CHANGE THE PRESCRIPTION: UPDATE

Transforming support for children in the welfare and education system

June 2026

The Centre for
Social Justice

Contents

Foreword

Something has gone badly wrong with how we support children with additional needs in England, but almost no one in public life is willing to say so.

I have been worried about this since I was first elected to Parliament in 2017. As a constituency MP in Redditch I met family after family locked in exhausting, heartbreaking battles to secure support for their children. I visited special schools where dedicated staff were stretched beyond belief, budgets were in crisis, and waiting lists grew longer every year.

Since joining the House of Lords I have continued to probe these questions – and I am struck by the messages I receive from professionals who share my unease privately but cannot say so publicly without professional consequences.

The rising number of children with additional needs is staggering – and driven by a range of factors. The pandemic disrupted children's development at critical stages. Screen time and social media have damaged attention spans and mental health in ways we are only beginning to understand. Family breakdown has left more children without the stable foundations they need. These often overlooked drivers of vulnerability all deserve a serious policy response.

But something else is also happening. The scale of the expansion goes well beyond what these factors alone can explain. One in five schoolchildren are now identified as having special educational needs, up from one in seven just ten years ago. Twice as many households receive health-related benefits for children over the same period, fuelled in part by soaring autism and ADHD diagnoses.

The combined annual cost to the systems designed to support children with the most complex challenges has doubled in a decade to over £24 billion, roughly the same as the entire wage bill for every teacher in England.

More importantly, despite the increase in spending, outcomes have not improved. The attainment gap has not closed, employment outcomes are dire, and as the caseload has broadened it is becoming ever harder for ministers to finance the support for the children most reliant on state help – those with profound learning disabilities, serious physical impairments and life-limiting conditions.

The landmark poll of over one thousand GPs at the heart of this report tells us why. Three quarters of family doctors believe diagnostic boundaries for conditions like autism and ADHD have expanded to include behaviours previously considered within the normal range. Strikingly two thirds believe "most" of the children referred for these conditions are primarily presenting with behavioural or environmental difficulties, rather than a neurodevelopmental condition. Well over half believe the financial rewards of a diagnosis are the primary influence for parents to seek one. These are the frontline clinical judgments of the doctors who see these children every day.

I have written in detail about the lucrative industry that has grown up around this expansion: private diagnostic clinics charging up to £3,500 for assessments that feed directly into legal entitlements worth tens of thousands of pounds a year, independent special schools backed by private equity, specialist legal firms processing 25,000 tribunal appeals annually. The incentives point in one direction: more diagnoses, more plans, more placements. None of this, in my view, is in the best interests of children.

To make the system more effective, more targeted and more sustainable, I believe we must intervene earlier. Structured parent support programmes have been shown to produce lasting improvements in children's behavioural and emotional development. The CSJ is right to put reinvestment in these programmes at the heart of its recommendations, as well as increased financial support for children with the most complex needs, funded from the savings of a more targeted approach.

The Government's SEND White Paper took some welcome steps. But it did not ask why the broader system of support has expanded so unsustainably, nor did it consider the possibility (against a prolonged cost of living crisis) that financial incentives are part of what is driving – quite rationally – the rise in diagnostic escalation. It deferred the most difficult reforms until 2030. By contrast, this report provides the missing half of that argument with rigour, with compassion and with a clear-eyed determination that any reforms to these systems must protect those with the most severe needs.

I hope it triggers the honest debate this country urgently needs.

Baroness Maclean of Redditch

Endorsements

This report is a courageous step towards delivering the right solutions for young people with additional needs. Too many children are being medicalised rather than properly supported to thrive and meaningful reform is urgently needed to ensure children and young people receive the right response to the challenges they face. I wholeheartedly support the CSJ's analysis of the current situation and hope policymakers across the political spectrum will listen.

Dr Sanjiv Nichani OBE, Senior Consultant Paediatrician and Author

This welcome research from the CSJ shows something we have known for some time: that most of the medical profession agree that we are over-diagnosing children at the expense of providing better care and support. I am pleased to see some bold and thoughtful ideas presented for how to improve this system for children with additional needs across the country.

Dr Katherine Townsend, General Practitioner, specialising in Paediatrics

This brilliant report sensitively but robustly explores a highly challenging and often emotive issue for families and a dilemma for health professionals.

As a society we are in danger of becoming compassion fatigued. We need to urgently gather focus, be brave in calling out preventable factors like screen use in childhood, and give our most vulnerable families the best opportunities to come forward for help.

With the right information, guidance and investment, families and community-based services can help rescue children from the 'escalation treadmill,' and reduce the strain on GPs.

Dr Rebecca Foljambe, General Practitioner and Founding Director of Healthcare Professionals for Safer Screens

Executive summary

England's systems to support children with additional needs are out of control, while failing those they were designed to protect.

The number of pupils with Education, Health and Care Plans has more than doubled since 2015/16, rising from 240,000 to over 480,000 in 2024/25.[1] Across all children and young people, there were 640,000 EHCPs in January 2025, up 80 per cent since 2019.

This growth has been highly concentrated. Eighty-eight per cent of the rise in school-pupil EHCPs has come from three areas of need: Autistic Spectrum Disorder, Speech, Language and Communication Needs, and Social, Emotional and Mental Health. These now account for over 70 per cent of EHCPs.[2]

The child disability benefit system has expanded on a similar trajectory. Child Disability Living Allowance (CDLA) claims doubled from 420,000 children in 2016 to almost 900,000 by 2025,[3] driven largely by behavioural disorders and ADHD.[4] It is set to exceed one million in 2026.

The central problem identified in this report is that systems designed to provide specialist support for children with the most severe and enduring needs are increasingly being used to manage a much broader range of behavioural, developmental and educational difficulties.

Children facing all types of difficulties deserve care and support. But in the course of this research, we have heard resoundingly from medical professionals that far too many children are being escalated into improper medical pathways via expanded diagnostic criteria, as well as through irresistible incentives to statutory entitlements and benefits, when earlier practical interventions – including from parents – would be both more supportive for children and more sustainable for the taxpayer.

However, rising demand reflects both rising levels of childhood vulnerability and systemic dysfunction. More children are arriving at school with additional needs, but the system then intensifies demand by making diagnosis and legal entitlement the main routes to support. The result is a model that stretches budgets, increases waiting lists, fuels conflict between parents and councils, and weakens support for children with the most complex needs.

In this report we call for a new approach: one that intervenes earlier, defines need more clearly, reduces incentives to escalate, and restores sustainability so that children with the highest needs remain the priority within the system.

New drivers of demand on the education and welfare system

Childhood vulnerability is on the rise. All the indicators show that more children are arriving at school with weak speech and language, poor emotional regulation, impaired attention, and lower school readiness. Screen exposure, worsening attendance, behavioural pressures and family instability are contributing to higher levels of need.

But through a landmark poll of British GPs, and interviews and focus groups with school leaders, SENCOs, charities, and families, it becomes clearer that the system itself is also intensifying demand. Support, including significant levels of additional income, is too often accessed through diagnosis, statutory designation and legal escalation rather than early practical intervention.

This creates incentives for parents, schools, clinicians and local authorities to move children towards higher-cost parts of the system and the 'medicalising' of behaviours where other interventions would be both more effective and sustainable.

Savanta polling of 1,002 GPs for the CSJ found that:

- 94 per cent say they are seeing more referrals for suspected autism or ADHD than five years ago;
- 66 per cent agree that clinical diagnoses for autism or ADHD are given out to children and young people too easily where behavioural interventions would be more appropriate;
- 66 per cent agree that a majority of children referred for autism or ADHD primarily present with behavioural or environmental difficulties rather than a neurodevelopmental condition;
- 75 per cent agree that the clinical boundaries for autism or ADHD have expanded to include behaviours previously considered within the normal range;
- 57 per cent agree that financial entitlements linked to autism or ADHD diagnoses strongly influence parental requests for assessment.

The result is an escalation treadmill. Mainstream schools lack the capacity and incentives to address special needs early. Local authorities retain financial responsibility but lack the authority to manage costs. If they reject an assessment or claim and it goes to tribunal, they have a 99 per cent chance of losing – trapped by equality legislation. Once the conditions of EHCPs are set, they are statutorily obliged to meet the costs of providing it, irrespective of affordability. The result is billions on transport and independent special school places that average £61,500 a year.

Child Disability Living Allowance – the main benefit to support families with extra costs of health conditions and disabilities – can see each child diagnosed with, for example ADHD, and receiving the benefit's most common components, provided an additional £5,500 per year, increasing to £10,000 with its passport to the disabled child element and the carer's element of Universal Credit. With the removal of the two-child limit, this means a family on Universal Credit with three children could receive more than £35,000 in child-related benefits alone.

Our GP polling suggests that in the years of the cost of living crisis and stagnant real wage growth, many parents – and particularly struggling lone parents – are making rational decisions to pursue additional income through the welfare system by seeking diagnostic labels for behaviour previously considered within the normal range.

Spending has soared as a result of these dynamics. In 2026/27 prices, high needs SEND spending rose from £8.0 billion in 2015/16 to £13.4 billion in 2024/25 and is forecast to exceed £16 billion in 2026/27.[5] Child Disability Living Allowance cost £4.8 billion in 2024/25 and is forecast to reach £7.7 billion by 2030/31.[6]

Our analysis finds that the combined annual cost of high needs SEND spending, CDLA (and the means-tested benefits it passports) doubled from £12.4 billion in 2015/16 to £24.1 billion in 2025/26 – roughly the same as the entire wage bill for every teacher in England.[7]

A system failing the most vulnerable children

Outcomes have not improved with increased spending.

There remains a 50-percentage point attainment gap between pupils with no identified SEN and those with SEN support or an EHCP. [8] Children with SEN support are six times more likely to be permanently excluded and twice as likely to be persistently absent.[9] By age 22, children receiving both CDLA and an EHCP are three times more likely to be not in education, employment or training and four times more likely to be on out-of-work benefits.[10]

We found that while children in poorer communities are more likely to have additional needs, they are much less likely to secure the most protected forms of support. Families with greater resources are better able to navigate assessments, appeals and tribunals.

The Government's 2026 SEND reforms move in the right direction by seeking to strengthen mainstream provision, reduce reliance on diagnosis and introduce clearer tiers of support. But they do not sufficiently address the incentives linking diagnosis, EHCPs, wider welfare entitlement, specialist placement and escalating cost.

