist. Whilst educational psychologists may ultimately be called in to assess a child's SEND needs, much of the early diagnosis, including whether to further assess a child's needs, will depend on the SENDCO's perspective. It is difficult to see how SENDCOs will consistently have sufficient psychological knowledge to do this effectively.

This presents significant challenges. SEND needs may be misdiagnosed or missed altogether by schools without the knowledge to identify SEND effectively. As the Government's 2022 SEND Review argued, '*Children and young people's needs are identified late, then escalate and become entrenched. In some cases, a child or young person may be incorrectly identified as having SEND.*'[198] Certain schools may have better systems in place to identify SEND needs, resulting in school-by-school inequality. Research has found that '*more than half of the differences in identification [can be] explained by the school attended*'.[199] This can result in stark regional variation. For example, the share of pupils with EHCPs in Tower Hamlets is three times higher than in Nottinghamshire.[200] This inequality is then rapidly propagated, as those with diagnosed SEND needs can move on to receive SEND Support or gain an EHCP, whereas those whose needs may even be more severe, but which are not recognised, do not receive the same support. Equally, resources may be wasted, and a child's learning disrupted, by providing inappropriate SEND support either because the child in fact has no SEND needs or because the nature of their SEND has been mis-diagnosed.

[196] University of Cambridge, 'Remapping the cognitive and neural profiles of children who struggle at school', 2019, link.

[197] UK Government, 'Special educational needs co-ordinator's (SENCO) national professional qualification', 2 February 2024, link.

[198] UK Government, 'SEND Review: right support, right place, right time', March 2022, link.

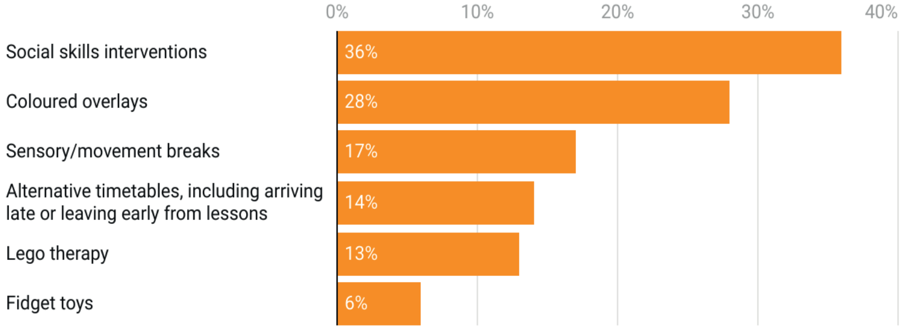
[199] Education Policy Institute, 'Identifying pupils with special educational needs and disabilities', March 2021, link.

[200] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

Too much SEND provision is low quality and underpinned by weak evidence

For SEND provision to be valuable it must be effective in delivering positive educational outcomes for children with SEND. However, a lack of evidence informing SEND practice has meant that a large number of frequently used SEND interventions rely on weak evidence, misinterpret cognitive science research, or have no supporting evidence at all. A 2022 research report for the British Educational Research Association, based on an analysis of interventions offered by 10 cluster schools across England and Wales, found that 67% of the interventions offered had no evidence to support them and 3% actually had published evidence to suggest they were ineffective.[201] Alarmingly, the study found that even when presented with this evidence, many schools in the cluster did not alter their provision to remove un-evidenced or harmful interventions.

Figure 23: Prevalence of SEND provision types supported by limited evidence amongst sampled schools



Our review of school SEND policies found widespread use of SEND interventions for which evidence was often very limited. 28% of schools surveyed referenced the use of coloured overlays to support SEND students, despite the visual theory of dyslexia having been widely discredited.[202] Over a third of schools surveyed offered some form of social skills intervention. However, the Education Endowment Foundation found in its evidence review of '*social and emotional learning*' interventions that whilst these might have moderate impact, there was '*very limited evidence*' of their efficacy.[203] Similarly, despite 13% of schools offering Lego therapy, a 2021 systematic review found '*the overall quality of the included studies [on the effectiveness of Lego therapy] was low*'.[204] Given the resources involved in providing these interventions, and the disruption to a child's mainstream education that they may entail, it is concerning that the evidence base is so insecure. Poor quality provision can also be a particular issue for young people with SEND post-16, when EHCPs often become outdated and goals for young people with SEND fail to accurately reflect their ambitions and needs as they transition into adulthood.[205]

One factor in the low quality of mainstream SEND Support has been the shortage of professionals such as Educational Psychologists and Speech and Language Therapists working with mainstream schools on

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201. BERA, 'Assessing the range and evidence-base of interventions in a cluster of schools', 25 February 2022, link.
202. National Library of Medicine, 'The Effect of Colored Overlays on Reading Fluency in Individuals with Dyslexia', August 2015, link.
203. Education Endowment Foundation, 'Social and emotional learning', link.
204. Brain Sciences, 'Could You Give Me the Blue Brick? LEGO®-Based Therapy as a Social Development Program for Children with Autism Spectrum Disorder: A Systematic Review', 26 May 2021, link.
205. Department for Education, 'Delivering Better Value in SEND: Phase 1 Insight Summary', link.

universal support. Lack of funding and the administrative burden of EHCP assessments has meant this specialist support is increasingly backloaded in the system, with limited resource for early schools-based intervention. Some professionals have suggested that the lack of involvement in SEND Support has resulted in a lack of expert advice to make initial support effective, escalating needs in the system and driving demand for EHCPs. In July 2025 the Health and Social Care Select Committee proposed to address this by separating '*the delivery of support and diagnostic services in the existing workforce*' to enable '*a needs-led model, providing early detection and care before a diagnosis*'.[206]

Whilst provision is often of higher quality in specialist settings, some is still of questionable quality. This is particularly true of Alternative Provision (AP). A joint report by Ofsted and the Care Quality Commission in 2024 described AP as functioning as '*a shadow SEND system*' finding '*children 'in limbo' at an inappropriate AP while waiting for a special school placement or for an appropriate needs assessment*'.[207] The report found that '*in some cases, we found less focus on academic attainment or long-term outcomes*'.[208] There has in recent years been a rise in the number of unregistered AP settings. These settings provide 'full-time' support to fewer than 5 children and were responsible for the education of 22,000 children in 2022.[209] Many of these settings are subject to limited oversight and yet charge very high fees to the local authorities commissioning their services. Investigations have found unacceptable failures to provide quality AP educational support to SEND students, including one case where 60 children with EHCPs were being educated in a polytunnel in an open field, at any annual cost of over £40,000 to the local authority.[210]

Interventions are overused at the expense of mainstream lesson time

In many mainstream settings a presumption has emerged that good SEND practice requires out-of-lesson interventions to support students. Schools may feel it is an easy way to visibly demonstrate that they are taking action to support SEND needs, potentially in response to parental pressure. However, interventions are not neutral acts. Provision that sees students removed from mainstream lessons has clear opportunity costs in terms of learning disruption. Children with SEND are those that most need high-quality teaching and are the most likely to struggle to catch up on any content missed. Too often certain schools implicitly shift their ambitions for children with SEND to be less academically focused, establishing a soft bigotry of low expectations which ignores that the core role of SEND provision is to deliver better educational outcomes.

Our systematic review found that interventions that required children with SEND to miss mainstream lessons were employed in at least 71% of the schools sampled. Ofsted's 2021 report, '*Supporting SEND*' found the extent of interventions during timetabled lessons '*raises concerns about pupils with SEND having full access to the high-quality teaching they need in order to have a chance of success*'.[211] This is despite extensive evidence that children with SEND generally benefit from the same high quality teaching techniques as their

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[206] Health and Social Care Committee, 'Letter to the Minister of State for Care: Autism and ADHD diagnostic pathway for children and young people', 21 July 2025, link.

[207] Ofsted and Care Quality Commission, 'Alternative provision in local areas in England: a thematic review', 1 February 2024, link.

[208] Ibid.

[209] Schools Week, ''Out of sight, out of mind': The rise of unregistered alternative provision', 9 October 2023, link.

[210] Schools Week, ''What we see are wasted lives'', 31 March 2025, link.

[211] Ofsted, 'Supporting SEND', 13 May 2021, link.

peers, whether that be cognitive science approaches or phonics.[212] As the Education Endowment Foundation argued in its 2025 guidance report on SEND in mainstream schools, '*far from creating new programmes, the evidence tells us that teachers should instead prioritise familiar but powerful strategies*' to support children with SEND.[213] Yet too often the focus is on establishing distinct educational pathways for SEND students that inadvertently deny them the same high quality teaching as their peers.

Separate SEND provision is further undermined by its dependence on unqualified Teaching Assistants to deliver interventions. Between 2011/12 and 2023/24, the number of Teaching Assistants in England increased by 28%.[214] This has given schools the capacity to provide small group and one-on-one support to SEN students, particularly those with high needs and EHCPs. However, by definition Teaching Assistants lack the specialist subject knowledge and teacher training of teachers. The risk is therefore that children with SEN receive a disproportionate amount of their instruction from less qualified professionals. Ofsted has highlighted that evidence suggests '*a negative relationship between the amount of TA support received and the progress made by pupils in mainstream schools*' and that '*pupils with SEN received less appropriate and lower quality pedagogical provision*'.[215]

There has been a drive towards specialist provision for milder needs

There are many reasons why children with complex SEND needs may need to be supported in specialist settings. Sometimes needs are too specialist and severe to be effectively supported by mainstream teachers and schools, who lack the expertise and capacity to effectively support these children alongside their wider responsibilities to other student's learning. As previously noted, special schools have resources and expertise that can enable them to make better provision for those students with complex SEND needs.

However, there are downsides to the overuse of specialist provision. Children in SEND schools miss out on socialisation with their wider peer group. The cost of specialist settings is also much higher. The average annual cost per pupil with SEND in a state-maintained special school is £23,900, rising to £61,500 for independent provision.[216] This is significantly higher than the costs associated with meeting SEND need in mainstream schools. Whilst this may be appropriate for those with complex and specialist needs, evidence suggests that too many children are presently being funnelled into costly specialist settings. Research by the Department for Education, in which the needs of 1650 children and young people with SEND were reviewed, suggested 65% could have had their needs met in a more effective way.[217]

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[212] Department for Education, 'SEN support: A rapid evidence assessment', July 2017, link.

[213] Education Endowment Foundation, 'Special educational needs in mainstream schools', link.

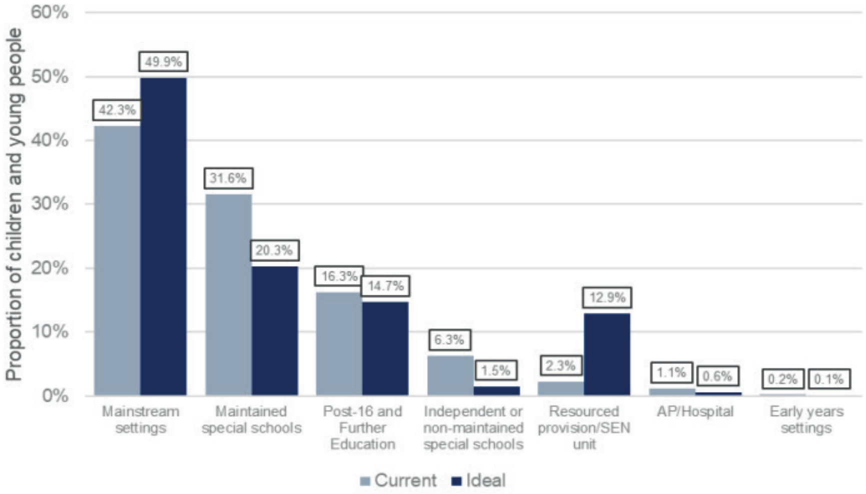
[214] UK Government, 'School workforce in England', 6 June 2024, link.

[215] Ofsted, 'Supporting SEND', 13 May 2021, link.

[216] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

[217] Department for Education, 'Delivering Better Value in SEND: Phase 1 Insight Summary', link.

Figure 24: Current and ideal provision mix for children and young people[218]



In many cases, the over-use of specialist settings has been driven by parental preference for such provision. As previously noted, under the Children and Families Act 2014 parents are able to request a named setting as part of the EHCP process to provide support for their child, which the local authority may only reject in limited circumstances. This power is often used to request a specialist placement. Demand for specialist placements is primarily driven by the low confidence of parents and children in the ability of mainstream settings to meet their children's needs. A report by the National Audit Office found that '*86% of parents of children with SEND at state special schools agreed their child got the support they needed, compared with 71% at mainstream primary and 56% in mainstream secondary schools*'.[219] Research by the Department for Education found that in over 20% of cases analysed parental opposition to mainstream settings was the primary reason that children with SEND were not in the right setting for their needs.[220] This example demonstrates how the wishes of non-expert children and parents, nonetheless empowered by the current SEND framework, has unduly influenced the support provided to SEND children. It is vital that professionals are empowered to decide based on evidence when these kinds of specialist support are needed.

Health and Social Care responsibilities have been shifted onto schools that are ill-equipped to meet them

The Children and Families Act 2014 and 2015 SEND Code of Practice specifically require co-working across education, health and social care to support a young person's needs. Sections C and D of the EHCP specifically detail any needs relating to health and social care.[221] However, in too many cases the involvement in health and social care services in delivering EHCPs has been minimal. A Schools Week analysis of Ofsted area SEND inspections found some EHCPs were '*finalised without contributions from health or*

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[218] Department for Education, 'Delivering Better Value in SEND: Phase 1 Insight Summary', link.

