Supporting Children
Young People
and Families

Towards Needs Led Support

Reclaiming Social and Emotional Development in a Diagnosis Driven System

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Summary

This briefing explores how rising neurodevelopmental referrals intersect with children's access to the environments and relationships that support core developmental tasks — particularly emotional regulation and social competence. It considers the ways in which diagnostic assumptions, referral processes, and system incentives can unintentionally limit children's opportunities to practise and develop these skills, regardless of whether a diagnosis is ultimately reached. The paper draws on data, research and lived experience to highlight the importance of early, inclusive, and needs-led support models that preserve developmental opportunities while avoiding unnecessary delays, separation, or misinterpretation.

Introduction

The past decade has seen a marked increase in referrals of children and young people to neurodevelopmental services for diagnosis of conditions such as Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). This rise reflects greater awareness and a desire to support neurodiverse children — a positive shift in many respects.
But it also raises questions.

Are we, in trying to help, sometimes diverting children away from the very developmental opportunities they most need?
Might some referrals reflect not a fixed neurodevelopmental difference, but a child's response to relational stress, adversity, learning difficulties, or inconsistent environments — behaviours that are situational, fluid, and potentially short-lived?
And could we be narrowing our understanding of these behaviours by interpreting them too quickly through a diagnostic lens?

At the heart of this issue is children's access to the relationships, environments and expectations that build social competence and emotional regulation — foundational skills for learning, wellbeing, relationships, and life chances. The ability to navigate social contexts, manage emotion, and persist in the face of difficulty is shaped through lived experience and repeated practice, particularly during early and middle childhood.

This briefing explores the potential unintended consequences of rising ND referrals. It considers how diagnostic framing, systemic incentives, and access routes to support may, in some cases, reduce rather than expand children's opportunities to develop core life skills. It also highlights the ethical tensions for practitioners navigating this system — and the importance of inclusive, needs-led models that offer help based on what it is that children, young people and families, need.

The Landscape of (Rising) ND Referrals

Recent NHS data highlights the scale of demand for neurodevelopmental (ND) assessment:

- ADHD: As of March 2025, 549,000 people in England were awaiting an ADHD assessment — a 13.5% increase from the previous year. Of those diagnosed, an estimated 741,000 are children and young people aged 5–24 (NHS Digital, 2025b).
- Autism: There were 224,382 open referrals for suspected autism, 89.9% of which had breached the 13-week target wait. This is a steep increase from 143,119 open referrals in June 2023 (NHS Digital, 2023; NHS Digital, 2025a).

The system remains under sustained pressure. These rising numbers have resulted in prolonged waits across services. Data from the Children's Commissioner for England (2024) shows:

- ADHD assessments in community services average 2 years and 5 months.
- Autism assessments average 2 years and 2 months.
- Referrals into mental health services also face delays of over a year.

Such delays coincide with critical windows for children's brain development and relational learning — particularly in early and middle childhood (WHO 2018). The consequence is not just deferred diagnosis, but deferred support, at the very time when children's emotional and social capacities are most malleable.

This surge in referrals has significant knock-on effects beyond Neurodevelopmental services:

- Child and Adolescent Mental Health Services **(CAMHS) report growing bottlenecks** as diagnostic pathways absorb more capacity. In some cases, children presenting with anxiety, trauma, or family stress are referred for ND assessment — not because practitioners are confident in that formulation, but because it *could* be possible.
- **Children's social care too feel strain**, as they feel like they lack the specialist knowledge or understanding of medical conditions to appropriately respond to a (presumed) medical diagnosis.
- **Similarly, colleagues in education refer to Educational Psychologists, or begin a process of asking for an Education and Health Care Plan (EHCP)** to provide bespoke guidance and advice on how best to support a child with a perceived medical diagnosis and need.

NHS England (2024) has acknowledged this pressure, describing a system shaped by "diagnostic gatekeeping" — where access to help is often contingent on formal labelling. The result is an overloaded referral system, with consequences not only for children with developmental differences, but also for those whose needs are relational, emotional, or contextual in nature.