This report recommends a fundamental reset based on four principles:

1. **Intervene earlier** by radically expanding Family Hubs, improving school readiness, expanding speech and language support, restoring attendance and behaviour expectations, and increasing access to sport and enrichment.
2. **Define need more clearly** by reforming the SEND Code of Practice, narrowing statutory thresholds, and ensuring specialist support is reserved for children with severe, enduring and complex needs.
3. **Reduce escalation incentives** by strengthening targeted mainstream support, reforming tribunals, restoring local authority commissioning power, controlling independent special school costs, and decoupling diagnosis and educational designation from welfare entitlement.
4. **Reinvest in effective support** by tightening eligibility to Child Disability Living Allowance for milder behavioural and neurodevelopmental cases, while protecting children with substantial functional impairment, redirecting savings into a £0.5 billion investment in evidence-based parenting support programmes as well as an above-inflation increase to benefits for children with the most severe and complex support needs.

These systems are a lifeline for thousands of families. Yet their ability to support those with the most severe needs is being weakened by the expansion of statutory and financial entitlement into lower-level behavioural, developmental and educational difficulties that could be addressed earlier, more directly, and outside the highest-cost parts of the system.

The problems facing vulnerable children extend well beyond the two systems examined here (from housing to social care to the NHS) but it is in the SEND framework and Child Disability Living Allowance where demand has grown fastest and the need for urgent reform is most acute. Taken together, our recommendations provide a plan to restore fairness and sustainability to these systems: intervening earlier, defining need more clearly, reducing escalation incentives, and reserving the most intensive support for children with the most severe and enduring needs.

Ministers should not delay reform any longer. Without it, costs will continue to rise, outcomes will remain poor, and support for the most vulnerable children will be further diluted.

Chapter 1:

What is happening to childhood need and support

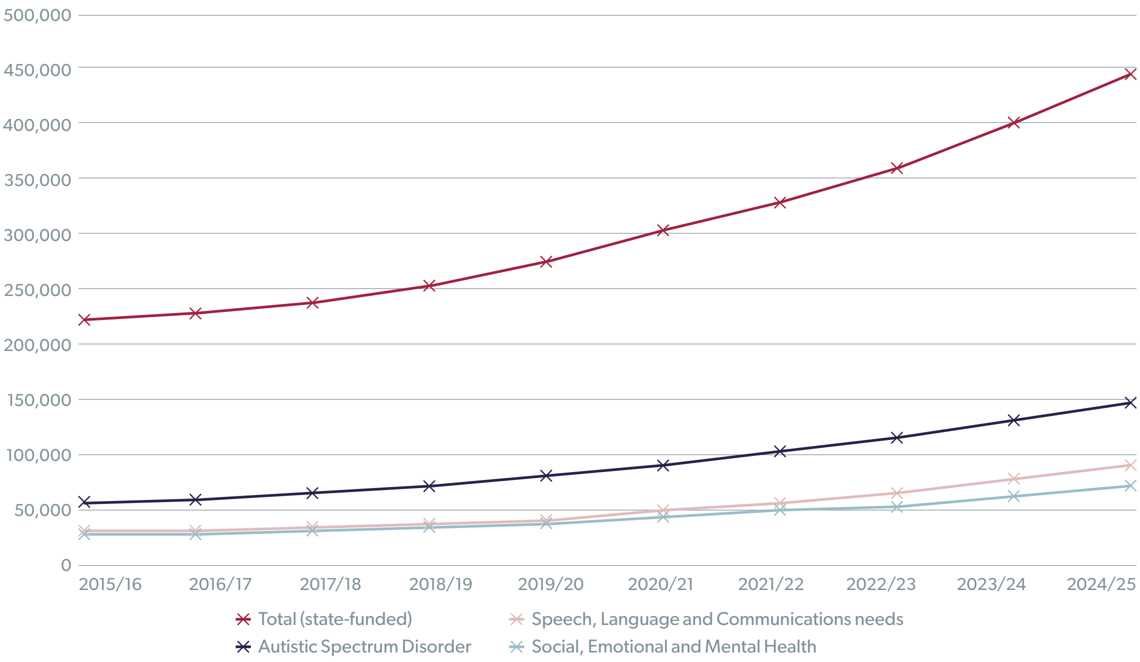
1.1. The rise in special educational needs and disabilities

Special Educational Needs and Disabilities (SEND) have increased dramatically in the last decade.

The number of pupils in all schools with Education, Health, and Care Plans (EHCPs) **has risen by 104 per cent since 2015/16** from 236,806 to 482,640 in 2024/25 – from 2.8 to 5.3 per cent of pupils.

Figure 1 shows the total number of EHCPs in state-funded schools by primary need. It shows that the rise has been uneven, with **88 per cent of the rise coming from three conditions**: Autistic Spectrum Disorder (ASD); Speech, Language and Communication Needs (SLCN); and Social, Emotional and Mental Health (SEMH). These have gone from half to over 70 per cent of the total caseload.

Figure 1 – the large rise in school pupils EHCPs is concentrated a few areas of need



Source: Department for Education (2025) Pupils with special educational needs in schools. Available at: https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england/2024-25#section-pupils-with-special-educational-needs-in-schools (Accessed: 6 May 2026). Note: the totals in this figure are lower than the overall totals as they do not include independent schools

Broadening the scope to the entire number of children and young people with an EHCP, as opposed to solely focusing on school pupils, there were **638,745 EHCPs in total in January 2025 – up 80 per cent since 2019.**

This rise in EHCPs corresponds with much smaller rises in broader SEN. In 2024/25, 1.28 million pupils had SEN support in England, up 29 per cent since 2015/16.

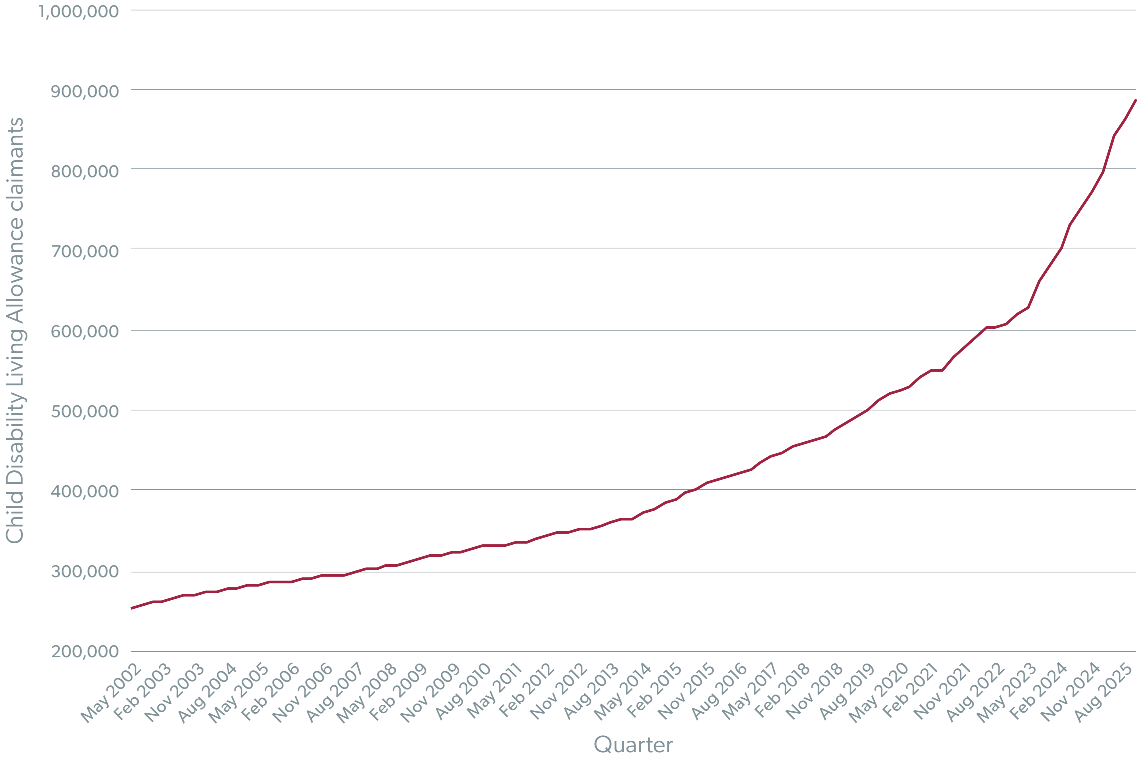
There has also been a substantial change in the proportion of children taught at special schools. The proportion educated at special schools fell from 1.5 per cent in the early 1980s to 1.1 per cent in the early 2000s. It is now back to 1.9 per cent of pupils.[11] This is not disproportionate, considering the scale of the rise – the number of pupils with EHCPs in mainstream schools doubled from 2017 to 2024.[12]

1.2. The rise in child disability support

Alongside this rise in high needs SEND has been a significant expansion in child disability benefits and related support within Universal Credit, especially in the Child Disability Living Allowance (CDLA). This rise started earlier but has been similar in the last decade.

As Figure 2 shows, the total caseload rose steadily over the 14 years from Q2 2002 to Q2 2016 by a total of 65 per cent from 253,048 to 418,609 children. Since then, this growth has accelerated, rising by 115 per cent from Q1 2016 to Q3 2025. Most strikingly, it rose by 41 per cent from 628,327 to 886,983 between Q2 2023 and Q3 2025 in fewer than two-and-a-half years.

Figure 2 – Child Disability Living Allowance caseload: Q2 2002 to Q4 2025



Source: Department for Work and Pensions, Stat-Xplore. Available at: https://stat-xplore.dwp.gov.uk/ (Accessed: 7 May 2026). This data captured CDLA by filtering for "Children" under "Client Type".

Note: The CDLA caseload data is for GB, in order to correspond with the DWP benefit expenditure and caseload tables. In 2025, cases in England make up over 95 per cent of the total. This is because in Scotland, Child Disability Payment has replaced CDLA, meaning that there are a negligible number of Scottish CDLA cases, and the Welsh caseload is under five per cent of the total. For historic data, around 12-14 per cent of cases were from Scotland or Wales. This means the caseload rise in England has been slightly faster than the above chart suggests.

Mirroring EHCPs, this rise in CDLA has been **almost exclusively driven by increases in children claiming for learning difficulties, behavioural disorders or ADHD** ('hyperkinetic syndrome').[13] Institute for Fiscal Studies research exploring the transition into PIP of this caseload found that the majority of the increase in 'learning difficulties' and about half of 'behavioural disorders' relate to autism and/or ADHD.[14] Even more notably, there are large overlaps in these groups: in 2020, 84 per cent of children receiving CDLA had SEN and 52 per cent had an EHCP. Similarly, 77 per cent of those with an EHCP received CDLA.[15]

1.3. The funding crisis

Local authority spending on SEND has surged in recent years. High needs spending is the main block of spending associated with SEND and has **risen in 2026/27 prices from £8.0 billion in 2015/16 to £12.2 billion in 2023/24[16] – rising to £13.4 billion in 2024/25.**[17] The Office for Budget Responsibility forecasted in Autumn 2025 that this will rise to exceed £19 billion in cash terms by 2028/29, with a spending growth of £1.7 billion in 2025/26 alone.