[219] National Audit Office, 'Support for children and young people with special educational needs', 24 October 2024, link.

[220] Department for Education, 'Delivering Better Value in SEND: Phase 1 Insight Summary', link.

[221] Department for Education, 'Special education needs and disability code of practice: 0 to 25 years', January 2015, link.

social care professionals', whilst research by the Children's Commissioner into EHCPs issued by two local authorities found data was missing from 40% of health and social care sections.[222] This has often left schools to provide specialist health and social care support which they are ill-equipped to offer. For example, one trust has been required to offer hydrotherapy as this provision has been written into section F, which schools are then required to provide.[223] This has forced schools to expand their services and take on wider social and health responsibilities towards children with SEND, detracting from their educational mission.

An Inflexible Statutory Framework

Given that knowledge of SEND and best practice is still evolving, and that the needs of children with SEND are inherently highly individual, an effective system of SEND support needs to give knowledgeable, well-situated professionals the discretion to shape support to best care for the child or young person. Yet the rigid and frequently statutory system of SEND support established by the Children and Families Act 2014 and SEND Code of Practice has achieved the reverse – a system with limited flexibility to adapt to practical considerations or the changing support needs of those with SEND.

The statutory framework is vague and enshrines a deficit model for SEND

The statutory definition of SEND within the Children and Families Act 2014 fails to effectively delineate what does or does not constitute a SEND need. Its definition as '*a learning difficulty or disability which calls for special educational provision to be made*' is effectively cyclical, as it does not establish a clear standard of need to justify such provision being made.[224] Since the 1978 Warnock Report, SEND has been identified based on individual need as opposed to specific categories. The confusion this has caused has meant the definition of SEND is interpreted on effectively a case-by-case basis, which has often resulted in a maximalist interpretation. This means needs may be classified differently by different schools or local authorities, and in some cases very mild needs have been classified as SEND. This has also changed over time as society's understanding of '*learning difficulty*', '*disability*' and '*special educational provision*' have evolved, typically in a more expansive direction.

Statutory guidance on EHCPs, such as the SEND Code of Practice, has established threshold tests in such a way as to set a relatively low bar for qualifying for support, whilst conversely making it very difficult for local authorities to demonstrate an EHCP is not required. For an EHCP assessment the applicant must only demonstrate that a child '*may*' have SEND and that special provision '*may*' be needed.[225] Similarly, to secure an EHCP the applicant must only demonstrate that '*it may be necessary for the local authority to make special educational provision*'.[226] Setting the standard so low effectively requires local authorities to prove comprehensively that a child does not have the requisite SEND needs. This is difficult to do with full

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[222] Schools Week, 'EHCPs: Schools pick up pieces of absent health and social care', 7 March 2025, link.

[223] Ibid.

[224] Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

[225] UK Government, 'Children and Families Act 2014', link.

[226] Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

certainty and therefore results in the very high number of successful EHCP applications and successful appeals to the SEND Tribunal.

The statutory system has also medicalised the process of identifying and supporting children and young people with SEND. The SEND Code of Practice establishes a deficit model for all elements of SEND provision, whether at the level of SEND Support or an EHCP. In either case, an unmet need must be identified. This deficit model encourages children, parents or schools seeking support to emphasise what a child cannot do, therefore maximising and perhaps even exaggerating the support they require to demonstrate the extent of their needs to unlock support. This in turn perpetuates a culture in which child with SEND are perceived to have lower capacity and capability than their peers. The necessity of labelling and medicalising SEND need does not acknowledge the potential damage to how a young person perceives themselves and their abilities. The medicalised approach does not effectively account for naturally uneven child development, instead tying children into inflexible long-term diagnoses and provision which may not consistently meet their needs.

The statutory nature of EHCPs means that providers lack flexibility – and can result in students receiving low quality support

As previously noted, EHCPs contain a section setting out the precise provision to which the child is entitled. As statutory documents, the educational setting at which the child is registered is then legally liable to make this provision. This can involve very specific and rigid instruction on how interventions should be conducted.

It is important that children with highly specific individual needs have these met by their educational settings. However, the current system does not provide the necessary flexibility for many EHCPs to be implemented within dynamic school environments. As Tom Rees, the Government's Inclusion Tsar has said, '*if you've got over 70 EHCPs and each of those is very individual and personalised, it's unrealistic for a school to deliver these effectively*'.[227] For example, an EHCP may say that a child should receive a one-to-one reminder of the instruction immediately after a class is set off on an independent task. Yet there are many reasons why this may not be possible – the teacher may need to deal with disruption in the room and then return, or may even be required to support another child with SEND simultaneously in the same way. Yet under the current statutory EHCP model, such common-sense accommodations amount to a breach of the law.

Nonetheless, some mainstream and specialist settings are taking risks within this framework to better manage the resources available to them. For example, our research found instances of specialist therapy sessions funded through individual EHCPs being shared with other children to extend the benefits, particularly when the level of support individually guaranteed by an EHCP was felt by professionals to be excessive for a single child.

The restrictive nature of EHCPs can compound the issues with poor quality interventions that have been previously identified. If a SEND intervention has no supporting evidence or may even be detrimental, yet

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[227] Schools Week, 'The special educational needs crisis goes mainstream', 9 September 2024, link.

is nonetheless written into an EHCP, then the education provider has no choice but to make this provision or be in breach of the law. A recent investigation by Schools Week, which submitted Freedom of Information requests to 25 councils in England in relation to the provision set out in Section F of SEND children's EHCPs, found several EHCPs explicitly set out entitlements to fidget toys and learning styles, despite neither approach having clear evidence of efficacy.[228]

Parental choice and influence has been over-extended

Parents and families should always be encouraged to play an active role in their child's education. These are the individuals who in many senses know their children best and are likely to have their best interests at heart. Yet parents and families are not trained educational or medical professionals and their ability to effectively diagnose SEND or identify appropriate provision is likely to be low. In spite of this, the current SEND system gives parents excessive influence over the system and in doing so ties the quality of care a child with SEND receives too closely to their parent's ability to advocate for them.

The Children and Families Act 2014 and the subsequent SEND Code of Practice both established a very expansive role for parents and the child themselves in the SEND process. Co-production and joint working with parents and other stakeholders are '*fundamental principles*' of the 2014 system.[229] Schools are consistently required by law to consult with parents and adapt SEND Support in line with their wishes. With regards to EHCPs, parents are directly involved in the drafting process and the views of the child and their parents are directly written into Section A of the document.[230] In some cases parental concerns are enough for schools to initiate a process of SEND assessment or support. Policy's Exchange's review of sample secondary school SEND policies found 56% of schools reviewed indicated parental concerns would be treated as a basis for providing a SEND diagnosis, or that parent's wishes could result in certain support being put in place for their child. It is difficult to see how this level of parental involvement supports the system's efficiency in making accurate SEND diagnoses or identifying the right provision to put in place.

The central role afforded to children and families has led to inequality within the SEND system. In a regime where parents and children are so empowered, the ability of these individuals to advocate effectively becomes central to the support offered. This in turn places those with the financial, social and cultural capital to effectively navigate the SEND system at a clear advantage as they are, in the words of the Government's 2022 SEND Review, '*often better placed to secure support for their children*'.[231] For example, those able to pay for private educational psychologist assessments, either to secure additional SEND Support or to support an EHCP application, are likely to be placed at a significant advantage. Whilst the price of such assessments vary, companies advertising online routinely cost between £800 and £1400.[232] Similarly some families with the means to do so may instruct solicitors as part of their case to the SEND Tribunal, at the cost

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[228] Schools Week, 'Fidget spinners and learning styles: EHCPs' questionable interventions', 7 March 2025, link.

[229] UK Government, 'SEND Review: right support, right place, right time', March 2022, link.

[230] Department for Education, 'Special educational needs and disability code of practice: 0 to 25 years', January 2015, link.

[231] UK Government, 'SEND Review: right support, right place, right time', March 2022, link.

[232] Children's Wellness Centre, 'Educational Psychology Assessments', link; Solutions Educational Psychology Ltd, 'Support packages', link.

of thousands of pounds. It is plainly wrong if the system disadvantages those without the resources or capacity to effectively advocate for a child's needs.

Misaligned Incentives

England's SEND system has produced a range of incentives for key stakeholders that impede the effective functioning of the system. The statutory nature of EHCPs established by the Children and Families Act 2014, and the uncapped local authority budgets that follow these, incentivise individuals to take a maximalist approach to SEND provision at the expense of the system's financial sustainability.

Opposing financial incentives create conflict in the system

Over the last 15 years school budgets in England have faced significant pressure. In real terms, per pupil funding in England fell by 9% between 2009-10 and 2019-20. Funding increases since 2020 have meant that per-pupil funding is now in real terms roughly equivalent to 2009-10 levels.[233] These issues have been compounded by inflation in recent years which have increased school operating costs. As such, many school budgets have been under significant strain. As a result, schools' notional SEND budgets have increasingly been applied to routine operations as opposed to SEND support. This means many schools have had less discretionary SEND funding per pupil.

With less funding stretched across more pupils with SEND, schools have been incentivised to attempt to find additional funding support. This is most readily available by pursuing EHCPs for children with SEND as this can unlock significant additional resources from local authority Higher Needs Funding. Schools are therefore incentivised to seek EHCPs for children whose needs may have effectively been met by SEND Support if this system was more effectively funded. Although the system hedges against this by requiring settings to meet the first £6000 of the cost of providing an EHCP, the declining purchasing power of this sum means it remains highly beneficial in many cases for schools to pursue EHCPs for children with increasingly moderate levels of SEND.

Similarly, many parents have become understandably concerned about the quality of SEND Support in mainstream settings given the lack of resources available. A survey of 2000 parents of children with SEND found fewer than one in ten felt their needs were being properly met through SEND Support.[234] For them, an EHCP may appear to be the only way to guarantee the provision they feel their child needs. In this their financial incentives to pursue EHCPs aligns closely with those of mainstream schools, effectively escalating SEND needs to the level of an EHCP to secure further funding.

These misaligned incentives are compounded by the design of the EHCP process. A core part of the EHCP assessment 'test' is to demonstrate that a mainstream setting has been unable to meet the child's needs through SEND Support. If funding pressures mean such SEND Support

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[233] Institute for Fiscal Studies, 'The latest picture on school funding and costs in England', 1 March 2024, link.

[234] Channel 4 News, "I'd prefer to be at school' – the long wait for SEND support', 30 March 2025, link.

is poor quality or inadequate, it is easier to demonstrate that the setting cannot meet the child's needs without them having an EHCP. This in turn produces a vicious cycle stemming directly from under-resourced SEND Support. As the Government's 2022 SEND Review highlighted, more resources being dedicated to specialist support continues to undermine '*early intervention and effective, timely support in mainstream settings*'.[235]

Conversely, the low thresholds and limited success local authorities have in rejecting EHCP applications has disincentivised them from actively scrutinising the assessment process. The cost of defending appeals can be extremely high, with Special Needs Jungle, a SEND parental advocacy group, estimated local authorities spent over £165 million defending Tribunal cases in 2024.[236] Yet with so few rejections being upheld by SEND Tribunals, many councils have decided to conserve funds by not routinely contesting appeals.

This has resulted in a situation where many parents and schools willing to undertake the arduous and lengthy appeals process ultimately face little resistance. This undermines the process and creates perverse incentives for applicants if they appreciate that any application, regardless of merit, is highly likely to be successful.

There are incentives for many families to seek SEND diagnoses – and a growing private industry to support applications

There has been a growing perception that a SEND diagnosis can unlock additional support for a child or young person which will in turn advantage them relative to their peers. Some have argued that EHCPs in particular represent a '*golden ticket*' which can provide children with expansive additional personalised support.[237] For example, there has been increasing concern about the number of children afforded extra time in exams and the demographic breakdown associated with this. Research by Ofqual has found that students at independent schools are over 50% more likely to have exam access arrangements than those at non-selective state schools. Whilst Ofqual has recently acknowledged errors in this data that are likely to have exaggerated the raw numbers of students receiving such arrangements, these figures still highlight the gap between the state and private sectors. It is highly unlikely that SEND needs in such schools are so significantly higher, but independent schools cater to parents who clearly possess the financial and social capital to effectively navigate the SEND system. In some cases, parents may feel that failing to seek SEND support which could unlock such favourable accommodations will see their child disadvantaged relative to their peers who are exploiting the system.

As previously noted, the current SEND system places parents in a powerful position to pursue SEND diagnoses and provision for their children. There is extensive freely available guidance online which advises families on how to navigate the system and the EHCP assessment process in particular, including paying for private assessments to support a child's claimed SEND needs.[238] Many teachers are sceptical about the role parents play in identifying SEND. In 2017, a poll found 57% felt some misdiagnosis

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[235] UK Government, 'SEND Review: right support, right place, right time', March 2022, link.

[236] Special Needs Jungle, '55% rise in 2024 SEND Tribunal appeals. LAs' 1.3% success rate cost £153m. The cost to families? Incalculable', 13 December 2024, link.

[237] Schools Week, 'The special educational needs crisis goes mainstream', 9 September 2024, link.