Interpreting Behaviour: Diagnostic Framing vs Contextual Understanding

How we interpret a child’s behaviour has deep implications for how they are supported. Increasingly, systems lean towards identifying neurodevelopmental conditions to explain patterns of distress, difference, or difficulty. This can be protective and helpful — when accurate. But when diagnostic language becomes the default frame for understanding behaviour, nuance is lost. We risk missing the broader social, emotional, and environmental influences that shape children’s development.

Behaviours such as inattention, agitation, defiance, poor social skills, or withdrawal can stem from a wide range of causes:

- Relational stress or insecure attachment
- Parental mental health difficulties
- Learning needs such as dyslexia
- Exposure to chronic adversity or trauma
- Interacting more through use of technology, texting, emoji’s etc rather than ‘face-to-face’ (where someone establishes and maintains eye contact for example), a note here that there is a generation of children and young people who missed significant amounts of schooling and opportunities for social interaction and relationships due to Covid-19 and lockdowns.

In many cases, these behaviours may be situational or transient. But under pressure to act, systems often treat them as symptoms of a neurodevelopmental disorder. This can narrow the response — directing children down pathways that emphasise diagnostic clarification over relational, contextual, or needs-led support.

Timimi et al. (2017) have critiqued this medicalisation of adversity, warning that pathologising normal responses to difficult circumstances can obscure what’s really going on. NICE guidance (2018) echoes this, emphasising that diagnostic assessment should always include a careful consideration of environment, caregiving, and lived experience.

The problem is compounded by diagnostic overshadowing. Once a child is referred — or even suspected — of having Autism or ADHD, other potential explanations for their behaviour are often overlooked. Davidson (2025) warns that professionals may unintentionally attribute all presenting issues to a presumed diagnosis, even when trauma, unmet learning needs, or family dysfunction are more likely causes.

The lens through which we view a child determines the kind of help we offer.
When that lens is too narrow, support may be misdirected — and opportunities to promote development in the here and now can be lost.

Navigating the System: Provision, Pathways and Ethical Pressures

In theory, support for children should follow need. In practice, it often follows diagnosis. This has led to the gradual entrenchment of what many practitioners describe as a two-tier system — one where access to help, funding, or specialist input is contingent on a clinical label. As a result, professionals and families can find themselves navigating not just what a child needs, but what label is most likely to unlock it.

Teachers and SENCOs consistently report being caught in this bind. Without a confirmed diagnosis, requests for teaching assistant time, specialist intervention, or statutory assessment are more likely to be rejected. Some describe the process as a form of reverse engineering — identifying the diagnostic route most likely to generate provision, rather than the one that best fits the child's profile. This is not a criticism of frontline practice, but of a system that has normalised workarounds.

The same dynamic applies in health. Referrals to CAMHS or community paediatrics are sometimes framed through a neurodevelopmental lens, not because this is the most accurate explanation, but because it is the most viable route to support. In many areas, ND referral pathways are the only clear and funded routes for children struggling with behaviour, regulation, or distress.

Families, too, are acutely aware of the dynamics at play. Research by the Children's Commissioner (2022) captures the frustration of parents who feel forced to 'medicalise' their child's needs in order to be heard. The cumulative impact of waiting lists, vague eligibility thresholds, and system fatigue can lead families to push for diagnoses — not necessarily because they believe their child has autism or has ADHD, but because it seems to be the only way to get help.

While these pressures are understandable, they carry costs. Once a referral is made — particularly for neurodevelopmental assessment — there is a strong likelihood that the child will be managed differently. This might mean a reduced timetable, withdrawal from mainstream activities, or informal social exclusion. It can also shift the tone of conversations between professionals, and between adults and the child themselves. Over time, the focus moves from what the child is learning or developing to what their diagnosis is or might be. Opportunities for growth may narrow just at the moment they are most needed.