Policy Exchange estimated in 2026 that half of all new schools spending in the previous decade had gone on SEND.[18] In the last six years, LA spending on SEND has risen by 58 per cent in real terms, equivalent to over £5 billion in additional spending.[19]

In mainstream schools, LA funding often fails to cover the costs of provision outlined in an EHCP, despite that provision being legally mandated, leaving schools struggling to meet need.

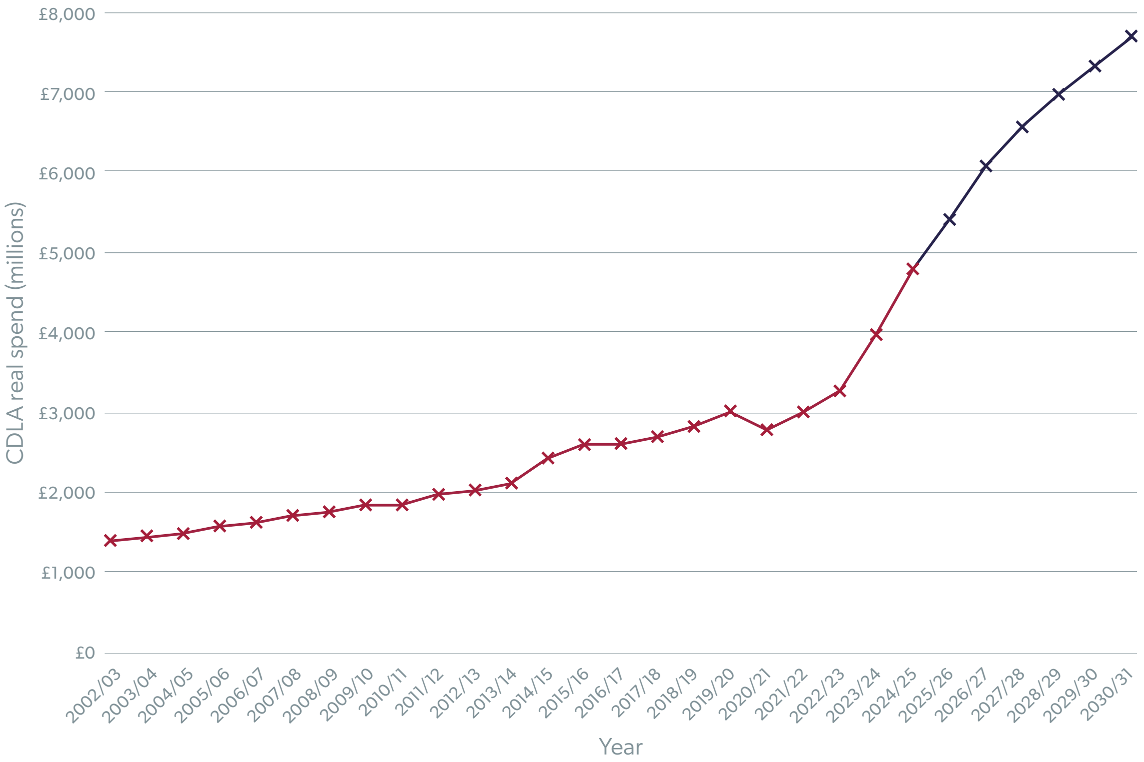
> *"It's becoming unsustainable within mainstream settings to meet the needs of all of the things that are outlined on these EHCP plans. The plans will talk about a set number of hours on them, and I find that's a little bit misleading, because there'll be an EHCP that says 25 hours, and the parent will believe that's 25 hours of one-to-one support. But actually 25 hours amounts to about £10,000 worth of funding, which really doesn't fund 25 hours of one-to-one support at all."*
>
> **Secondary school SENCO**

A substantial portion of LA spending is accounted for by independent special schools. A placement at an independent special school for a single pupil cost an average of £61,500 a year,[20] such that the schools account for over £2 billion of high needs spending despite only six per cent of pupils with EHCPs attending them.[21]

The SEND reforms in the Government's long-awaited 2026 White Paper made little change to this forecast, with all high-needs saving coming from 2030 onwards. In the immediate term, the reforms instead pledged a £4 billion package of expansion in mainstream SEN support over the coming years.[22]

The cost of CDLA has been just as stark. **The cost in 2024/25 was £4.8 billion, twice the real terms cost of £2.4 billion just a decade beforehand in 2014/15**, and over two-and-a-half times the real terms cost of £1.85 billion in 2009/10. As of the 2025 budget, this is only set to get more expensive, with a forecast annual real terms cost of £7.69 billion in 2030/31.

Figure 3 – the rapid rise in the cost of CDLA



Source: Department for Work and Pensions (2026) Benefit expenditure and caseload tables 2026: Outturn and forecast tables: Spring Forecast 2026. Available at: https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2026 (Accessed: 6 May 2026). Note: the figures from 2025/26 to 2030/31 are forecasts.

Note: The CDLA caseload data is for GB, in order to correspond with the DWP benefit expenditure and caseload tables. In 2025, cases in England make up over 95 per cent of the total. This is because in Scotland, Child Disability Payment has replaced CDLA, meaning that there are a negligible number of Scottish CDLA cases, and the Welsh caseload is under five per cent of the total. For historic data, around 12-14 per cent of cases were from Scotland or Wales. This means the spending rise in England has been slightly faster than the above chart suggests.

CDLA also passports access to further means-tested support – the UC disabled child element, UC carer's element and carer's allowance – worth an estimated £3.2 billion annually (2026/27 prices) across England.[23] The combined cost therefore exceeds £7.5 billion, almost double the headline CDLA figure alone.

These rises are far faster than is sustainable. Focussing on the SEND system, in February 2026, a £5 billion bailout from government to councils was announced to avoid bankruptcies.[24] The IFS estimated in 2024 that annual high needs spending would rise by at least £2-3 billion between 2024/25 and 2027/28, and the OBR estimated in the 2025 Budget that there will be an *annual shortfall* by 2028/29 of £6 billion.[25] Although savings are planned for 2030-2035, the Government's White Paper only expanded the surging cost within a £4 billion mainstream investment package.[26]

It is already the case that half of the growth in school spending in the last decade was in SEN support.[27] There has been a more than doubling in the level of spending on SEND transport,[28] which now costs almost two billion a year.[29] There has been a real terms rise of £1.8 billion in top up spending to special schools.[30]

All these calculations focus on the SEND system, accounting for the £7.1 billion real terms rise in spending from 2015/16 to 2025/26. Alongside the rise in CDLA and passported benefits, the total spending on children with additional needs has risen from £12.4 billion in 2015/16 to £24.1 billion in 2025/26.[31] At current projections, this rise is not only expected to continue but is expected to accelerate.

1.4. Outcomes and unfairness

The enormous rise in the fiscal scale of the SEND and child disability system has neither improved outcomes nor support for disadvantaged children.

Outcomes

Outcomes for pupils with SEND have not increased with the rise in funding nor the policy reforms over the last decade.[32] There remains a 50 percentage point gap between pupils with no SEN identified and those with SEN support or an EHCP meeting the expected attainment standard in state-funded schools.[33] Indeed, the gap between children with and without SEND in the proportion sustaining a post-16 destination widened between 2015/16 and 2022/23.[34]

Broader indicators reflect how much children with SEND struggle in the education system. The permanent exclusion rate for children with SEN support is six times that of children with no identified SEN.[35] The rate of persistent absence is double.[36] There is also often a ‘snowballing’ effect, we see that children with a separate SEND are twice as likely to later also develop SEMH needs as the overall cohort.[37]

These challenges extend well beyond childhood. IFS analysis found that among 15-year-olds who had both an EHCP and CDLA, half were not in education, employment or training at 22 – three times the rate of their peers; well over half (60 per cent) were on out-of-work benefits, four times the rate of their peers.[38] Figures from the DWP also found that fewer than two in five of those who claimed disability benefits as children are in work by age 30.[39]

Unfairness

Children from the most disadvantaged neighbourhoods are more likely to be identified with SEND, especially high needs, yet they are also much less likely to be granted an EHCP.[40] A recent study into provision for children with intellectual and developmental disabilities found that those living in more advantaged areas were between 1.5 and nearly four times more likely to be granted an EHCP compared to those living in the most deprived areas.[41] Similarly, those living in London were between two and three times more likely to be granted an EHCP than those living elsewhere in England.[42] This mirrors overall trends in SEND spending, in the six years between 2018/19 and 2024/25, SEND spending increased in real terms by 65 per cent in the most affluent half of local authorities in England, but by just 51 per cent in the most deprived half of local authorities.[43]

Similarly, research by the Education Policy Institute has found that over half of different SEND identification can be explained by the school a child attended.[44]

> *“We are creating a two-tier system… What we have now is a middle-class EHCP system… Those families that have access to the right resources are getting the diagnoses… The research is being skewed into this battle for EHCPs, for children’s plans, and for inclusion. But it is not considering who’s fighting the battle for the disadvantaged children whose parents aren’t able to fight the system in the same way. So, we’re getting a disproportionate number of children with EHCPs coming through from more middle-class families.”*
>
> **Headteacher in the Midlands**

1.5. What the White Paper did and did not do

In February 2026, two important Government documents were published, the white paper *Every child achieving and thriving*[45] and *SEND reform: putting children and young people first.*[46] These outlined the Government's medium-term strategy for schools policy and also proposed major reforms to the SEND system alongside commencing a consultation on SEND reform.

The *SEND reform* paper proposed a major restructuring of the SEND system towards earlier intervention and mainstream inclusion. In doing so, it sought to move away from the diagnosis-led and EHCP-driven system we have today.

Expansion of mainstream support

The Government's overall SEND reform strategy is to expand mainstream provision – 'inclusivity' – over the next three years without making major reforms to the issues in the high needs sector and then reforming the high needs provision (especially through reforming EHCPs) from 2030 onwards.

In mainstream provision, the investment package included:

- Best Start Family Hubs being expanded through a £200 million enhanced SEND fund;
- A new £1.6 billion 'Inclusive Mainstream Fund';
- A new £1.8 billion 'Experts at Hand' service, starting immediately; and
- 'National Inclusion Standards' to go alongside the introduction of 'Inclusion' into the Ofsted framework.
- Increasing the capital maintenance and renewal budget from £2.4 billion annually to £3 billion annually;
- Almost £2 billion per year in a School Rebuilding Programme;
- £3.7 billion over five years to create new specialist places, including adapting mainstream schools to create more inclusive environments.

Movement away from diagnosis and EHCPs

Over the long term, the Government has also taken some directional steps towards tightening the high needs SEND sector from 2030 onwards.