[238] IPSEA, 'EHC needs assessments', link; Special Needs Jungle, 'EHCP Assessment: SNJ's "Get started" Checklist', link; SOS!SEN, 'EHC Needs Assessment', link.

of SEND could be attributed to pressure from parents, and 38% felt some parents sought SEND diagnoses to secure extra time for exams.[239]

There is also some evidence to suggest that the increasing expenditure on SEND needs in England has begun to generate an industry with a financial stake in the continuation of an expensive and legalistic SEND system. Some organisations now offer paid services navigating the EHCP process for clients, sometimes costing hundreds of pounds per case.[240] Disputes over EHCPs has driven increased demand for private, independent educational psychologist assessments financed by parents or schools. This has correlated with growth in private educational psychologist practice, where previously almost all had been employed by local authorities. 24% of lead educational psychologists in local authorities said they outsourced work to private providers and 76% said some educational psychologists employed by local authorities also had private practices.[241] This is concerning. In the antagonistic EHCP system, with parents, schools and local authorities facing jarring financial incentives, it may be possible for educational psychologists to profit from increasing demand for private assessments and second opinions, in a manner which is financially costly and further obfuscates the SEND process. Additional pressure and need within the system has also created new demand for private SEND providers, with some for-profit firms making hundreds of millions of pounds providing support to children with SEND, with profit margins sometimes exceeding 20%.[242]

Consequences

The dysfunctional structure and incentives of England's SEND system has had far reaching consequences. The system does not appear to be working – for local authorities, schools, parents or, most importantly, children and young people with SEND needs.

The current SEND model is bankrupting local government

The costs of SEND provision, particularly meeting the obligation of EHCPs, have become a major burden on local authorities. By the end of the decade, home-to school transport for SEND children alone is anticipated to cost local authorities £1.125 billion annually.[243] Increasingly expenditure on SEND exceeds funding, resulting in local authorities establishing SEND funding deficit. These amounted to £4 billion in 2024.[244] Local authorities are not allowed to run deficits and are expected to declare bankruptcy if they cannot balance their books. The County Councils Network estimated that almost three quarters of England's councils may have to declare bankruptcy in 2027 as a result due to rising SEND costs.[245] This threat has been delayed by the Government's introduction of a statutory override in 2020, which effectively temporarily removed SEND deficits from local authority balance sheets. In June 2025 the Government announced a further two-year extension to the statutory override in light of this

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[239] The Guardian, 'Parents pushing for special needs diagnosis for children, survey says', 24 February 2017, link

[240] Sunshine Support, link; SEND Advocacy, 'SEND Advocacy Services', link.

[241] Department for Education, 'Educational psychology services: workforce insights and school perspectives on impact', June 2023, link.

[242] BBC News, 'Lib Dems call for cap on SEND school profits', 31 July 2025, link.

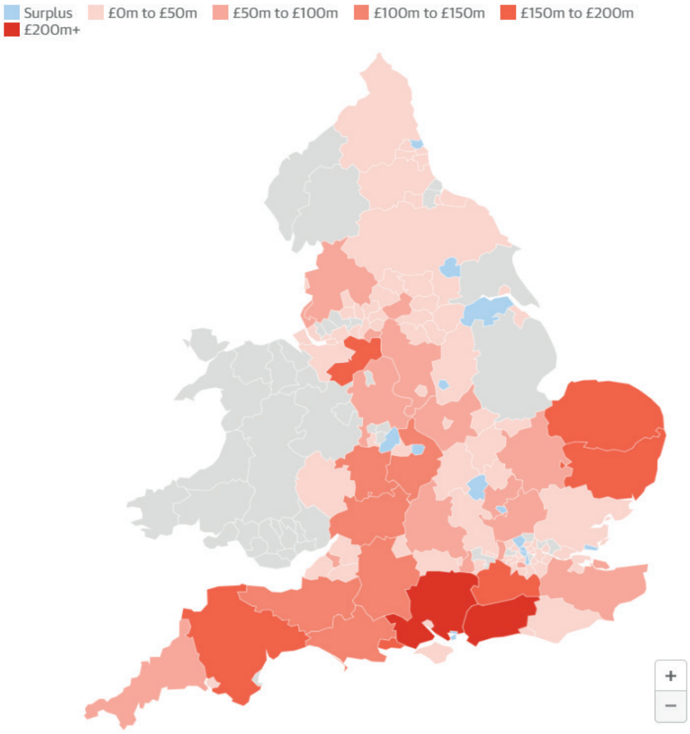
[243] County Councils Network, 'Spiralling SEND transport budgets threaten financial sustainability of England's largest councils, report reveals', 18 November 2023, link.

[244] County Council's Network, 'SEND deficits risk bankrupting almost three quarters of England's largest councils by 2027, with government urged to take action', 21 October 2024, link.

[245] Ibid.

challenge.[246]

Figure 25: SEND deficit or surplus by council in England in million, 2025-26[247]



Guardian graphic. Source: Guardian research, local authorities

Outcomes for children with SEN

In spite of increased awareness of SEND, more widespread diagnosis of SEND conditions and expanded, costly SEND provision, the evidence indicates that children with SEND continue to be comprehensively let down by the system. As a report by the County Councils Network concluded '*there is… little evidence to suggest that these trends have coincided with an improvement in outcomes for young people*'.[248] There is evidence to suggest that SEND outcomes have in fact declined in the last decade, in spite of increases in resources and attention. Young people with EHCPs who turned 19 in 2015/16 were 6 points more likely to have achieved Level 2 qualifications than those in the cohort that became 19 in 2022/23.[249]

Less than a quarter of children with SEND needs and less than one in ten with an EHCP meet the expected standard for reading, writing and mathematics at the end of KS2, compared to 70% of their peers.[250] Less than one in four children with SEND needs secure a Level 5 or better in English and Maths GCSE, compared with 46% of their counterparts without SEND needs.[251] Whilst the challenges faced by children with SEND, particularly those with the most severe needs, means that it would be unrealistic to expect parity in attainment, the scale of this achievement gap is unacceptably large.

[246] TES Magazine, 'SEND: Government extends councils' statutory override', 20 June 2025, link.

[247] The Guardian, 'Nearly 20 councils in England 'at risk of insolvency' due to Send costs', 30 March 2025, link.

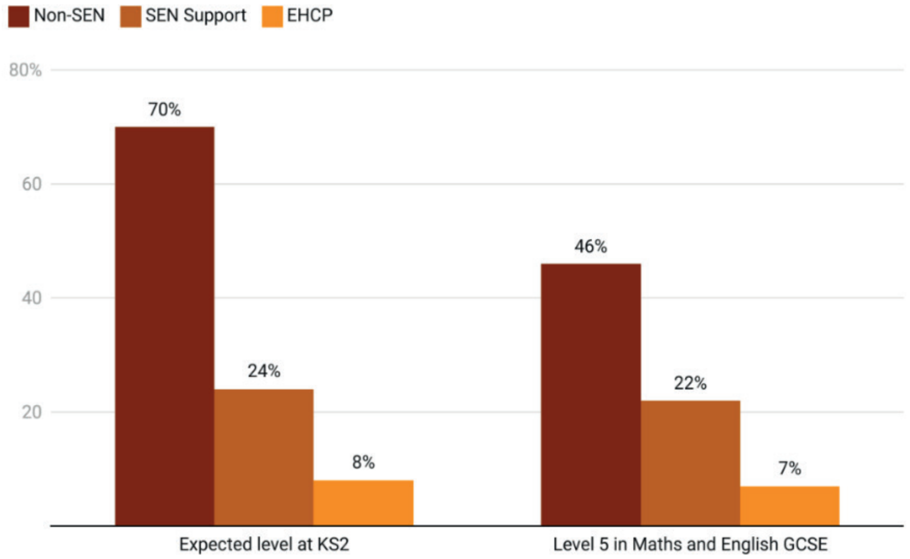
[248] Isos Partnership, 'Towards an effective and financially sustainable approach to SEND in England', July 2024, link.

[249] Ibid.

[250] Isos Partnership, 'Towards an effective and financially sustainable approach to SEND in England', July 2024, link.

[251] UK Government, 'Key stage 4 performance', 27 February 2025, link.

Figure 26: Percentage of students achieving expected level in reading, writing and mathematics at KS2 and Level 5 grades in English and Maths GCSE by SEND need[252]



Although many children and young people will always require SEND provision to overcome the barriers they face, for some effective SEND support at the right time should close the gap such that the child's needs can be met through Quality First Teaching alone. There is very limited data on how many children cease to need SEND provision. However, there is little evidence of this occurring. In 2023 the Department for Education began to collect data on the reasons for the cessation of EHCPs. Only 8% (395) EHCPs were terminated because the young person's needs were being met without a plan – lower than the number of EHCPs which cease because the child was deceased (440).[253]

The evidence also suggests that young people with SEND are struggling to adapt as they move beyond school. In recent years the number of young people with EHCPs in mainstream post-16 settings has fallen from 65.5% in 2016/17 to 61.7% 2021/22, whilst the proportion in special settings has risen.[254] SEND needs are also a key risk factor for young people Not in Employment, Education or Training (NEET). Research by the National Centre for Social Research found that 36% of young people with SEND had been NEET at some point between the ages of 18 and 25, compared with 20% of young people without SEND.[255] Young people with SEND are also disproportionately likely to have been cautioned or sentenced for an offence.[256]

Confidence in the SEND system is low

Evidence suggests that families and teachers have limited confidence in the SEND system. The Department for Education's 2023 SEND Review identified a '*vicious cycle*' of '*low confidence*' as one of the key challenges facing the system.[257] Just 56% of parents with children with SEND needs felt their child got the support they needed in mainstream secondary

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[252] Ibid.

[253] UK Government, 'Education, health and care plans', 13 June 2024, link.

[254] Isos Partnership, 'Towards an effective and financially sustainable approach to SEND in England', July 2024, link.

[255] National Centre for Social Research, 'Risk factors for being NEET among young people', December 2023, link.

[256] UK Government, 'SEND Review: right support, right place, right time', March 2022, link.

[257] UK Government, 'Special Educational Needs and Disabilities (SEND) and Alternative Provision (AP) Improvement Plan', March 2023, link.

schools, although this was higher for mainstream primary schools (71%) and special schools (86%).[258] A 2025 report by the House of Commons Public Accounts Committee concluded that '*families lack confidence in a system where it does not meet expectations*', citing increasing delays for EHCP plans and acrimonious tribunal disputes with local authorities over support needs.[259]

Teachers also have limited confidence in their abilities to support SEND students, with 88% of primary school teachers and 85% of secondary school teachers saying they need more help to do. Teachers surveyed cited the need for more Teaching Assistant support, more time to plan and better advice on how to meet the needs of students with SEND as crucial to improving the support they provide.[260]

Recommendations

The current SEND system and the policies that underpin it should be scrapped. The Children and Families Act 2014 and 2015 SEND Code of Practice should be repealed and replaced with a new statutory regime.

a. As part of this process EHCPs should be reformed to become non-statutory documents, and the obligation for local authorities to meet the costs associated with EHCPs should be removed.
b. No new EHCPs should be issued for mainstream settings from 2026. EHCPs should be reformed to serve as a passporting assessment into specialist settings.

A new national model for SEND in mainstream settings.

a. Schools should receive expanded, ringfenced SEND budgets from national government through a new National SEND Funding Formula. Schools should retain discretion over how to spend this budget, including to support high quality teaching by teachers within mainstream classes.
b. Schools should be expected to commission specialist support for their routine SEND provision, such as Educational Psychologists and Speech and Language Therapists, as part of this expanded offer.
c. Schools should be encouraged to create and expand specialist unit hubs to support children with SEND needs alongside mainstream settings. These could be delivered across multiple schools, such as within a trust. Schools should fund these unit hubs from within their new SEND budgets.

A new passporting system for special schools.

a. Local authorities should hold responsibility for baseline funding for special schools and alternative provision from their Higher Needs Funding block. Where the block is not fully spent local authorities would be obligated to distribute outstanding funds to schools within the local authority.

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[258] National Audit Office, 'Support for children and young people with special educational needs', 24 October 2024, link.

[259] Public Accounts Committee, 'Support for children and young people with special educational needs', link.

[260] Public Accounts Committee, 'Support for children and young people with special educational needs', link.

  b. Local authorities should retain responsibility for conducting EHCP assessments for those deemed to require provision outside of mainstream settings. The assessment criteria should be revised to raise the standard for securing an EHCP, with the grounds for appeal tightened to streamline the system. Sections F, G and H should be removed from the EHCP, with specialist settings given flexibility to meet the needs established in the document.
  c. Local authorities would be authorised to manage passporting into specialist settings based on the resources and capacity available within budgets to support students.
  d. In cases where there are localised spikes in acute SEND need, local authorities may apply directly to a National Emergency Relief Fund for a temporary uplift in their Higher Needs Funding block.

A new National Institute for Special Educational Needs and Disabilities Support (NISENDS) should be created to formulate NICE-style guidance for schools on how to identify and support SEND needs effectively.

  a. NISENDS should establish guidance for defining and identifying SEND needs, including clear symptoms identified with specific conditions.
  b. NISENDS should evaluate the efficacy of different forms of SEND provision and establish tariff bands for what may be paid for specific kinds of provision. This should include assessing and recommending effective pedagogy and techniques to support SEND within mainstream lessons.
  c. All schools, regardless of status, should only be allowed to commission or utilise SEND provision and pedagogy approved by NISENDS. Local authorities may only include NISENDS-approved provision in their Local Offer.

Chapter 3 – Welfare

This chapter explores the function of the health and disability benefits system for claimants under 25 years of age. It focuses on the Disability Living Allowance (DLA) for children, a tax-free benefit for children under 16 with a disability or health condition, intended to meet additional care and mobility costs. It also considers the Personal Independence Payment (PIP), a benefit aimed at meeting the additional costs of a disability for those aged 16 and over.