SEND Code of Practice

The SEND reforms announced several changes to the SEND Code of Practice. Mechanically, the main change announced was to move the areas of need in the Code of Practice into new 'areas of development'. Such a change had three explanations: first, to move away from 'increasing reliance on diagnosis' in the system and instead towards need; second, to make them easier to use by ensuring that the categories more obviously 'bridge' into the appropriate support for children; and third, to have clearer definitions in general.[47]

The second announced change is that the Code will seek over time to disaggregate educational support and clinical interventions and clarify that clinical intervention should be led by medical professionals.

Tiered system and Individual Support Plans

The SEND reforms also committed to separating high needs into ‘targeted’, ‘targeted plus’, and ‘specialist’ support, with only the final category having EHCPs.

The first, and most heavily invested in, part is the ‘Universal Offer’, which seeks to make the mainstream education system more ‘inclusive’ and better able to support those with SEND. This is best understood not as a replacement of SEN support but as a pivot in the entire education system, although the intention is that many children who currently receive SEN support would no longer need to do so.

The layers of support are then being split from two to three. Replacing the system where children can receive school-led and variable SEN support or enter the high needs system through EHCPs will be a formalised, three tier system of support: targeted, targeted plus, and specialist. Targeted support will be introduced in the first instance, via an ‘Individual Support Plan’. Targeted Plus support will then be introduced for children with more severe needs who require access to an ‘Inclusion Base’ and to the new ‘Experts at Hand’ offer. Finally, Specialist support will bring in new ‘Specialist Provision Packages’.[48]

EHC needs assessment process

The EHCP process is also set to be substantially changed through the SEND reforms. A few changes are set to be made here, including moving from a focus on inputs to intended outcomes, and greater flexibility in what settings provide. There are also plans to standardise the EHCP needs assessment process and template, improving clarity of the agreement, and an improved review process, introducing annual reviews for EHCPs.

Notably, much of this is highlighted as needing primary legislation – most strikingly establishing that only those who require a Specialist Provision Package will need an EHCP.[49]

What it did not do

Many of these policies are encouraging steps in the right direction, albeit with the most difficult and essential reform set to be introduced from 2030 onwards. However, there are a number of key areas not addressed.

Within their focus on having a more ‘inclusive’ mainstream, the SEND reforms do not respond to why more children are treated as unable to learn in school environments as they are, and related concerns around early years development, family stability, behaviour, and the impact of smartphones.

The SEND reforms do not address directly the concerning and rising tendency to diagnose throughout the children’s support system. In particular, the financial incentives that exist to get a diagnosis within the current organisation of the system.

> *"Everyone's so focused on an assessment or a diagnosis . . . their [mental health trusts] support websites are all about what to do when you get your diagnosis. There's a big chunk of time where you've got zero support and you don't know where you sit with things and you had help with how to live well in the meantime, then maybe a diagnosis wouldn't be such a big thing to be focusing on."*
>
> **CEO of a charity supporting families in the Midlands**

They also do not address the complicated and problematic relationship between EHCPs and CDLA, with the focus instead solely on the education system.

Finally, although pivoting to an extent towards an outcome orientated system, the SEND reforms do not properly disentangle the fact that the current lack of accountability across the system incentivises blaming over ownership, especially when needs initially present themselves.

Chapter 2:

Four failures in the English system

We see four failures in the English systems to support vulnerable children. First, a rise in childhood vulnerability increasing need. Second, an excessive tendency to diagnose behavioural and neurodevelopmental conditions where earlier practical intervention could be more effective. Third, structural incentives to escalate into higher cost support. Fourth, a lack of clarity, direction, and accountability.

2.1. The crisis upstream: rising childhood vulnerability

The first fault in the SEND system is a rise in childhood vulnerability, increasing the level of need among children. We see this in the early years, in the rapid expansion of social media and screen time, and rising family instability.

Early years

A third of children in England are also starting school not "school-ready".[50] Many arrive with delayed language, weak emotional regulation, poor social development, and impaired attention. These substantially increase the likelihood of being diagnosed with poor communication development and with emotional and behavioural disorders.[51]

Social media and screentime

The rapid expansion of smartphones and social media has also caused increased vulnerability. Currently, 8- to 14-year-olds are averaging three hours a day online,[52] up from just over 2 hours in 2018.[53]

First, there is a growing consensus that the rise in mental ill-health among children and young people is at least partially caused by increased social media use and possession of smartphones.[54]

> *"I'm really concerned about it [screens], like I despair, actually, for the amount of time children are on screens in the classroom and outside the classroom."*
>
> **Educational Psychologist based in London**

Second, increased social media usage may also be harming children's attention spans, leaving them less able to concentrate in their lessons at school. Jonathan Haidt highlights attention fragmentation as one of the "foundational harms" of consuming short-form content on social media.[55] A 2018 longitudinal study of 15 to 16 year olds found that there was a strong association between social media use and increased risk of developing symptoms of ADHD.[56] From this perspective, it is no wonder that the so-called "iPad kids" are growing up with increasing difficulties concentrating at school. One CEO of a charity supporting young people told the CSJ how social media may be reducing children's engagement in the classroom.

> *"Social media has contributed to shorter attention spans — a struggle to engage with 'slow information' — someone talking to you, having a conversation, the way that often lessons are taught in school."*
>
> **CEO, Golddigger Trust**

Third, social media content can directly increase a child's inclination to self-identify as having SEND. Between September 2021 and 2024, there were three million TikTok posts using the hashtag '#adhd' in the UK alone.[57] Most of this content is inaccurate.[58] University of British Columbia research has found that this is also true for the most-viewed TikTok videos.[59] This has fuelled a large rise in self-diagnosis. A 2023 survey found that 30 per cent of Gen Z had self-diagnosed a mental health condition due to information obtained through social media, with 32 per cent that self-diagnosed receiving treatment.[60]

Family instability

Finally, family instability increases the incidence of SEND as it undermines a core protective factor for children's mental wellbeing.[61] The UK is a global leader in family breakdown,[62] with 46 per cent of 14-year-old first-born children not living with both biological parents, compared to just 21 per cent in 1970.[63]

Part of this is a decline in marriage. Cohabiting parents are an estimated three times as likely to separate as married parents even controlling for other factors,[64] yet the proportion of children born to married parents fell from 91 per cent in 1972 to half today.[65] Those who have experienced family breakdown before they turn 18 are 1.7 times as likely as those who haven't to experience mental ill-health,[66] and 11-to-16-year-olds with a probable mental health disorder have an over 10 percentage point higher occurrence of family functioning problems.[67] Among 5 to 10 year olds whose parents cohabit, 12 per cent had a mental disorder, compared with 6 per cent of those whose parents were married.[68] Mental ill-health has a direct impact on SEND through SEMH, which is a formal SEND category.[69] It also contributes to a number of behaviours associated with SLCN.

2.2. The crisis at entry: Excessive tendency to diagnose

Alongside a substantial rise in childhood vulnerability, we also see a step-change in the inclination to diagnose.

The unprecedented rise in the incidence of SEND far exceeds what could be realistically explained by changes in underlying incidence – although vulnerability has worsened, human neurobiology does not dramatically transform at a population level in a decade. If, as some argue, the increase in diagnoses is driven by better awareness of conditions in fact held widely across the population, the systems currently in place to support smaller numbers of people with more acute needs must be reviewed.

There is a strong body of evidence suggesting an increased inclination to diagnose in the SEND system. The rise in SEND has been driven by rises in ASD, SLCN, and SEMH needs, focusing on these rises, we find several reasons to suspect overdiagnosis.

Direct evidence of misdiagnosis and inaccuracy

Research directly focused on the SEND diagnosis process finds that it is often ineffective. A 2018 study by the University of Cambridge found that, among 550 children referred by schools for suspected learning difficulties, one quarter were developmentally typical and showed no clear evidence of SEND needs.[70]

The government's 2022 SEND Review found similarly, arguing that "in some cases, poor quality teaching, particularly in reading, may cause a child or young person to fall behind their peers and be incorrectly identified as having special educational needs".[71]

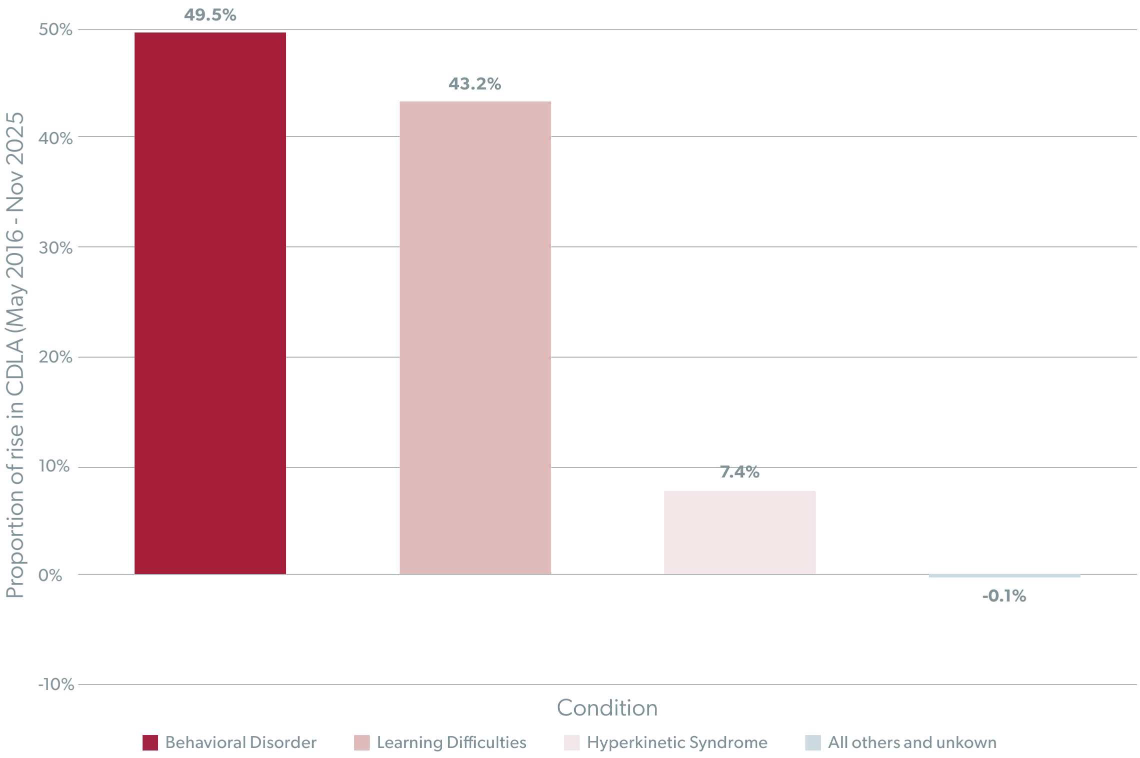
Uneven growth pattern

SEND growth in the last decade has been conspicuously uneven, which when examined suggests there is more to the picture than the rising incidence of health conditions and disability.