Context

Disability Living Allowance (DLA)

The Disability Living Allowance (DLA)[261]

Overview

- Claimants must be under the age of 16.
- Benefit is not means-tested and their parent(s) can be either in or out of work.
- Must live in England or Wales when claim made (unless eligible to claim from abroad).

The child's disability or health condition must mean at least one of the following apply:

- They need much more looking after than a child of the same age who does not have a disability.
- They have difficulty getting about.

DLA can be claimed for a child from 3 months (for 'care component').

However, there are different age rules for the mobility component: the higher rate of the mobility component can be claimed from the age of 3 years old. The lower rate of the mobility component can be claimed from the age of 5 years old.

Assessment
Based upon two components:

- Care component, with the rate depending on the level of support required, for example:

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[261] UK Government, 'Disability Living Allowance (DLA) for children', link.

  - Lowest rate - help for some of the day- £29.20 a week.
  - Middle rate - frequent help or constant supervision during the day, supervision at night or someone to help while they're on dialysis - £73.90 a week.
  - Highest rate - help or supervision throughout both day and night, or a medical professional has said they might have 12 months or less to live - £110.40.
- Mobility component: The rate the child gets depends on the level of help they need getting about, for example:
  - Lowest rate - they can walk but need help and or supervision when outdoors -£29.20 a week.
  - Highest rate - they cannot walk, can only walk a short distance without severe discomfort, could become very ill if they try to walk or they're blind or severely sight impaired - £77.05.

Note: There are also age limits to receiving the mobility component: lowest rate - the child must be 5 years or over; highest rate - the child must be 3 years or over.

The Disability Living Allowance (DLA) is the is the main benefit paid to children up to the age of 16 where there are additional costs associated with a disability or their development.

First introduced in 1992, the DLA combined the previous Mobility Allowance and Attendance Allowance. It aimed to provide a non-means-tested, tax-free benefit to those with care and/or mobility needs arising from a disability. 'Care' and 'mobility' needs were a proxy for extra costs. Before changes were introduced in 2013, UK residents under the age of 65 were able to claim DLA. It consisted of two components: a **'Care Component'** which was paid at three rates (low, medium, high) based on the level of personal care needed and a '**Mobility Component'**, paid at two rates (low, high) based on the claimant's walking difficulties. The 'Care Component' was supposed to support 140,000 people and the 'Mobility Component' 150,000 people. [262]

Eligibility was based on the impact of the disability on an individual's ability to manage their individual care or their mobility, rather than the specific medical condition. There was a greater emphasis placed on self-assessment. The form, which was around 55 pages long[263], was reviewed alongside other evidence including reports from GP's or medical consultants and a determination was made as to the amount of DLA the claimant should receive. There were 11 different rates that a claimant could receive and if a claimant has a change of circumstance, there could be a review of their case, but this was not done systematically.

Some of same issues that beset PIP existed with DLA. The DLA Benefit Gateway was not robust, based largely on claimants self-reporting combined with a lack of regular review. Only 50% of awards were corroborated by medical evidence at all (6% face to face assessments) and 70% of recipients have been given a lifetime award, without any regular

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[262] Department for Work and Pensions, 'Public consultation: Disability Living Allowance reform', December 2010, link.

[263] BBC News, 'Disability Living Allowance replaced by PIP scheme', 8 April 2013, link.

review.[264] An ONS fraud and error review found that in 2004/2005 around £730m was overpaid on DLA (9.1% of expenditure).[265]

The introduction of Personal Independence Payment (PIP) sought to address these weaknesses. Unlike DLA, which primarily focused on physical disabilities, PIP was designed to provide a more balanced approach, reflecting a broader understanding of both physical and non-physical disabilities.

Post-2013 Changes

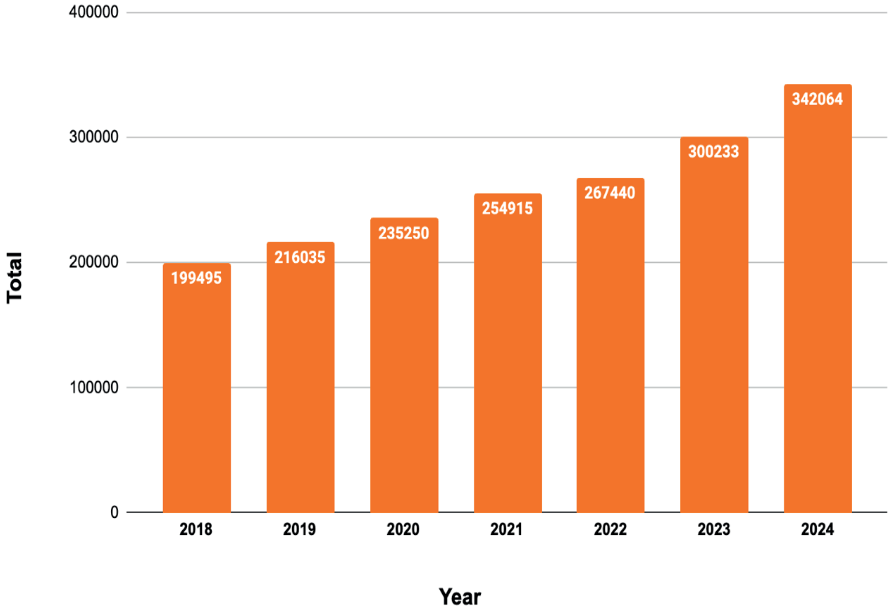
From April 2013, significant changes were implemented to DLA, with the Personal Independence Payment (PIP) beginning to replace DLA for individuals aged 16 to 64. As of 2013, new DLA claims were restricted to children under 16. Existing DLA claimants who were 65 as of April 2013 continue to receive it.

Four out of every five are successful in transferring from DLA to PIP.[266] There are also a sizeable number who are on DLA, but who never apply to transfer to PIP.

The number of children in receipt of DLA has grown sharply in recent years. Children who were awarded DLA in England and Wales grew from 333,000 to 682,000 between 2013 and 2023.[267]

There was a 71% increase in the total number of DLA cases awarded with entitlement between 2018 to 2024.[268] The total number of claimants was 258,000 in 2002/3, but is now over 700,000.[269] It has been forecast to grow to almost a million (948,000) by 2028/29. The Figure below sets out this growth amongst the 11–15-year-old cohort in recent years as an example. Forecasts suggest total expenditure on DLA will rise by over £2bn from 5.078bn in 2025/2026 to £7.041bn in 2029/2030.[270]

Figure 27: Disability Living Allowance, Cases with entitlement, 11- to 15-year-olds, 2018-2024 (figures given for the August of that year)[271]



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[264] Department for Work and Pensions, 'Public consultation: Disability Living Allowance reform', December 2010, link.

[265] L. Clark, 'Disability living allowance over-payment hits £730 million', *Community Care,* 14 July 2005, link

[266] Resolution Foundation, 'Growing Pressures', 17 August 2024, link.

[267] Resolution Foundation, '15-16-year olds are more likely to be receiving a disability benefit than adults under the age of 52 – but one-in-four suddenly stop claiming as they approach adulthood', 17 August 2024, link.

[268] Resolution Foundation, 'Growing Pressures', 17 August 2024, link.

[269] Neil O'Brien, 'Welfare spending and mental health', 9 May 2024, link.

[270] DWP Benefits Expenditure Tables, 23 July 2025, link

[271] Stat-Xplore, 'DWP', link.

This growth in claims has been predominantly driven by adolescents with ‘*learning difficulties*’ and/or ‘*behavioural disorder(s)*’. As of August 2024, the ‘main disabling condition’ which determined eligibility for the DLA for 11–15-year-olds was within one of those two categories in 68% of cases. (See Fig. 28.)

Figure 28: Disability Living Allowance, Cases with entitlement, ‘Main disabling condition’, August 2024[272]

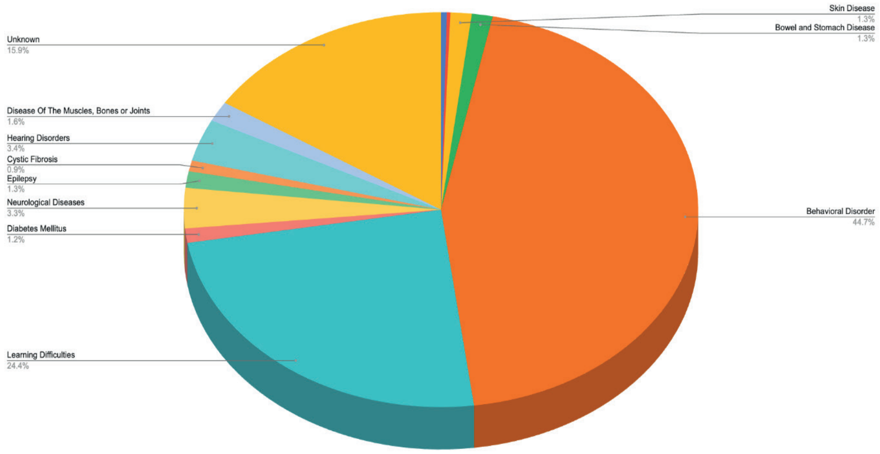
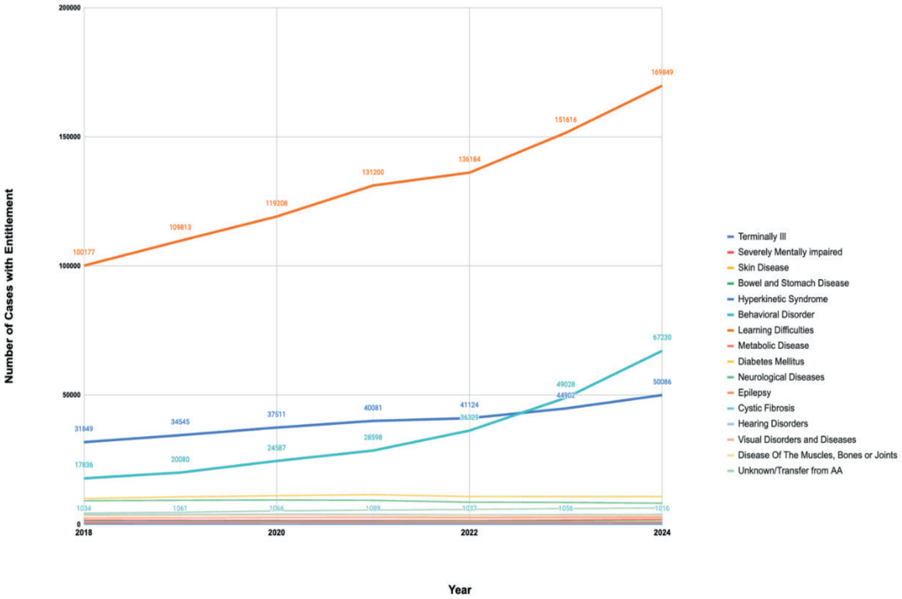


Figure 29: Disability Living Allowance, Cases with entitlement, ‘Main disabling condition, 11- to 15-year-olds, 2018-2024[273]



Note: Line in orange is for ‘Learning Difficulties’, in Turquoise are ‘Behavioural Disorders’, with Hyperkinetic Syndrome in blue. To compare, figures for ‘Cystic Fibrosis’ provided in Mint.

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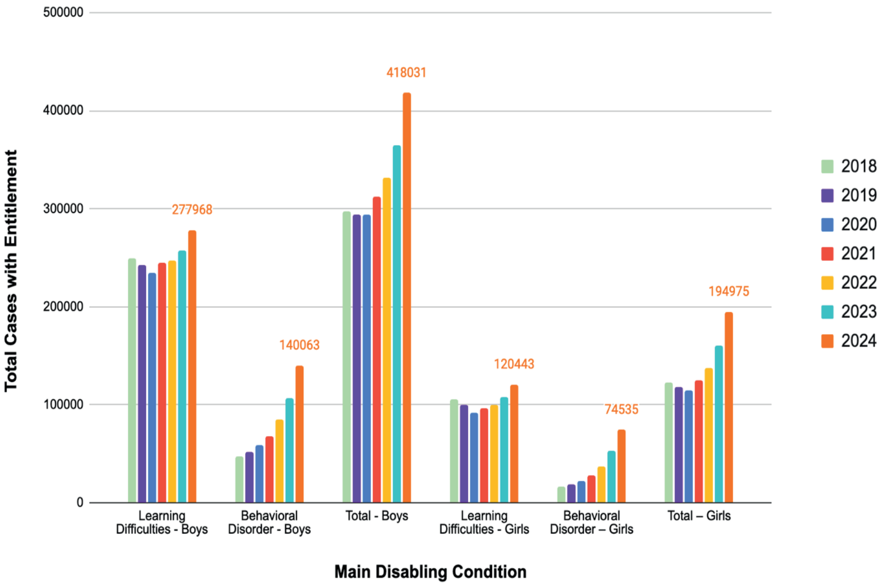
[272] Stat-Xplore, ‘DWP’, link.

[273] Stat-Xplore, ‘DWP’, link.

There is a notable divide by gender for the '*main disabling condition*' determining eligibility for the DLA. In August 2024, there were over 418,000 boys in receipt of DLA for '*learning difficulties*' or '*behavioural disorder(s)*' alone, compared to just under 195,000 girls for the same conditions. See Fig. 30, below.

Figure 30: Total Cases with Entitlement for DLA, all ages, for the two 'main disabling conditions' of the benefit, 2018-2024[274]



Personal Independence Payment (PIP)

Whilst the DLA caseload has risen significantly in recent years, the number of children who claim disability benefits falls significantly between the ages of 15 and 17, as young people transition (or are 'passported') from DLA to the Personal Independence Payment (PIP).

As Policy Exchange has explored in its recently-published report, *For Whose Benefit?* There has also been considerable growth in PIP claims amongst young people. Fig. 31 below shows PIP cases with entitlement for the month October 2024 (amongst the 16-19 and 20-24 age cohorts). From 2019, a 'psychiatric disorder' has been noted as the primary condition in more than 80% of cases of PIP with entitlement for those between the ages of 16 and 24. Fig. 32 shows the breakdown of some of the most recent figures (from January 2025).

This is being driven principally by claims for individuals with Autism and ADHD.

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[274] Stat-Xplore, 'DWP', link.

Figure 31: PIP Cases with Entitlement by Condition, October 2024[275]

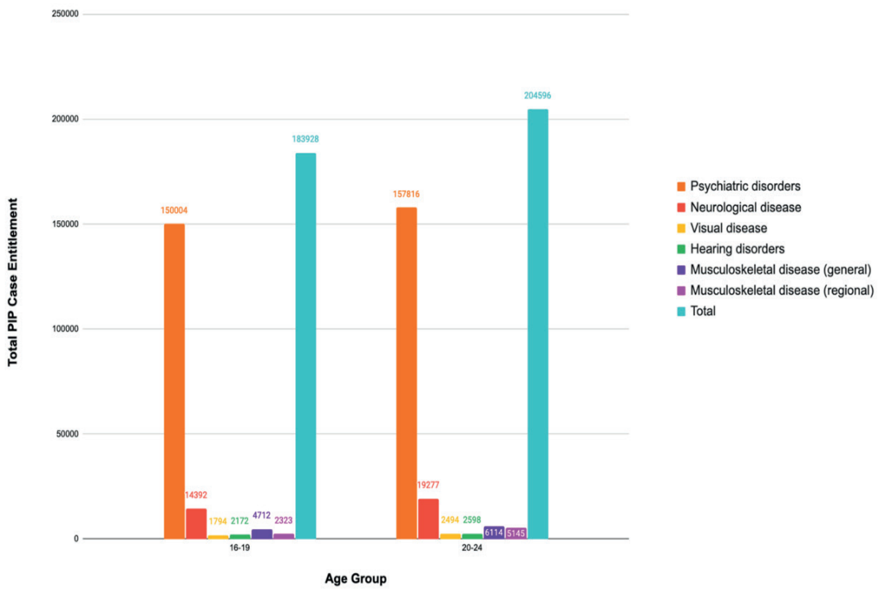

Figure 32: PIP Cases with Entitlement, 16-24 years, January 2025[276]

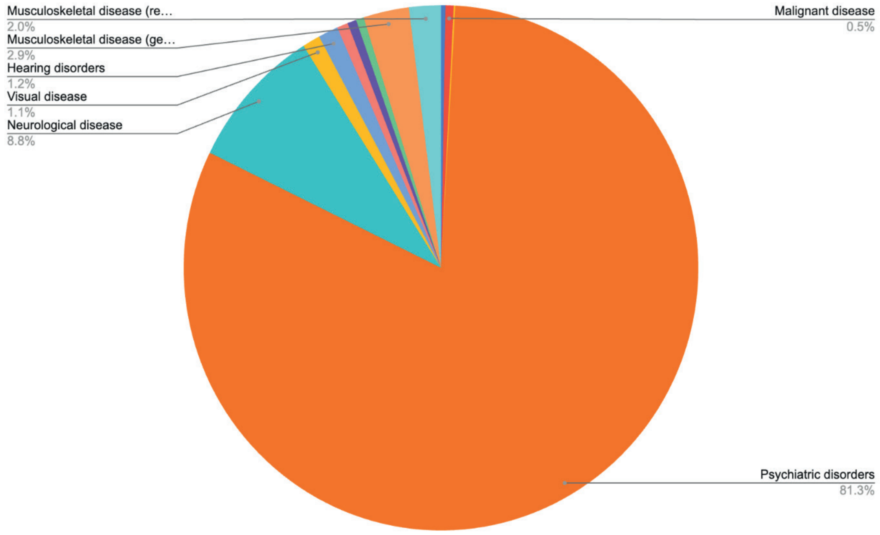

Fig. 33 below shows the growth in PIP cases where a ‘*psychiatric*’ condition was given as the ‘*main disabling condition*’, revealing a year-on-year increase across 17- to 24-year-olds, with 17-year-olds the largest age cohort of claimants (44,141 in total in January 2025).

[275] Stat-Xplore, ‘DWP’, link.

[276] Ibid.

Figure 33: PIP Cases with Entitlement, Psychiatric Conditions, 2019-2025 (Data taken from January release of each month)[277]

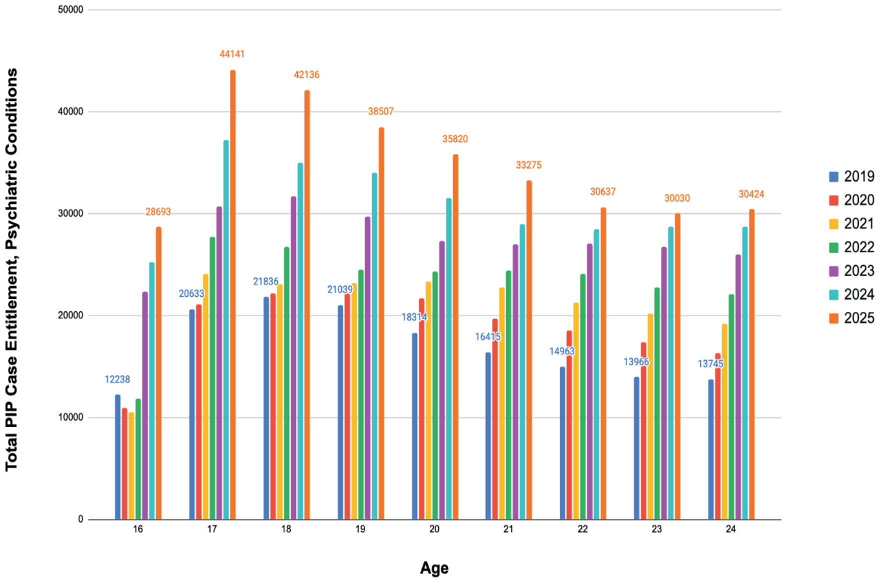

Fig. 34 reveals that the total caseload for 20–24-year-olds where a psychiatric condition was the main disabling condition grew from 89,831 in January 2019 to 157,816 in January 2025. Growth of more than 75%.

Figure 34: PIP Cases with Entitlement, Psychiatric Condition(s), Ages 16-24, 2019-2024[278]

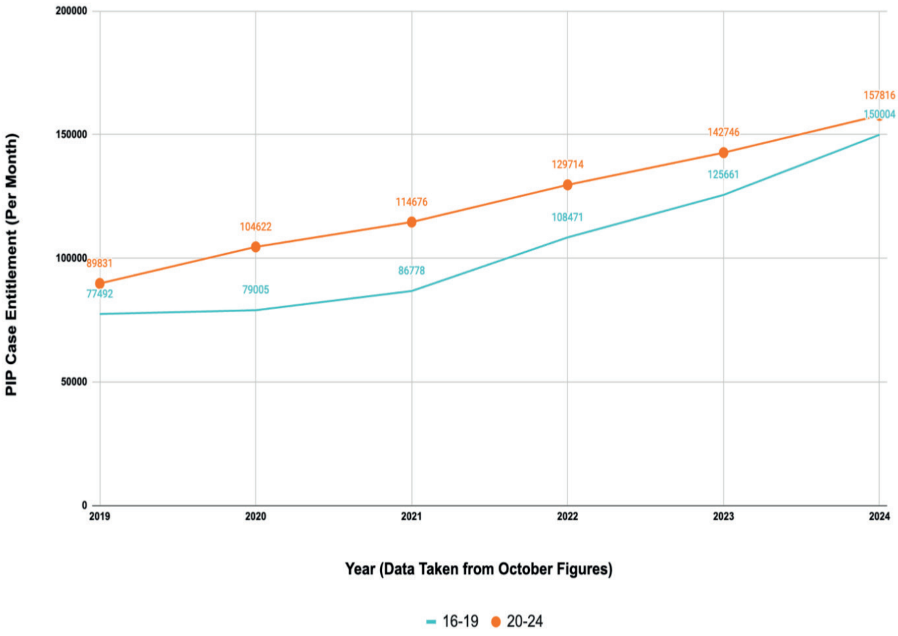

Fig. 35 below reveals that whilst the overall caseload has grown, this has been driven by psychiatric conditions, with other conditions, such as neurological diseases, visual impairment or musculoskeletal conditions, demonstrating flat growth over this six-year period.

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[277] Stat-Xplore, 'DWP', link.

[278] Stat-Xplore, 'DWP', link.

Figure 35 – PIP Entitlement for 20–24-year-olds cohort by primary disability (data taken from October figures in given year)[279]

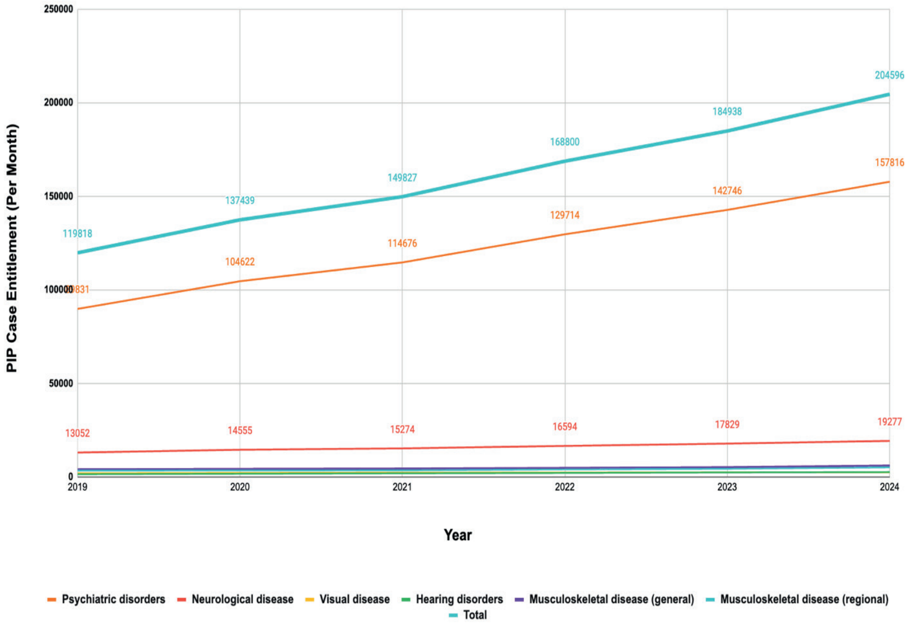
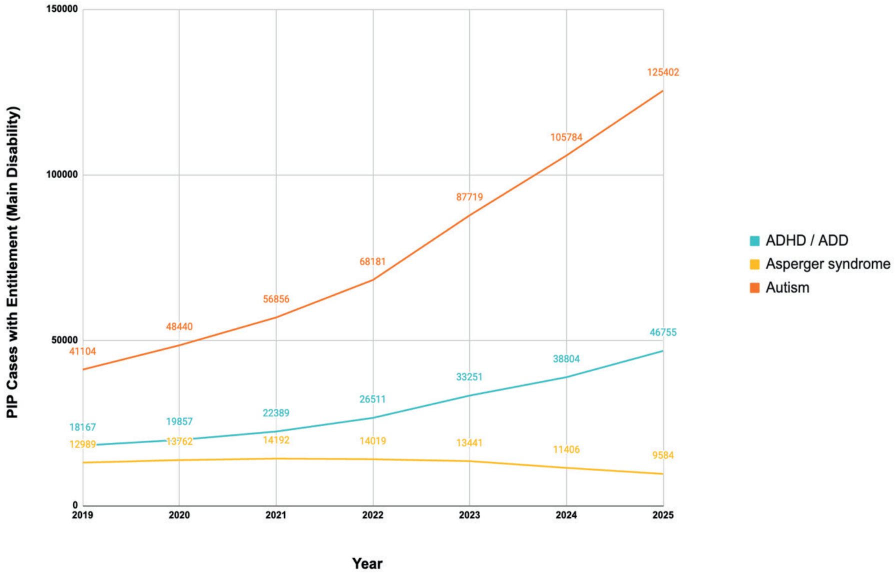


Fig. 36 presents the caseload of the 'top three' psychiatric conditions which result in award with entitlement. This demonstrates a significant growth in claimants with Autism and ADHD, whilst claimants for Asperger's syndrome have in fact decreased over the period January 2019 to January 2025. Growth in Autism claims grew from 41,104 to 125,402 – growth of more than 200%.

Figure 36: PIP Cases with Entitlement from 2019, top three psychiatric disorders, 16-24 years, figures taken from January release[280]



279.Stat-Xplore, 'DWP', link.

280.Stat-Xplore, 'DWP', link.

Figs. 37 & 38 present a breakdown of the growth in claims where Autism was the main disabling condition.