First, the rise in SEND has been driven by three specific conditions: ASD, SLCN, and SEMH needs. These have gone from half to over 70 per cent of all EHCPs. These are also precisely the categories where boundaries are widest and most ambiguous, and where professional judgement plays the largest role.[72] And – as will be returned to – in these cases, the professional opinion is clear: two thirds of GPs agree that "clinical diagnoses for autism or ADHD are given out too easily" and three quarters agree that "the clinical boundaries for diagnosing autism or ADHD have expanded to include behaviours previously considered within the normal range".[73]

For CDLA this is even starker. Over 100 per cent of the rise in cases between May 2016 and November 2025 was in learning difficulties, behavioural disorders (which have increased nearly sixfold), and hyperkinetic syndrome, with 93 per cent solely in the former two. These overlap very closely with ASD, SLCN, and SEMH needs – especially autism, ADHD, and behavioural issues. As noted earlier, Institute for Fiscal Studies research exploring the transition into PIP of this caseload found that the majority of the increase in 'learning difficulties' and about half of 'behavioural disorders relate to autism and/or ADHD. Around 41 per cent of these are on the highest rate care award and around 16 per cent are on the highest rate mobility award.[74]

Figure 4 – Over 100 per cent of the rise in CDLA is in three conditions



Source: Department for Work and Pensions, *Stat-Xplore*. Available at: https://stat-xplore.dwp.gov.uk/ (Accessed: 7 May 2026). Note: this data presents the main disabling condition for children but does not mean that they exclusively report this condition. This data captured CDLA by filtering for "Children" under "Client Type".

Second is seasonal variation. Relative age within a year group is an arbitrary, institutionally constructed factor and yet has a large impact on the likelihood of diagnosis. A 2024 study by the University of Bristol exploring the environmental influences of SEND in Wales[75] for pupils born between 2002/03 and 2007/08 found that when controlling for health and birth variables, summer born pupils were three times more likely to be identified with SEN than autumn born pupils.[76] It also found that pupils born in the most deprived areas were 4.6 times more likely to be identified with SEN than pupils born in the least deprived neighbourhoods, and that increasing attendance by one per cent reduces the likelihood of being identified as SEN by eight per cent.[77] LSE research published in 2021 found the same for children in England: for those reaching year six in 2018, 16 per cent of autumn born girls received some form of SEND support during primary school, rising to 40 per cent of summer born boys.[78]

Concentration among mild and often transient cases

The most recently released Centre for Disease Control and Prevention report on autism from April 2025 revealed a quintupling in the prevalence of autism in the United States between 2000 and 2022.[79] But a further large-scale study suggested that this rise is entirely driven by children with 'mild or no significant functional impairment'. Between 2000 and 2016, there was a 20 per cent decrease in the prevalence of autism with 'moderate to profound challenges'.[80] It has also been well established for decades that many early years language difficulties are transient, making the trend towards seeing them through a medical lens concerning.[81]

Similarly, the government's own Independent Review into Mental Health Conditions, ADHD, and Autism, published in March 2026, reached a consistent finding: while population prevalence of autism and ADHD remains broadly stable at around five per cent in children, referrals and diagnoses have risen sharply – with child waiting lists for ADHD assessment rising from 21,000 in 2019 to 270,000 in 2025.[82] Parent-reported prevalence of autism rose by a quarter between just 2022 and 2024.[83]

The view from experts on the frontlines

Finally, and perhaps most conclusively, those on the frontlines are clear-eyed about overdiagnosis.

Table 1 – GPs are clear-eyed about overdiagnosis

Proportion agreeing	Statement
94%	"Compared to five years ago, I am seeing more referrals for suspected autism or ADHD"
66%	"Clinical diagnoses for autism or ADHD are given out to children and young people too easily where behavioural interventions would be more appropriate"
66%	"A majority of children referred for autism or ADHD assessment primarily present with behavioural or environmental difficulties rather than a neurodevelopmental condition"
75%	"The clinical boundaries for diagnosing autism or ADHD have expanded to include behaviours that would previously have been considered within the normal range"
57%	"Financial entitlements linked to autism or ADHD diagnoses strongly influence parental requests for assessment"

Source: Savanta polling of 1,002 GPs for the CSJ, March 2026

2.3. Incentivised and mutually enforcing escalation

The support children receive is not well-directed towards improving their outcomes, and instead incentivises cost escalation, conflict, and delays.

Escalation in the SEND system

Once young people enter the SEND system, the support they receive is not well-directed towards improving their outcomes.

Mainstream SEN provision in schools has been hollowed out in real terms as the notional SEN budget within the DSG has remained at £6,000, incentivising EHCP applications which then often escalate a child to a special school that costs several times more and is not necessarily better for their education.

> *"The local authority gave us £8,000 pounds for a student with a 32-and-a-half-hour plan, and that doesn't even touch the sides for employing a teaching assistant . . . because there's no places in special schools, we've got young people waiting years. They've had on their EHCP that it names us but says 'with transfer to a specialist provision when one becomes available.' But we've had young people waiting 18 months for that to happen, but in the meantime, we're not getting the funding that would have been going to that specialist school to provide anything for that child."*
>
> **Assistant headteacher and SENCO based in the East Midlands**

Inability to expand the availability of state school places, combined with inability to manage the demand for overall special school places, has had two distortionary and costly effects. The first is that places have increasingly been sought a long distance away, exacerbated by the named school clause in EHCPs which councils have minimal power to stop, causing an extraordinary ratchet effect in transportation costs.[84]

The second is that it has caused a large rise in demand for independent special schools, which has been capitalised on by private equity firms – which own over 30 per cent of these schools.[85] There has been a rapid growth in independent special school places, which now cost almost three times as much as state special schools, at an average of over £61,000 a year. These high fees are unsurprising: once an EHCP has been granted, and especially if it has a named school on it, local authorities must pay the fee to place the child at the school, irrespective of price level. This is fertile ground for predatory pricing.

The White Paper has taken steps to manage this,[86] but the price is downstream of a surge in price inelastic demand and a shortage of supply – these are the issues that need resolving.

Councils cannot stop the effect from happening as they are statutorily bound in every direction, such that the overall consequence is that, as opposed to expansions in the sector creating returns to scale, market failure instead leads the sector's expansion to cause a continual *increase* in the marginal cost of each additional child.

The rise over the last decade has led to huge waiting lists,[87] a fall of almost a third in real terms funding per EHCP,[88] and oversubscribed special schools. It has also created an industry for private assessments, which cost an average of around £1,361 for ADHD. Over 400 private clinics now operate across the UK.[89] This system has also driven a large rise in the number of tribunals, as rejecting assessments becomes one of the only rationing mechanisms for local authorities. Parents are then likely to challenge this in a tribunal, not least as they are highly likely to succeed, doing so in 99 per cent of cases in 2023/24 – often using disability discrimination claims citing the Equality Act.[90] The number of tribunals hit 25,000 for the first time in 2024/25, an astonishing rise from 7,000 in 2018/19.[91] Pro Bono Economics estimated that, in 2021/22, each tribunal had a cost to the state of £11,116.[92] This would suggest that, in 2024/25, the total cost of tribunals was £309.2 million.[93] This is an extortionate cost, not least considering that the state loses virtually every single tribunal.

The funding crisis is not as simple as a surge in need; there are egregious design failures in the system that are simultaneously worsening support and driving up costs.

Escalation in the CDLA system

The welfare system offers families a significant financial incentive to medicalise their child's difficulties.

The CDLA caseload has risen by 41 per cent in under two-and-a-half years, with that rise driven almost exclusively by the conditions where diagnostic boundaries are at their widest and most ambiguous with professional judgement playing a large role. The rise in CDLA over the last decade very closely mirrors the rise in SEND. It is most driven by behavioural disorders, learning difficulties, and neurodevelopmental conditions such as ADHD. Although the categorisation is not identical, these are equivalent to SLCN, ASD, SEMH in the SEND system.

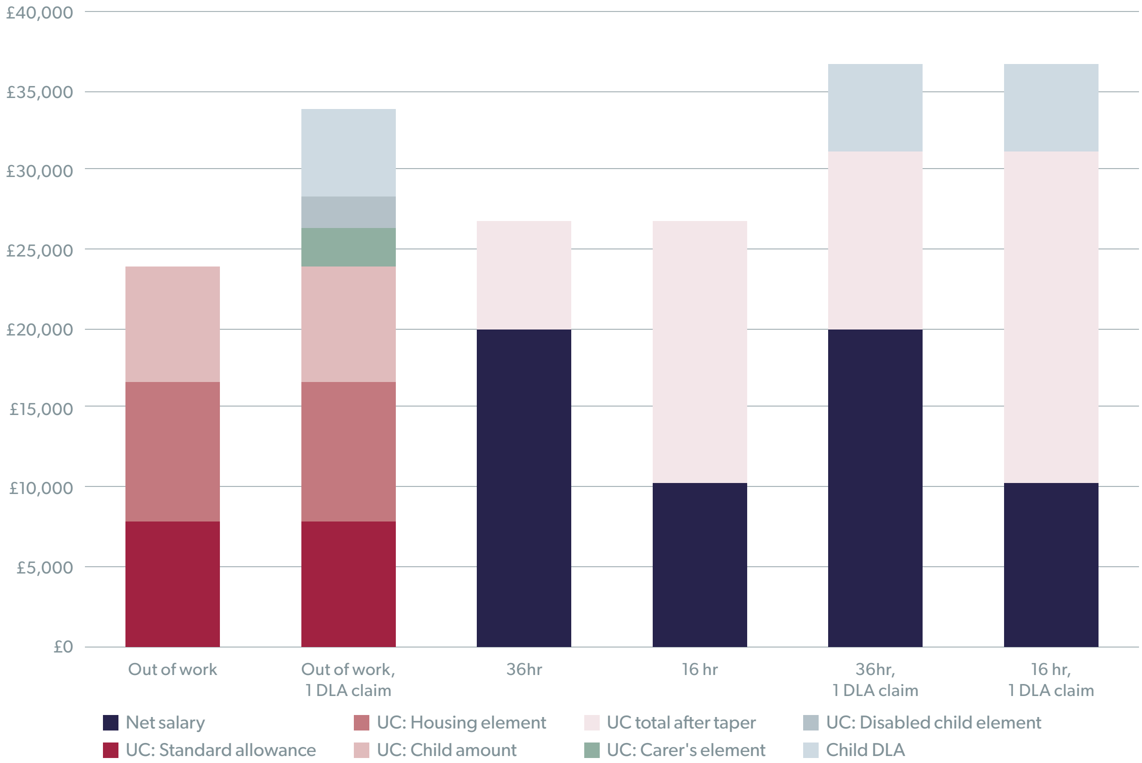
CDLA is constituted of two components: a mobility component – for children who need additional support with moving about – and a care component – for children who need more looking after in day-to-day life. The mobility component is paid at two possible rates: a lower rate worth £29.20 per week and a higher rate worth £77.05. The care component has three possible rates of £30.30, £76.70, and £114.60.