Figure 37: PIP Cases with Entitlement January 2019- January 2025, Autism, 16–24-year-olds[281]

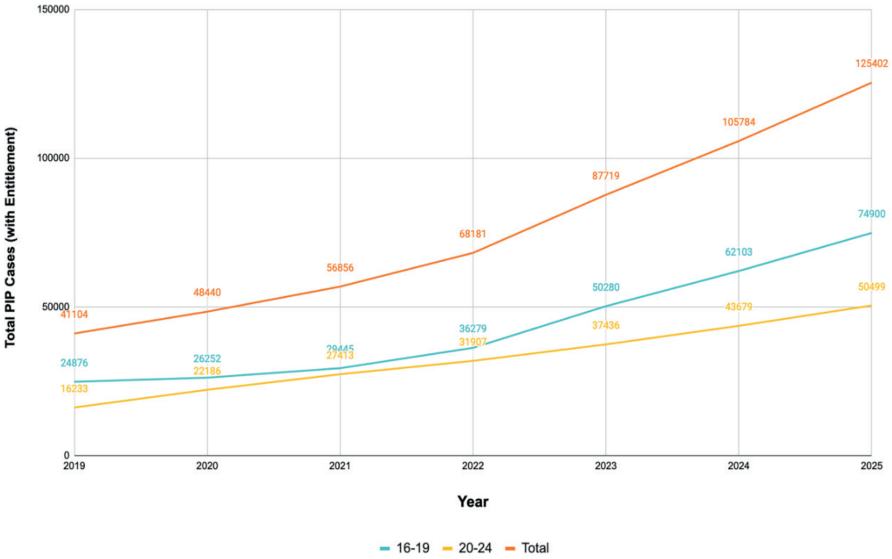
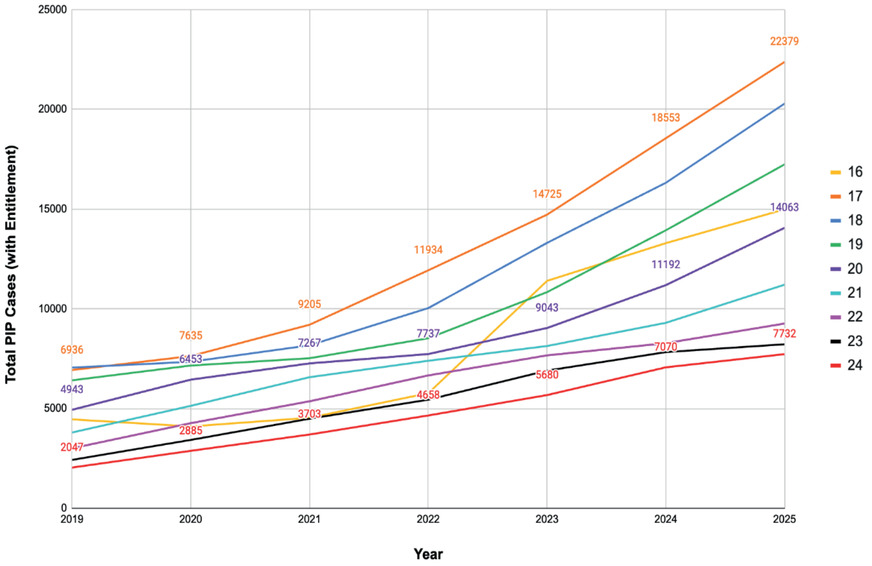


Figure 38: PIP Cases with Entitlement January 2019- January 2025, Autism, 16–24-year-olds (17-, 20- and 24-year-old cohorts numbered)[282]



Figs. 39 & 40 present a breakdown of the growth in claims where ADHD/ADD was the main disabling condition.

281.Stat-Xplore, 'DWP', link.

282.Stat-Xplore, 'DWP', link.

Figure 39: PIP Cases with Entitlement January 2019- January 2025, ADHD/ADD, 16–24-year-olds[283]

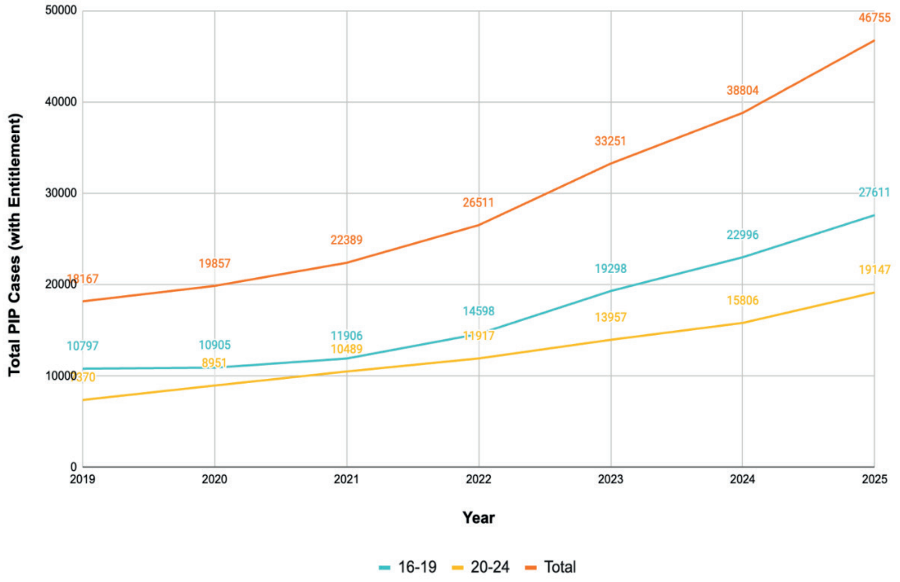
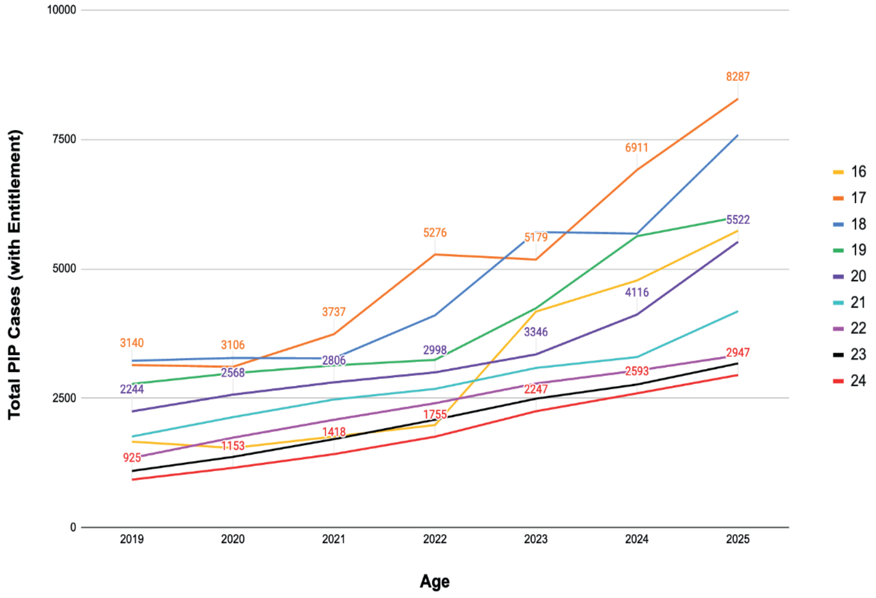


Figure 40: PIP Cases with Entitlement January 2019- January 2025, ADHD/ADD, 16–24-year-olds (17-, 20- and 24-year-old cohorts numbered)[284]

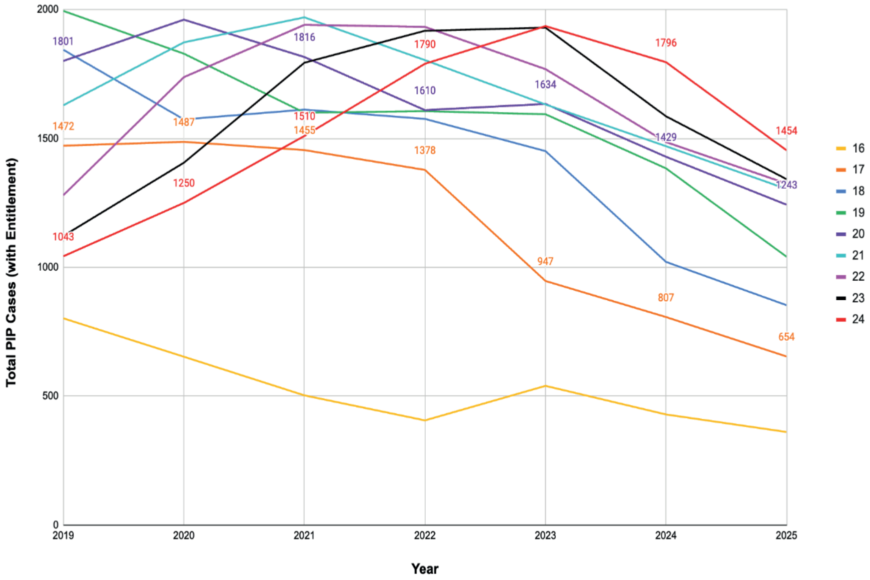


Figs. 41 & 42 present a breakdown of the claims where Asperger's syndrome was the main disabling condition, representing a decline (which is in line with wider cultural change as a result of recent reinterpretation of the legacy of Asperger's work.)

[283] Stat-Xplore, 'DWP', link.

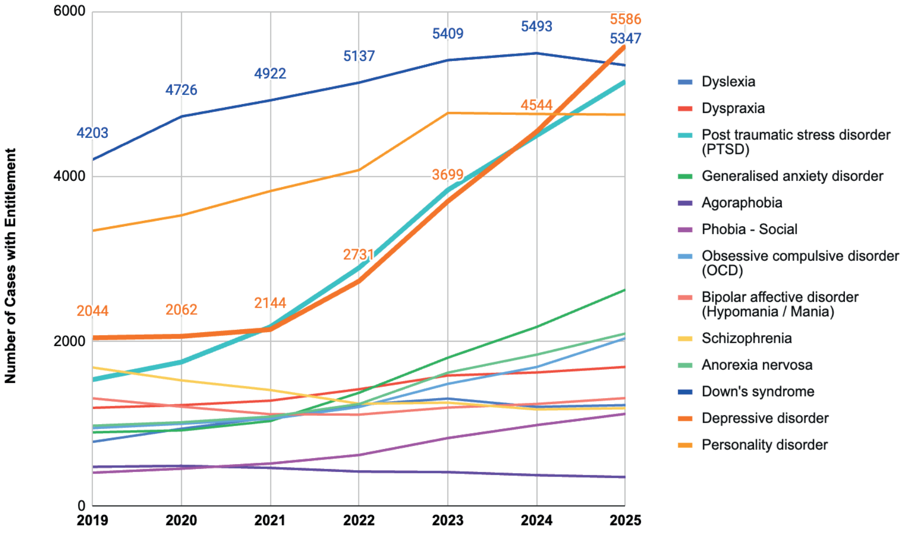
[284] Stat-Xplore, 'DWP', link.

Figure 41: PIP Cases with Entitlement January 2019- January 2025, Asperger's syndrome, 16–24-year-olds (17-, 20- and 24-year-old cohorts numbered)[285]



Drilling down further into the data on the range of psychiatric conditions for which young people have been awarded PIP, we see that for the first time, more individuals are now in receipt of the benefit for depressive disorders than for Down's syndrome. See Fig 42, below.

Figure 42: PIP Cases with Entitlement from 2019-2025, psychiatric disorders (omitting ADHD, Autism and Asperger syndrome), figures taken from January release[286]



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285. Stat-Xplore, 'DWP', link.
286. Stat-Xplore, 'DWP', link.

Figure 43: PIP Cases with Entitlement January 2019- January 2025, Depressive disorders, 16–24-year-olds[287]

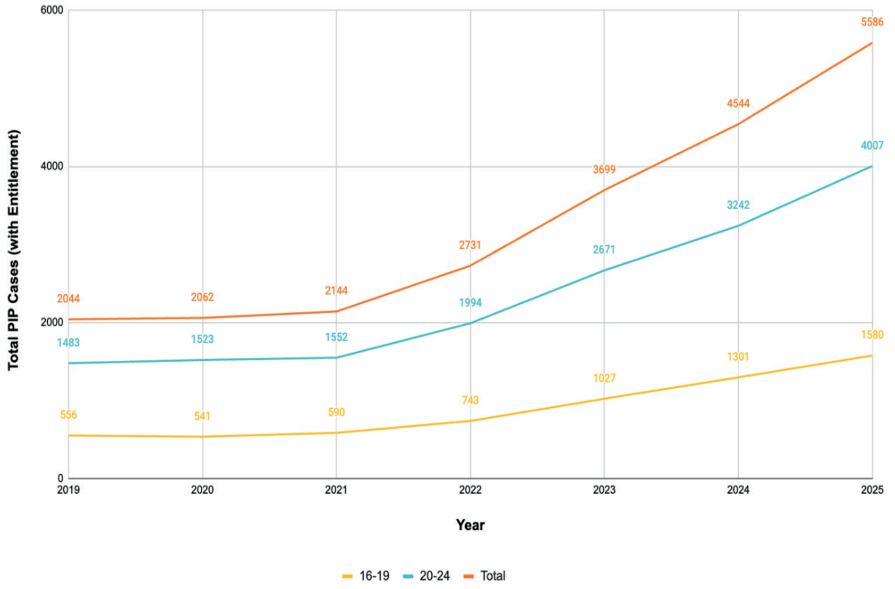
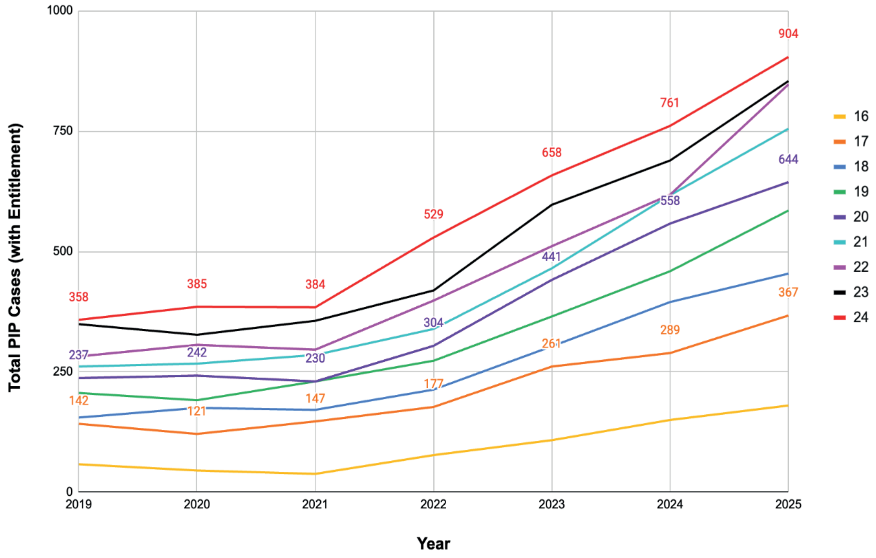


Figure 44: PIP Cases with Entitlement January 2019- January 2025, Depressive disorders, 16–24-year-olds[288]



Eligibility

DLA

To quality for DLA, a child must have been disabled or had a condition '*for at least 3 months*', and should expect for this '*to last for 6 more*'.[289] A formal diagnosis of any condition from a doctor (or other healthcare professional) is not required.[290]

Assessment for the DLA is based upon an assessment of 'development'.