This means that a parent with a child on CDLA can receive up to £830.48 per month. The most common combination is the middle rate of care component and the lower rate of mobility. Around two in five (41 per cent) claimants receive this combination, which comes to £458.90 per month.

However, the financial benefit of claiming CDLA is not limited to the benefit itself. A parent whose child receives CDLA is automatically entitled to the lower rate of the disabled child element of UC – worth £165.79 per month – and can receive the higher rate of £514.71 if their child receives the highest care component rate of CDLA. They are also entitled to the carer's element – worth £209.34 – if they (and their partner) spend at least 35 hours per week caring for their child.

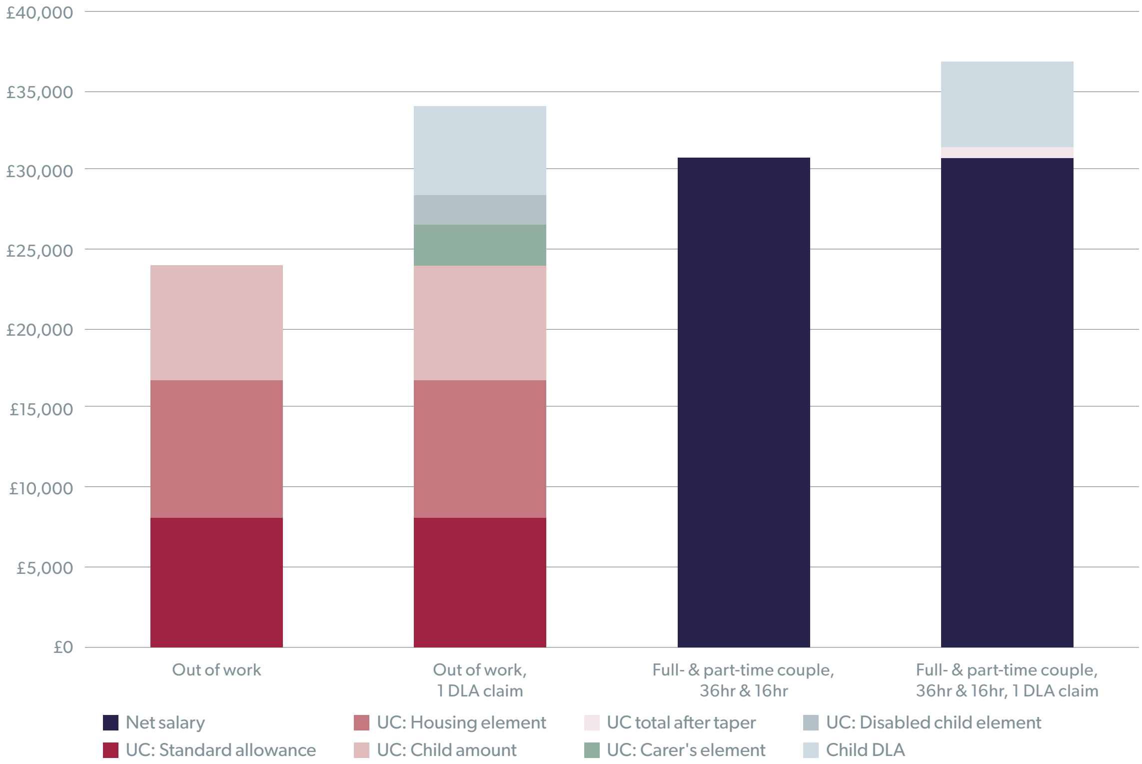
Figures 5 and 6 demonstrate the financial benefit that CDLA unlocks. In both examples, the parents live in a house with two bedrooms and have two children, one of whom receives CDLA with the middle rate care component and lower rate mobility component. The lone parent receives almost £10,000 in additional income per year, while the couple receives either £6,218 extra if they are in work or £9,996 extra if they are out of work.

Figure 5 – Comparative financial incentives for a lone parent



Source: CSJ analysis of UK benefit rules. Note: the lone parent receives the UK-wide median local housing allowance for a Category C property. They have two children and claims CDLA for one child with the middle rate of its care component and lower rate of the mobility component.

Figure 6 – Comparative financial incentives for a couple



Source: CSJ analysis of UK benefit rules. Note: the couple receive the UK-wide median local housing allowance for a Category C property. They have two children and claim CDLA for one child with the middle rate of its care component and lower rate of the mobility component.

There is, in summary, a significant amount of additional income available to parents whose child receives CDLA. For families of children with the most severe and complex needs – including those with profound learning disabilities, serious physical impairments, and complex medical conditions – this support is essential and reflects genuine extra costs that these families face every day.

The concern this report identifies is narrower and more specific. Where diagnostic boundaries are wide and clinical judgement plays a large role – as GPs themselves confirm is increasingly the case for autism, ADHD and behavioural conditions – the financial incentives created by CDLA and its associated passports into Universal Credit can influence decisions to seek a diagnostic label for difficulties that might otherwise be addressed through earlier, practical interventions. This is not a moral failing on the part of parents navigating a system that offers few alternatives; rather, it is a rational response to financial pressure and a system design that has made diagnosis the primary route to support.

Mutual enforcement of SEND and CDLA

In 2020, 84 per cent of children receiving CDLA had SEN and 52 per cent had an EHCP. Similarly, 77 per cent of those with an EHCP received CDLA.[94] This is unsurprising given the nature of CDLA.

When the Coalition Government replaced working-age DLA with Personal Independence Payments (PIP) in 2013, they argued that assessments for DLA were subjective and ill-targeted. [95] Under DLA, applicants sent a form with medical evidence to a DWP Decision Maker, with certain conditions having automatic entitlement. The DWP feared this led to overly subjective decisions about eligibility that did not necessarily reflect claimants' capacities or needs.

There was also long-term and bipartisan disquiet about the system's over-reliance on paper-based medical evidence, often from GPs. From the mid-1990s, governments of all stripes had reformed incapacity benefits to remove GPs from benefit assessments because they feared that GPs could be placed under undue pressure to support patients' claims and had too little time to assess whether providing benefits was the best answer to a patient's needs.[96]

However, the Coalition decided not to introduce an independent assessment process for children equivalent to PIP's face-to-face or telephone assessment, saying they "[wanted] to build experience of developing the objective assessment for claimants of working age before applying it to children."[97] Parents still apply for CDLA through a form where they describe their child's needs and the effect of those needs and attach medical evidence. Letters from a GP and EHCP or SEN plans are the most common sources of medical evidence.

Table 1 expresses the problems with the former: three quarters of GPs believe "clinical diagnoses for autism or ADHD are given out too easily where behavioural interventions would be more appropriate" and 57 per cent believe "financial entitlements linked to autism or ADHD diagnoses strongly influence parental requests for assessment." GPs are, again, coming under pressure to diagnose conditions that lead both to benefit entitlement and (often) EHCP and SEN plans, despite disbelieving themselves that these diagnoses fairly reflect or will solve children's difficulties.

The role of EHCPs and SEN plans in evidencing CDLA claims, meanwhile, is the link that connects parents from the SEN system to CDLA. Receiving an SEN plan or EHCP indirectly unlocks access to CDLA and the financial benefits it brings.

2.4. The crisis of leadership: no clear thresholds or accountability

> *Complexity matters. If the rise in diagnoses were simply the correction of historic under-recognition, the response would be straightforward: more assessment capacity and more clinical treatment. If, as the evidence increasingly suggests, the current patterns are shaped as much by the design of systems as by underlying need, including the incentives those systems create and the tendency to medicalise forms of distress that may have broader social or developmental roots, then the response must be broader. It must include earlier, more accessible forms of support that do not depend on long waits for specialist diagnosis. And it must address the social determinants producing the distress in the first place: poverty, family instability, social media. Critically, as there seems to have been a widening of what is recognised as disability within the system – and with it an expansion of the range of diagnoses and conditions that legitimise non-participation - the key issue is not the label itself but the functional impact. Until the health – and wider – system gets to grips with that key distinction, too many young people will be categorised as unfit to work when, with help, support and earlier intervention, they would be able to do so.*[98]
>
> **Milburn Review**

The SEND system lacks clear definitions of terms, conceptions of success, and accountability.

Definitions of terms

As noted by Policy Exchange, the statutory definition of SEND in the Children and Families Act 2014 is cyclical, defining it as 'a learning difficulty or disability which calls for special educational provision to be made'.[99] In other words, a child has SEND when they do, and we know that they do by the fact they have SEND.

The process for EHCPs, as in the SEND Code of Practice, has made it virtually impossible for councils to reject EHCPs. For an EHCP assessment, the applicant only needs to show a child 'may' have SEND and that special provision 'may' be needed. Similarly, to secure an EHCP the applicant must only demonstrate that 'it may be necessary for the local authority to make special educational provision'.[100] This means a child effectively needs an EHCP until proven otherwise, something that it is very difficult for local authorities to do within such vague definitions. As such, 99 per cent of tribunals rule in favour of the claimant and the only rationing mechanism is shocking waiting lists and delays.[101]

Conceptions of success

There should be one objective and one constraint. The objective must be to **prepare young people with additional needs to thrive in adulthood, if possible, independently.** The constraint must be fiscal sustainability, which in the current context means a renewed targeting of support.

Accountability

The accountability structure also needs to be simplified and clarified. If a child with SEND performs poorly, who is responsible? The school may argue it lacks sufficient funding; the local authority may argue that an EHCP was unaffordable, and that the school is responsible for delivering the education; the parent may argue their child's needs have been ignored or that an EHCP was either unsuitable or not followed.

In each context, the incentives are defensive. Local authorities are judged on budget control and statutory compliance, schools are judged on attainment of their whole school community, parents are only seeking outcomes for their child and often want the strongest possible protection.

Chapter 3:

Reforming the system to support children

Clearly, the way we support vulnerable children needs to fundamentally change. It needs to change upstream, giving children the very best start in life. It needs to change at point of entry, moving away from diagnosis to earlier intervention. It needs to change within the system, reforming broken incentives to stop the constant treadmill to escalation. And it needs better definitions, purpose, and accountability.

All of this is most important for the most vulnerable children. The love and care received by children whose needs are most severe is being eroded by a distorted and oversaturated support system for vulnerable children. All steps made must ensure that these children get the help they need in a system that is fiscally sustainable. Today we are failing on both counts.

The recommendations that follow focus on the SEND framework and Child Disability Living Allowance – the two systems examined in this report. They do not address the full breadth of what disabled children and their families need (from social care, NHS, housing and beyond).[102] But it is in the SEND framework and Child DLA that the case for reform is most urgent and the evidence base strongest.

Reform will take time, but with the following plan we believe it is possible to build a fairer, more effective and more sustainable system of support for some of our country's most vulnerable children.

3.1. Rebuild protective factors and strengthen early support

RECOMMENDATION 1

90 per cent school readiness ambition

The Government should adopt a clear target of 90 per cent of children reaching a good level of development by age five. Recommendations 2 to 4 will help the country achieve this through:

- Birth registrations should be moved to Family Hubs to identify families where children at risk of not being school ready – such as lone parent families – from birth;
- Stronger developmental assessments should be introduced in the early years; and
- National expectations on language development should be set to ensure that children entering school can understand and communicate in English, including mandatory English classes for parents that are identified as not able to speak English.

RECOMMENDATION 2

Birth registrations should be moved to Family Hubs

Officially moving birth registrations to Family Hubs, although the policy has been effective where it has been proactively introduced, has been rendered difficult through the joint responsibilities of the Home Office (population), DHSC (children's health) and DfE (education), as well as union resistance.

Through the Home Office, ministers should move birth registrations to Family Hubs – a low-cost adjustment that would substantially improve the joining-up of the support mothers receive in the first days of their children's lives, including identifying children who are likely to be at risk of not being school ready. This will also remove the perceived stigma around seeking help, as all families will be engaging with Family Hubs from the outset.

RECOMMENDATION 3

Stronger developmental assessments should be introduced in the early years

Stronger developmental assessments should be introduced in the early years, through enhancing the role of health visitors and through the Department of Health and Social Care expanding antenatal classes from purely clinical into wider relational support for families in navigating the early years of their children's lives.

RECOMMENDATION 4

National expectations on language development should be set

The Department for Education should set clear national expectations for early language development, defining the standard of spoken English a child is expected to reach by school entry and embedding it within the early years foundation stage and reception baseline assessment, so that delays are identified and addressed before they entrench.

Where a child's language development is held back because English is not used or supported at home, the Department for Education and the Ministry of Housing, Communities and Local Government should jointly fund English language provision for parents, delivered through Family Hubs and existing adult education routes, prioritising households identified at birth registration or early years assessment as needing support.

RECOMMENDATION 5

From screens to physical activity through an enrichment entitlement and Right to Sport

Access to enrichment activities such as sport, music, debating, volunteering, and outdoor education remains highly unequal.[103] Pupils from disadvantaged backgrounds are significantly less likely to participate in structured extracurricular activities, limiting opportunities to develop confidence, teamwork, and leadership.

The government should introduce a national enrichment entitlement ensuring that every pupil has access to a minimum number of hours each year dedicated to enrichment activities such as sport, arts, volunteering, outdoor education, and civic engagement. This will be supported by a School Activity Standard in primary schools,[104] and by unlocking the facilities and making pitches, courts, and halls available for more hours of the week. Schools will be expected to provide structured opportunities for pupils to develop character and leadership beyond the classroom.

RECOMMENDATION 6

Restore behaviour and attendance standards in schools

The Department for Education should launch an urgent review of behaviour and attendance standards in schools, alongside a mandatory Attendance Awareness Course for parents of persistently absent children.

The review should examine worsening classroom disruption, violence towards teachers, inconsistent behaviour policies, and the impact on learning and teacher retention. It should establish clearer national expectations for behaviour, discipline, and attendance, with a focus on restoring calm and orderly classrooms.

Alongside this, parents of children with persistent unauthorised absence should be required to attend an Attendance Awareness Course once voluntary support has been exhausted, before fines or formal case management begin.[105] Failure to attend should result in a higher financial penalty.

Together, these reforms would reinforce that good behaviour and regular attendance are core expectations of the school system.

3.2. Reforming the broken SEND system

In the Department for Education's white paper, the reforms to the high needs SEND system are projected to bring costs back down to 'today's level by 2035', peaking in 2030. We can use this to calculate the expected reduction in demand from the interventions.

RECOMMENDATION 7

Introduce primary legislation to reform the SEND Code of Practice to bring in a clearer, narrower, and needs-based statutory definition of SEND

As announced in the white paper, the Department for Education has committed to amending regulations under the Children and Families Act to provide a clearer definition of SEN. This definition should be based on severe and enduring impairment, evidence that universal interventions are inappropriate, and identified appropriate specialised interventions.

Eligibility for statutory assessment should be based on persistent functional impairment in accessing learning, not on diagnosis alone. Clinical diagnosis, including a CAMHS diagnosis, should not determine entitlement to specialist educational provision.

The SEND Code of Practice should be amended to make explicit that most SEMH needs, speech and language difficulties, and mild ASD can and should be met within universal provision.

The notional SEN budget should rise in line with inflation, alongside a time limited SEND Protective Factor Development Grant to build behaviour management and speech and language capacity in mainstream schools.

RECOMMENDATION 8

Ensure specialist statutory support is tightly focused on children with the most complex and enduring needs

The white paper's proposed three-tier system of Targeted, Targeted Plus and Specialist support is a welcome step if specialist statutory intervention is tightly defined, consistently applied, and focused on children with the highest levels of need.

To ensure that the new Specialist layer is reserved for children and young people with severe, persistent and complex barriers to learning and participation, the Government should have a clear expectation that the proportion of children requiring Specialist statutory support should remain limited and stable over time, at a level comfortably below where it is today.

Education, Health and Care Plans should operate as dynamic and regularly reviewed interventions rather than long-term default designations. Annual reviews should re-evidence severity, assess progress, and begin from the presumption that children and young people should move back into lower layers of support where this can be achieved safely. Statutory enforceability should focus primarily on core educational provision rather than creating open-ended obligations around ancillary elements of support such as transportation.

Stronger Targeted and Targeted Plus provision, alongside clearer national thresholds, should also ensure that the perverse incentives to seek EHCPs are remedied, such that intensive statutory support is targeted for the most vulnerable children with the most complex needs. The effectiveness of this should be monitored.

RECOMMENDATION 9

Reduce the market distortions driving unsustainable growth in independent special school costs

The rapid growth in independent special school costs reflects structural failures within the SEND system. Local authorities provide legally enforced demand for specialist placements – especially when schools are named – while lacking maintained specialist capacity.

This effect should be muted when moving towards an outcome orientated EHCP system and substantial tightening of statutory enforceability around named schools and transportation.

Alongside this, the Department for Education should introduce mandatory pricing frameworks for special school placements by providers that are over 50 per cent local authority funded.

RECOMMENDATION 10

Alongside the improvements in the system lowering demand, the Ministry of Justice should amend tribunal procedure to make it clearer and less adversarial

Much of the rapid growth in SEND tribunals reflects wider structural weaknesses in the SEND system. Local authorities are incentivised to reject claims as the statutory framework around EHCPs gives them no alternative rationing mechanism, and the vague definition of SEND alongside equality legislation ensures that parents are almost certain to win any tribunal, incentivising escalation.

Clearer definitions, as in Recommendation 7, alongside strengthened mainstream provision and reduced concentration of enforceable rights within EHCPs as in Recommendation 8 should substantially alleviate this process. However, steps also need to be taken to ensure the tribunal process is less adversarial, and with more balanced incentives, to improve consistency and amicability of proceedings.

The Ministry of Justice should introduce clearer national evidential standards, mandatory pre-tribunal mediation, and greater statutory weight for local provision and the efficient use of public resources when considering named placements and ancillary provision such as transport.

RECOMMENDATION 11

Restore LA commissioning capacity and cost control within the SEND system

Currently, local authorities retain legal and financial responsibility for SEND provision and yet have minimal practical control over placement allocation or cost and demand management. This undermines any sense of local strategic insight and drives up dependence on expensive placements.

The Department for Education needs to strengthen local authority commissioning powers and expand the domain of local authority strategic judgement, alongside sharper accountability. The feasibility of this depends on the successful implementation of recommendations 7, 8, 9 and 10.

3.3. Targeting benefits and expanding early intervention

RECOMMENDATION 12

The Government should better target child benefits to reinvest £0.5 billion in front-line support for children with behavioural needs

Of 900,000 children on CDLA in November 2025, approximately 750,000 were claiming for behavioural disorders, ADHD, or learning difficulties – the conditions driving over 100 per cent of caseload growth since May 2016. IFS analysis of CDLA-to-PIP transition data confirms that the growth in the learning difficulties category is substantially driven by autism and ADHD diagnoses recorded under that label, rather than moderate or severe learning disability.[106]

With spending forecast to rise from £4.8 billion to £7.7 billion by 2030/31, due to a rise in caseload to nearly 1,200,000, the current trajectory is unsustainable. More importantly, for children with milder presentations of need, cash transfers are not the most effective form of support. Evidence consistently shows that structured parenting programmes such as Incredible Years and Triple P Parenting can produce lasting positive outcomes for children with these conditions.[107]

The Government should introduce a new in person assessment of functional care and mobility needs for new and renewed CDLA claims where the primary condition is behavioural, ADHD-related or neurodevelopmental – replacing the current paper-based self-report process with an assessment process equivalent to that used for Personal Independence Payment, in which entitlement is determined by demonstrable functional needs relative to same-age peers. Based on GP clinical evidence that the majority of behavioural and neurodevelopmental diagnoses are given where functional impairment does not warrant them, and that 54 per cent of PIP claims with autism or ADHD as the primary condition are unsuccessful under functional assessment criteria,[108] we estimate conservatively that between 50 and 75 per cent of new claims in this category would not meet a properly administered functional needs threshold. This would see around 151,000 to 227,000 fewer cases by 2030, while children with severe or complex needs would be fully protected at their current award rate.[109]

Of the £980 million to £1.47 billion savings this reform would produce annually by 2030,[110] a £500 million Early Intervention Capital Fund should be ring-fenced and reinvested in parenting and support programmes that meet NICE criteria, funding an estimated 300,000 additional courses[111] to reach families at the point of greatest need, when early intervention is most effective. See Appendix A for two case studies of evidence-based parenting programmes that could be rolled out to support early intervention in behaviour difficulties.