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287. Stat-Xplore, 'DWP', link.

288. Stat-Xplore, 'DWP', link.

289. UK Government, 'Disability Living Allowance (DLA) for children', link.

290. Scope, 'Disability Living Allowance (DLA)', link.

In this sense it differs from other assessments for health and disability benefits which are based upon 'function'. As Citizens Advice state, '*DLA isn't just for children who are physically disabled. It can be given for a wide range of medical conditions including behavioural and mental health conditions as well as learning disabilities and developmental delay. You might be able to claim even if you wouldn't describe your child as 'disabled'.*'[291]

Child development is a subjective topic matter. The DLA form is a self-assessment – regarded by many claimants and professionals as being lengthy to complete. It was suggested to us that modernising this process would be beneficial, i.e. enabling parents to upload images or video footage to support a claim. It also remains the case that the assessment form is geared toward physical disabilities.

Determining the base line for eligibility in a consistent manner is challenging for the state. As we heard during interviews conducted for this report, some genetic conditions which can cause delay to speech, feeding etc. may not be formally diagnosed because of the volume of tests needed, meaning that support is harder to come by, even though there is evidence of developmental delay.

In rare cases the DWP might require an in-person assessment but in the vast majority of cases it will be paper-based. This is carried out by a healthcare professional, employed by an assessment provider on behalf of the Department for Work and Pensions. As one of the providers states, '*the healthcare professional is not there to diagnose or treat a medical condition but to assess how a condition affects the child*'. [292] The assessment may encompass a discussion of the child's medical history, medication and activities undertaken in a typical day. Claimants are recommended to bring extra information or medical evidence to the assessment.[293]

There is evidence to suggest – which was reinforced anecdotally during interviews - that DLA claims are reviewed every five years on average (and indeed there are many claims that are given an indefinite award). Greater flexibility in this approach could be an advantage, given the changing nature of child development and the fact that conditions are unlikely to be 'settled' in childhood.

How long a child must have lived in England, Scotland or Wales before a claim can be made for the DLA, depends on how old they are, as follows:[294]

Child's age	Minimum time spent living in England, Scotland or Wales
Under 6 months old	at least 13 weeks
Between 6 months and 3 years old	at least 26 of the last 156 weeks
Over 3 years old	at least 6 of the last 12 months

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291. Citizens Advice, 'Check if you can get DLA for your child', link.

292. Capita, 'Disability Living Allowance (DLA) for children', link.

293. Ibid.

294. UK Government, 'Disability Living Allowance (DLA) for children', link.

The Personal Independence Payment (PIP)

Overview

- PIP is intended to help with the additional costs caused by a long-term health condition or disability.
- It was introduced by the Coalition Government in 2013 to replace Disability Living Allowance (DLA).
- It is tax-free, not impacted by household income and is paid whether the claimants are in work or not.
- As of 31 October 2024, there were 3.6 million claimants entitled to PIP (caseload) in England and Wales.[295]
- PIP replaced Disabled Living Allowance and there are still people migrating to the new benefit.
- Of the individuals who currently apply for PIP, 37% are in employment in the month their PIP case is cleared. Of those awarded PIP, 23% are still in employment after 12 months.[296] Even though PIP is an extra cost benefit, there is clearly a reduction in employment figures after award of the benefit (of roughly a third).
  - When people are on PIP, they largely stay on it. About two-thirds of people who start a claim are still on five years later.[297]

Eligibility

- To be eligible to apply for the first time for PIP the individual must be aged between 16 and 64, have a long-term health condition or disability and difficulties with '*daily living*' or '*mobility*'. There are special rules to expedite claims for people with a terminal illness.
- In order to be entitled to PIP, claimants have to satisfy a qualifying period of 3 months and a prospective test of 9 months. These 2 conditions are referred to as the '*required period condition*' and help establish that the health condition or disability is likely to be long term.[298]
- A disability under the Equality Act 2010 if defined by whether you have a physical or mental impairment that has a '*substantial*' and '*long-term*' negative effect on your ability to do normal daily activities. '*Substantial*' is more than minor or trivial, for example it takes much longer than it usually would to complete a daily task like getting dressed. '*Long-term*' means 12 months or more, for example a breathing condition that develops as a result of a lung infection.[299]

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[295] Department for Work and Pensions, 'Personal Independence Payment statistics to October 2024', 17 December 2024, link.

[296] UK Parliament, 'Personal Independence Payment: Employment', 7 January 2025, link.

[297] House of Lords Economic Affairs Committee, 'Corrected oral evidence: Economic inactivity: welfare and long-term sickness', 29 October 2024, link.

[298] Department for Work and Pensions, 'Guidance: PIP handbook', 25 November 2024, link.

[299] Department for Work and Pensions, 'Guidance: PIP handbook', 25 November 2024, link.

Payment Rates

- The payment rates are between £29.20 and £187.45 per week. Claimants can be entitled to one or both components. The assessment focuses on how an individual is impacted by their condition, not their disability or health condition itself - it is a functional, not a medical assessment. The rates are:

Daily Living Component		Mobility Component	
Standard	£73.90	Standard	£29.20
Enhanced	£110.40	Enhanced	£77.05

The assessment for PIP is also carried out by a healthcare professional, employed by an assessment provider on behalf of the Department for Work and Pensions.

Claimants need is based upon their ability to perform Daily Living Activities to determine eligibility for the Daily Living Component. These include: preparing food, eating and drinking, managing your treatments, washing and bathing, using the toilet and managing incontinence, dressing and undressing, talking, listening and understanding, reading, mixing with other People, and managing money.

There are also two Mobility Activities to determine whether a claimant should receive the Mobility Component: Planning and following a journey and moving around.

Levels of need are determined through descriptors against each activity, which attracts a point score - the greater the help, the higher the score will be. If an individual receives between 8 and 11 points in total, they will receive the daily living component of PIP at the standard rate. If they receive at least 12 points in total, they will get the daily living component at the enhanced rate. If they score between 8 and 11 points for their mobility needs, they receive the standard rate of the mobility component. If they score 12 points or more they get the enhanced rate of mobility component.

Figure 45: Example of a Daily Living Activity - Washing and Bathing[300]

Descriptor	Points
Can wash and bathe unaided	0
Needs to use an aid or appliance to be able to wash or bathe	2
Needs supervision or prompting to be able to wash or bathe	2
Needs assistance to be able to wash either their hair or body below the waist.	2

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[300] PIPInfo, 'Daily living - Activity 4: Washing and bathing', link.

Needs assistance to be able to get in or out of a bath or shower.	3
Needs assistance to be able to wash their body between the shoulders and waist.	4
Cannot wash and bathe at all and needs another person to wash their entire body.	8

Figure 46: Example of a Mobility Activity - Moving Around[301]

Descriptor	Points
Can stand and then move more than 200 metres, either aided or unaided	0
Can stand and then move more than 50 metres but no more than 200 metres, either aided or unaided.	4
Can stand and then move unaided more than 20 metres but no more than 50 metres	8
Can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres	10
Can stand and then move more than 1 metre but no more than 20 metres, either aided or unaided.	12
cannot, either aided or unaided – (i) stand; or (ii) move more than 1 metre. 12 points	12

Observations

So what has driven these developments? We posit the following reasons for the growth we see in the overall caseload for health and disability benefits amongst CYP:

1. **Growing awareness (and diagnosis) of conditions.** Similarly to comments made across previous chapters, greater awareness, recognition and increased contact with mental health services has played a role.
2. **The changing nature and definition of disability:** There has been a shift in our understanding of – and in societal acceptance of what constitutes disability. For instance, severe mental impairment and behavioural problems can qualify a child for the higher rate of the mobility component of DLA, even if they do not have physical walking difficulties
3. **Interaction with the wider welfare system:** A factor which has been under-weighted in the debate is the compound effect. Receipt of DLA can act as a "gateway" to other benefits and can increase the amount received from other benefits such as Universal Credit, Housing Benefit, and Carer's Allowance.

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[301] PIPInfo, 'Mobility - Activity 2: Moving around', link.

Successful DLA claimants are eligible for an extra £1,873-a-year top-up in Universal Credit, rising to £5,851 for children with the most severe disabilities. They may also be eligible for an increase in Housing Benefit. Parents claiming disability benefits for their children meanwhile are not subject to the benefit cap of up to £25,320 a year in London and just over £22,000 outside the capital.[302] For children in receipt of the higher rate mobility component of the DLA, parents may also be eligible for an exemption from vehicle tax (payment not required); a blue badge and a Motability vehicle (e.g. a car or powered wheelchair).[303] We do not know how many individuals in receipt of Universal Credit were exempt from the benefit cap (because a member of their household was in receipt of Disability Living Allowance), because this information '*is not readily available*'.[304]

Recommendations

1. **The Department for Work and Pensions (DWP) should review the role of the child DLA over the next twelve months, to dovetail with their planned review of the Personal Independence Payment (PIP) (Timms Review).**

The review into Child DLA should closely replicate the Timms Review. It should examine the full assessment process, including the assessment criteria, eligibility criteria (specifically, the duration of time a child must have lived in England, Scotland, or Wales), and the interrelationship between DLA and other support for young disabled people, as well as the transition from DLA to PIP**.**

The DWP should move to reviewing DLA awards every three years to provide more effective ongoing monitoring and assessment of development.
The latest data suggests that almost 60% of current awards are for more than 5 years.

Medical evidence should be provided to support every claim for the DLA, with each claimant offered the opportunity to attend an in-person assessment.
To modernise the provision of evidence, parents (or carers) should be able to upload photo or video evidence to support their claim through an updated portal.

The Prospective Test for PIP is currently nine months in duration. PIP is supposed to be in place for long-term health conditions or disabilities. While we recognize that this aligns with the definition in the Equality Act and its guidance, we think there should be a re-evaluation as to whether nine months constitutes long-term. While recognising that this is arbitrary, we believe that a medical panel

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[302] The Telegraph, 'Thousands of preschoolers on benefits for behavioural disorders after lockdown', 14 August 2024, link.

[303] Citizens Advice, 'Extra benefits and help you can get while on DLA', link.

[304] UK Parliament, 'Universal Credit', 19 May 2025, link.

should undertake a review of whether the length of time for the Prospective Test is correct, and we would suggest that the Prospective Test should be set at 18 months.

For those aged 16 to 30, all health and disability benefits – including the Personal Independence Payment (PIP) as previously recommended by Policy Exchange – should become 'conditional'.

Chapter 4 – Comparative Analysis

This chapter provides a short commentary on the key themes we identify as part of our analysis:

- ***A mismatch between demand and supply across programmes;***
- ***A lack of alignment with regard to the definitions used to diagnose or determine eligibility for benefits;***
- ***A commentary on the incentives which have driven compound demand for services;***
- ***The inflexibility and incoherence of the current cross-Government approach.***

Supply and Demand

It is clear that our current systems of support designed to support CYP across education, healthcare and welfare are struggling to deliver current levels of demand and too infrequently deliver positive outcomes.

Although designed along very different lines (and in the case of DLA, not aimed at those with learning difficulties or behavioural disorders specifically) and with different statutory foundations, in each case, we see a common challenge: an over-expanded gateway which has resulted in escalatory approaches, leading to inflexibility and frequently maximalist conceptions of need, crowding out entirely or diluting support for those who need it most. All three systems are insufficiently preventative as a consequence also.

In all three areas demand for support has increased rapidly, outstripping the resources available.

Figure 47: Estimation of the percentage (%) growth in service demand over the last decade (from a 2014 baseline)

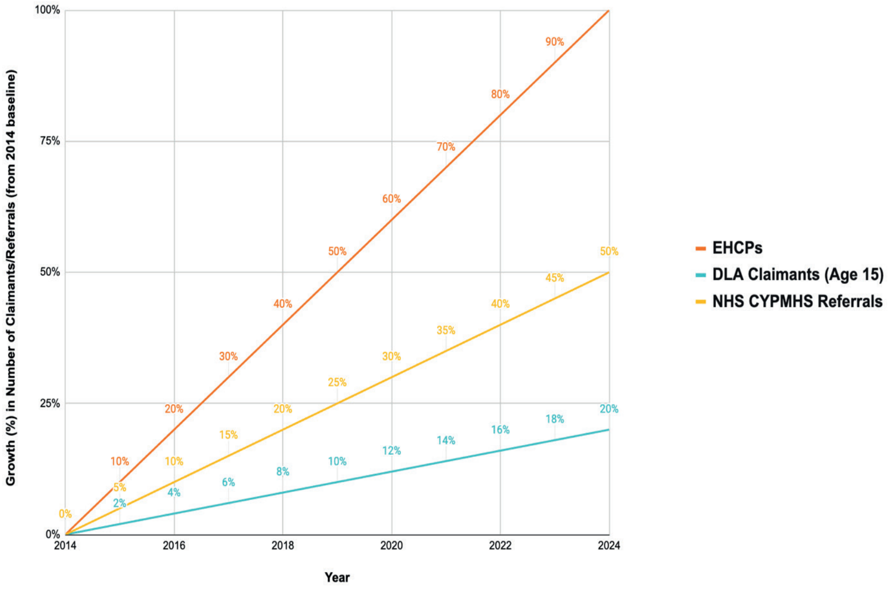
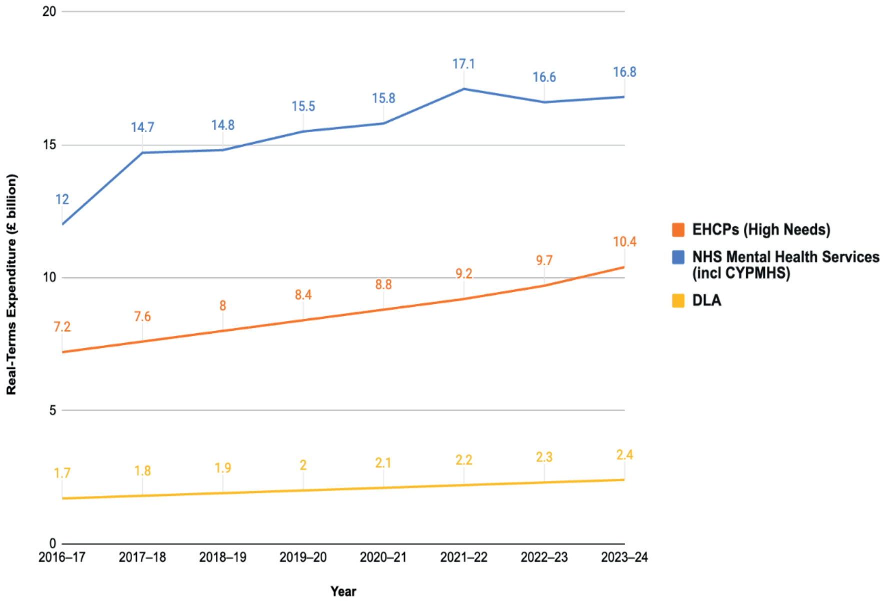


Figure 48 : Real terms expenditure (£ billions) across key comparator programmes, 2016/7 to 2023/4



Despite increases in overall expenditure across all areas (see Fig. 48 above), growing caseloads have meant that funding per head has fallen. For example, high needs funding per EHCP in 2024 prices has declined by almost a third since 2015/16.[305] This has meant that, despite considerable additional resource being devoted to mental ill-health and neurodivergence in recent years, too many people in the system feel that it is not working for them and delivering the kinds of support they require.

[305] Institute for Fiscal Studies, 'Spending on special educational needs in England: something has to change', December 2024, link.

Between 2013-2023, in DLA, the caseload for '*learning disabilities*' has risen by over 110%; for ADHD it has risen by over 70%; and for behavioural disorders it has risen by over 550%.

Supply outstripping demand has resulted in huge pressure on diagnostic gateways. In SEND, those in the system have respond to the lack of resources for early intervention with an escalation of need required to access support. As a result, demand for EHCPs has risen more than three times faster than overall SEND diagnoses. In the NHS context, we have seen significant capacity constraints and long waiting times for initial assessments and specialist intervention. The changing nature and expansion of demand has resulted in an ineffectively coordinated 'front door' to mental health services, inadequate 'intermediate' support and ill-defined model of prevention – particularly across services to be delivered by non-NHS providers.

Definitions and Evidence

All three systems have been dramatically impacted by the evolution of social definitions of mental ill-health and neurodivergence over the last 20 years. As more people have identified with diagnostic labels, and as 'concept creep' has expanded definitions to wider (and often, less acute) needs, a lack of clarity surrounding core definitions and diagnostic standards has resulted in a widening of the gateway for support.

Across these systems, there is far too much subjectivity in the targeting of support at present. This has resulted in inconsistency in how needs are defined, identified and met, creating further inequality and undermining public confidence in the systems to provide support. The DWP for instance, does not appear to use a consistent approach to diagnostic coding across each of its health and disability benefits (or programmes of support, such as Access to Work). The approach is broadly consistent across DLA, PIP, and UC in focusing on functional impact, but the specific assessment criteria, the activities considered, and the points systems (where applicable) differ between these benefits.

These issues have been perpetuated by the absence of an extensive and robust evidence base and comparison mechanisms. As a result, shared nationwide understandings about 'what works' have not emerged uniformly, forcing practitioners to use their best judgement with the means at their disposal.

For instance, while DLA eligibility criteria are set out by the DWP, the application relies heavily on the personal account of the claimant detailing the child's needs in comparison to a child of the same age without a disability. This inherently involves subjective interpretation of what constitutes '*substantially more care, attention or supervision*' or '*walking difficulties*'. Decision-makers review this information alongside any provided medical evidence. Similarly, whilst there are categories of need outlined in the SEND Code of Practice, determining whether a child's difficulties are '*significantly greater*' than their peers often require educators and specialists to make subjective assessments based on their observations and experience.

In too many cases this has resulted in unevidenced or outdated approaches being deployed which waste the scarce resources within the system.

Across the NHS, the greatest issue here lies in the inconsistency of service provision across geographies. Whilst some services have begun to adopt single point of access models and to provide greater coordination of activities across service provision which may have developed separately for historic reasons (e.g. an autism assessment service not part of formal CAHMS), this can limit the ability for clinicians to consider a case holistically, or to pool their resources, creating a 'diagnostic odyssey' meanwhile for CYP.

Inflexibility

All three systems reviewed in this report appear to have an outdated or ineffective approach at identifying and meeting the needs of CYP. Each was envisioned to manage relatively small caseloads, where those seeking support had quite intensive and acute need.

Despite growing pressure and an expanding gateway, none of the systems have been sufficiently reformed to deal with the 'new normal' and how the public's understanding of mental ill-health and neurodivergence has adapted over time. An outdated deficit approach focuses on what those in each system cannot do, rather than an optimistic approach focused on better outcomes with a mix of targeted and universal support.

Outdated system design channels those seeking to access support through a prescriptive pathway that often medicalises needs unnecessarily. The individualised model, based on personal entitlements has meant resources are not available early on for more holistic early intervention that could more effectively and efficiently meet needs. For example, the time and resource intensity of the EHCP process means that specialists such as Education Psychologists have not had the capacity to effectively support early intervention in schools, whilst local authorities have not had the resources to expand this capacity.

Incentives

The inadequate functioning of these systems and the 'backloading' of support and resources within them has created a set of perverse incentives which have in turn created compound demand. The lack of flexibility and resources for early intervention previously discussed have incentivised those in the system to escalate their needs to secure the support they feel they need.

Growing awareness of the statutory regime and design of systems for mental ill-health and neurodivergence has resulted in a population better equipped to navigate and manoeuvre through the system to achieve their individual desired goals for support, even when this results in the inefficient allocation of resources or the crowding out of others with needs. Those who are well placed to advocate for themselves possess an unreasonable advantage that has distorted the system. In the SEND system, families with who are able to afford independent assessments and even professional legal advice are better positioned to navigate an adversarial appeals process that nonetheless rewards persistence. This is the case in the healthcare system also, where you hear of instances where parents have both the resource and the willingness to 'shop around' across providers in order to seek to secure a diagnosis for their child entitling them to additional support.

Lack of Consistency

It is striking that across all three areas – SEND, NHS mental health services and welfare – there remains a real limit on the shared language, evidence base and institutional cooperation which underpin the state's approach to individuals that are being supported with very similar conditions. Best practice is not efficiently shared. In SEND, where responsibilities were designed to fall across education and health and social care, they have – in many instances – increasingly fallen exclusively on schools to the detriment of the most efficient and effective support. As a result, too many people navigating these systems face difficulties and frustrations navigating them where they seem to operate to different rules and standards. More effective interaction is needed to prevent this and ensure that ongoing assessments of need and provision are robust enough, and shared sufficiently widely, to prevent abuse.

Recommendations

The Government should ensure greater coherence across mental health and neurodevelopmental services by aligning the age-based eligibility for supportive services.

   a. This should proceed by using the legal point of adulthood 18.

   b. EHCP provision should finish at the end of the academic year at which a child turns 18.

   c. The age at which the Personal Independence Payment (PIP) can be claimed should be increased incrementally to 18.

Information/Data Sharing Protocols across services, spanning health, education and welfare must be enhanced.

   a. This will be essential to developing case management systems and to support service integration (where applicable).

   b. Clear protocols should be established for sharing relevant information between different agencies to avoid duplication.

An expansion of Family Hubs should be regarded as an opportunity for improved information sharing, early identification of issues and as an opportunity to boost the role of parents in driving improved outcomes across psychiatric and neurodevelopmental conditions.

a. The role of Family Hubs in meeting the needs of families with SEND should be reviewed, with particular attention to the Care Review recommendations for SEND at a locality level.[306]

A full, statutory ban on the possession and use of smartphones in all schools in England – as first proposed in Policy Exchange's report, *Disconnect* – should be announced.[307]

The Government should introduce a new scheme called 'Active Start' to expand the range of premises for physical activity for CYP in areas of current areas of under-provision.

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[306] Department for Education, 'Family Hubs Innovation Fund Evaluation', November 2023, link.

[307] Policy Exchange, 'The Case for a Smartphone Ban in Schools', 30 April 2024, link.

Conclusions

The growing prevalence of mental ill-health and neurodevelopmental disorders amongst CYP represents one of the most significant challenges faced by policymakers. We see a higher recorded prevalence of emotional disorders, such as depression and anxiety, or of loneliness, but also a growth of serious mental illness and suicide.

We have approaches across education, health and welfare systems which all have the same bug: each were designed as specialist services, aimed at meeting the needs of a small number of cases, rather than sizeable proportions of the total CYP population overall. Each has, therefore, been unable to keep with demand due to the fact that services have not swiftly evolved in step with societal shifts in understanding and expectation around the type of support the state offers people with mental ill-health and neurodiversity.

A paradigm shift is therefore needed in the way the state approaches the provision of support for CYP with reported and diagnosed mental ill-health and neurodevelopmental disorders.

Ensuring capacity and support for those with the most severe disabilities, mental ill-health and developmental or behavioural conditions should be the target of resource. Equally, supportive services need to be far better at proactive, or early intervention, so that the system handles fewer acute cases.

Overall, we have under-weighted the significance of the 'wider determinants' of behaviour or poor mental health – both in terms of the nature of care provided and our overall public policy response: the vital role of a supportive family life and of the role of parenting; of the importance of sleep; of regular physical exercise; of securing good employment or undertaking further education or training and of minimising excessive screen time.

It is crucial that the Government – and key professional groups responsible for our systems of support, including healthcare and teaching professionals – consider the risks of over-diagnosis and how current support may encourage an escalation of need, rather than effectively targeting support where it is needed most. This will be an essential consideration as the Government conducts a wider review into mental health services, as it sets out reforms to the SEND system and as it rolls out other supportive services, such as Family Hubs and as it finalises its National Youth Strategy.

For those requiring support from formalised healthcare services, **far more effective initial triage and coordination of resources (delivered**

by the NHS and Local Government) is required. So too will be more effective data collection and reporting of service performance and outcomes. Improvement in these areas should inform in turn improved coordination of professionals working across services. The latest evidence on the impact of 'excessive' screen time – as a risk factor for mental ill-health and upon neurodevelopmental disorders – should be updated in guidance and integrated into clinical practice. This information should also be imparted to parents from as early as their first engagement with neonatal and early years services.

The fundamental principles of England's SEND system must be re-evaluated – and reforms introduced. Current incentives that escalate need through the system need to repealed. Crucially, the potential for the system to deliver unlimited, personalised support must be ended to restore financial sustainability and empower professionals to make efficient and effective decisions on support. To that end, The Children and Families Act 2014 and 2015 SEND Code of Practice should be repealed and replaced with a new statutory regime. EHCPs should become non-statutory documents and a new national model for SEND in mainstream settings should be introduced, supported by a new National Institute for Special Educational Needs and Disabilities Support (NISENDS) to formulate NICE-style guidance for schools on how to identify and support SEND needs effectively.

Commensurate with reforms being undertaken for Universal Credit and the Personal Independence Payment: the application process and assessment for the Disability Living Allowance (DLA) should be reformed. Every case should be supported by medical evidence, with the opportunity for video and photo evidence to be supplied; the DWP should meanwhile introduce more frequent review of cases for younger claimants (every 3 years for DLA, rather than 5).

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