RECOMMENDATION 13

Uprate the highest-rate CDLA care component in real terms to reflect the rising cost of caring for severely disabled children

Child Disability Living Allowance was designed to help families meet the extra costs that severe disability creates – specialist equipment, adapted transport, higher energy bills, overnight care, and products and services that statutory provision no longer reliably covers. The highest-rate care component – paid to children who require help or supervision throughout both day and night – currently stands at £114.60 per week, or £5,959 per year. It serves approximately 272,000 children with the most severe and complex needs, including profound learning disabilities, life-limiting conditions and serious physical impairments.

The highest-rate care component has been uprated annually in line with CPI. Yet the specific costs facing families of severely disabled children – for example, specialist car seats and adapted buggies not covered by NHS provision; posturepedic sleep systems; incontinence products; sensory equipment; and overnight care that was once provided by social services but increasingly falls to families – have risen substantially, while NHS and local authority provision of equipment and support has failed to keep pace with demand.[112] The gap between what this benefit provides and what severe disability actually costs has widened.

The reforms in Recommendation 12 will generate annual savings of between £980 million and £1.47 billion annually by 2030. A portion of those savings – approximately £160 million annually – should fund a meaningful real-terms uplift in the highest-rate care component, raising it by 10 per cent above CPI in the first year of full savings realisation. This will help to restore the real value of support for those whose needs are greatest.

RECOMMENDATION 14

Decouple diagnosis and educational designation from welfare entitlement

Education, Health and Care Plans (EHCPs) and SEN plans should no longer be treated as supporting evidence for Child Disability Living Allowance claims where the primary condition is behavioural or ADHD related.

In practice, EHCPs and SEN support plans increasingly function as near-automatic gateways into CDLA for many children, with 77 per cent of EHCP holders receiving CDLA, 84 per cent of CDLA claimants having an identified SEN, and both being routinely submitted as supporting evidence in CDLA applications.[113]

Child Disability Living Allowance entitlement should instead be more clearly based on demonstrable functional care and mobility needs substantially above those of other children of the same age.

This should be understood as an initial step towards wider long-term reform of disability benefits for children, as are being designed in the Centre for Social Justice's work *Welfare 2030*.[114]

3.4. Restoring accountability and sustainability

RECOMMENDATION 15

Conduct a major review of Alternative Provision

The Government should conduct a major review of the Alternative Provision sector to identify best practice and ensure that tighter EHCP eligibility does not produce negative second-order effects.

This review should focus on quality, reintegration, attendance, behaviour, safeguarding and post-16 outcomes.

RECOMMENDATION 16

Establish a SEND fiscal sustainability framework

The Department for Education and HM Treasury should introduce a SEND fiscal sustainability framework, requiring annual publication of:

- high-needs spending;
- local authority deficits;
- EHCP growth;
- independent special school spending;
- SEND transport costs;
- child DLA caseloads linked to behavioural and neurodevelopmental conditions.

The framework should make explicit that fiscal sustainability is a safeguarding principle and have explicit fiscal targets. A system that spends without discipline fails the most vulnerable children with the most serious needs.

RECOMMENDATION 17

Clarify responsibilities across parents, schools, local authorities and health services

The Government should roll out school charters, including a national SEND responsibility charter, setting out what parents, schools, local authorities and health services are each responsible for.

This should make clear that schools are responsible for high-quality teaching, behaviour, attendance, and universal support; local authorities are responsible for specialist commissioning and statutory provision; health services are responsible for clinical assessment and treatment; and parents are responsible for attendance, routines, engagement with support, and ordinary care.

The purpose of the system should be reset. Not to maximise diagnosis or entitlement, but to help children with genuine need flourish, learn, attend school, and move successfully into adult life.

Appendices

Appendix one: Early intervention case studies

Incredible Years

The Incredible Years parenting programmes are well-evidenced early intervention measures for children at risk of developing, or already experiencing, behaviour problems, ADHD and autism. The Incredible Years programmes are 12–14-week courses targeted at different groups, such as parents of pre-school children with early conduct problems, or primary school children with ADHD symptoms, or primary school children with autism diagnosis/suspected autism/speech and language delay.

Following successful trials, the Incredible Years programmes have been adopted and rolled out by some UK councils, and they could be made more widely accessible to families of children with behaviour difficulties if funding were set aside for early intervention.

ADHD and conduct problems

In Bradford, the Incredible Years Preschool Programme is delivered by Barnardo's through family hubs, available to any family with a child aged 3-4 needing support with speech and language development, routines, attachment, boundaries and social interactions.[115] A study of the programme's efficacy with pre-school children at risk of behaviour problems and ADHD found that 52 per cent of children whose parents completed the programme showed clinically reliable improvements in inattention and hyperactivity post-intervention.[116] An 18 month follow-up study confirmed that these improvements were maintained over time, and also recorded a decline in families' reliance on formal services.[117]

Another study of children aged 3-7 displaying ADHD-type behaviours showed that children of parents participating in the Incredible Years Basic Parent Training Programme showed lower levels of hyperactive and inattentive behaviour post-intervention than children in the 'waiting list control group', and higher levels of social competence.[118] Parents also reported that their child's behaviour was calmer and less agitated after the intervention, and that the programme helped them identify and address their own negative parenting techniques that impacted their child's behaviour.[119]

Autism and Language Delay

North Somerset, Southwark and Merton, among other councils, offer the Incredible Years Autism and Language Delay programme through family hubs to parents and carers of children aged 2-7 displaying traits of autism or already diagnosed. This course is focused on helping parents build children's self-regulation, social skills, emotional understanding and language. Parents who completed the programme in a trial in Wales reported improvements in children's social-emotional, pre-academic and self-regulatory skills.[120] A trial conducted by the Northern Health and Social Care Trust in Northern Ireland found that parents reported improvements in their child's autism-characteristic behaviours and the impact of these behaviours on everyday functioning.[121]

National scaling

The delivery infrastructure for Incredible Years exists, as the programmes are already operating in family hubs and NHS trust settings across the UK. The £500 million Early Intervention Capital Fund proposed in Recommendation 12 would fund around 300,000 Incredible Years courses at an estimated cost of £1,700 per family.[122] This would scale these local initiatives up into a national offer available to all families at the point of greatest need.

Triple P Positive Parenting

Early intervention funding could also be used to roll out the Triple P Positive Parenting Programme. The Triple P Programme is a public health approach to parenting support that is designed to build parents' skills in managing behavioural issues through different levels of intervention, such as online or community seminars or eight weeks of group sessions.

Numerous trials show a positive impact of the interventions on children's behaviour.[123] In one example, the Positive Parenting Programme was made universally accessible to parents in a three year trial in two counties in Ireland, and was found to be effective at reducing cases of children with clinically-elevated emotional and behaviour problems by 37.5 per cent.[124]

A trial specifically targeting pre-school children with co-occurring disruptive behaviour and attentional and hyperactive difficulties found that both standard and enhanced Triple P were associated with significantly lower levels of parent-reported child behaviour problems compared with a waiting list control group, with improvements maintained at 12-month follow-up.[125] A trial of the online self-directed version of the programme 'Triple P Online' with families of pre-school children displaying extreme levels of hyperactivity and inattentiveness found significant post-intervention improvements in mother-rated child hyperactivity and inattention, restlessness and impulsivity, defiance and aggression, and social functioning, as well as teacher-rated prosocial behaviour.[126]

National scaling

Triple P has a flexible delivery format and scale. Between 2023-25, the Department of Health and Social Care commissioned Triple P UK to train 680 practitioners across all 75 Family Hubs and Start for Life areas in England to deliver the Triple P for Baby programme, demonstrating that national rollout at scale is both feasible and has recent precedent. Lower-intensity levels of intervention can be delivered via self-directed online materials, making the programme accessible to a wide range of families, including those who would not attend more intensive group sessions. The tiered structure means Triple P can function as both a universal early offer and a targeted intervention for parents whose children are already displaying significant difficulties, with group programme delivery at a similar estimated cost to Incredible Years.

Appendix two: rising cost of support for children with additional needs

Table 2 – Spend on high need support for children with additional needs, 2015/16-2026/27, £ billions, 26/27 prices

Financial year	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26	2026 - 27
SEND (nominal)	5.7	5.9	6.4	6.7	7.1	7.7	8.6	9.7	11.1	12.7	14.8	16.3
SEND (26/27 prices)	8.0	8.2	8.7	9.0	9.2	9.5	10.6	11.2	12.2	13.4	15.1	16.3
CDLA (26/27 prices)	2.6	2.6	2.7	2.8	3.0	2.8	3.0	3.3	4.0	4.8	5.4	6.1
UC disabled child element and carer's allowance or equivalent (26/27 prices)	1.7	1.7	1.8	1.9	2.0	1.9	2.0	2.2	2.7	3.2	3.6	4.0
Total (26/27 prices)	12.4	12.5	13.2	13.7	14.2	14.2	15.6	16.7	18.8	21.4	24.1	26.4

Source: SEND: Office for Budget Responsibility (2025) Economic and Fiscal Outlook, November 2025. Available at: https://obr.uk/efo/economic-and-fiscal-outlook-november-2025/#chapter-5 (Accessed: 28 May 2026). Chapter 5. Chart 5.A. CDLA: Department for Work and Pensions (2026) Spring Forecast 2026, DWP Expenditure and Caseload Tables, Table 2b Available at: https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2026 (Accessed: 29 May 2026). UC disabled child element and carer's allowance: Centre for Social Justice analysis of Institute for Fiscal Studies (2025) *Support for children with disabilities and special educational needs.* Available at: https://ifs.org.uk/publications/support-children-disabilities-and-special-educational-needs (Accessed 6 May 2026). Source, GDP deflator: HM Treasury (2026) GDP deflators at market prices, and money GDP March 2026 (Spring Statement). Available at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2026-spring-statement (Accessed: 29 May 2026).

Notes: UC disabled child element and carer's allowance counts the income received by families on universal credit that include a child who received CDLA, who can also claim the disabled child element of UC and, if someone in the household spends at least 35 hours a week caring for a child with CDLA, the carer's element. The IFS estimated that spending on these passported for CDLA claimants in England (2025/26 prices) was £3.1bn in 2024-25. It is difficult to trace how spending on these benefit elements has changed over time, due to UC being rolled out gradually over the last decade, and there being limited data on the disabled child elements of its predecessor benefits (such as the disabled child element of Child Tax Credit and disability premia within the legacy system). As such, we have adjusted to 2026/27 prices and have then assumed, considering the passported nature of these benefits, they have grown – and will continue to – at the same rate as CDLA. Please also note that the totals are calculated from unrounded figures and may therefore differ slightly from the sum of the rounded components shown. Please finally note that SEND and the UC disabled child element and carer's allowance figures relate to England. CDLA figures are for Great Britain; from 2021 these increasingly exclude Scotland as recipients migrate to the devolved Child Disability Payment, bringing the series progressively closer to an England-and-Wales basis over the forecast period.

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