Professionals report a parallel ethical discomfort. Some describe feeling compelled to refer despite doubts about diagnostic fit, because they know the system won't respond otherwise. Others express concern that children are being managed differently based on suspicion or label, rather than need. In both cases, the principle of equitable, needs-led support becomes compromised.

The result is a system where the route to help is not shaped by what will most benefit the child, but by what will most likely be accepted or resourced. This has a chilling effect on reflective practice and ethical decision-making. When the conditions for inclusive, developmental support are made contingent on diagnosis, the system begins to confuse access with identity — and in doing so, risks losing sight of the child altogether.

Developmental Impacts: Social, Emotional, and Educational

The consequences of interpreting children's behaviours as neurodevelopmental — and managing them as such — are not confined to assessment outcomes. Even before a diagnosis is made, the pathway a child enters can begin to reshape their experience of education, social relationships and emotional learning. When children are excluded from developmentally rich environments, or redirected into narrower contexts framed around 'difference', the effects on growth and identity can be lasting.

Social Development

Children develop social skills through participation, observation and repetition. Conflict resolution, cooperation, empathy, self-advocacy — these are not abstract competencies but learned behaviours, built over time through engagement with diverse peer groups and settings.

When children are removed from mainstream environments, either because of behaviour that is assumed to be neurodevelopmental or in anticipation of a diagnosis, they may miss these opportunities. Common consequences include:

- Reduced exposure to varied peer interaction (e.g. mixed-ability group work, playground negotiation, team activities)
- Fewer chances to model or internalise pro-social behaviours
- A narrowed view of social norms, with interactions primarily limited to others experiencing similar challenges

While smaller or specialist environments can be protective in the short term, they can also limit the scope of children's social experience — especially if they are organised primarily around managing behaviour or assumed difference. Over time, this can lead to entrenched social skill gaps which are then taken as confirmation of an underlying neurodevelopmental condition, reinforcing the original assumption.

As Han and Weiss (2005) observed, inclusive educational environments support children in developing confidence and competence by allowing them to observe a wider range of peer behaviours. This is true not only for children with diagnosed needs, but also for those whose behaviours are transient or contextual. The inverse is also true: separation, even when well-meaning, can prevent development of the very skills children are believed to lack.

Emotional Regulation and Co-Regulation

Emotional self-regulation is another core developmental task — one that is shaped not through instruction alone, but through repeated opportunities to experience, express, contain and recalibrate emotions in safe contexts.

Settings that provide relational safety, consistent expectations, and the opportunity to co-regulate with peers and adults are essential for this process. But when a child is seen primarily through a diagnostic lens — or positioned as unable to cope with emotional challenge — they may be removed from these settings. This can happen through:

- Reduced timetables
- Learning in separate rooms or units

- Being exempted from emotionally demanding tasks (e.g. group work, performances, PE)
- Receiving highly structured support that avoids, rather than scaffolds, emotional challenge

Denham et al. (2012) stress the importance of co-regulation as a foundation for emotional competence. When opportunities to practise this are limited, children may internalise the idea that they are incapable of managing emotion — or come to believe that distress must be avoided rather than navigated. This risks embedding low tolerance for frustration or challenge, limiting growth in areas such as resilience, interpersonal trust, and stress recovery.

Crucially, these patterns may be understood — by the child or by others — as evidence of neurodevelopmental difference, when they are equally attributable to missed opportunities for development.

Educational Placement and Learning Culture

Decisions about school placement are among the most consequential that professionals and families make. When placements are made based on assumptions of ND rather than confirmed need, the developmental implications can be wide-ranging.

Children educated in mainstream settings with appropriate scaffolding often benefit from:

- Higher academic expectations and broader curriculum access
- Wider peer modelling
- Greater access to extracurricular activities
- A stronger sense of inclusion and belonging

While specialist or alternative provision may offer a more tailored or emotionally safe environment, it can also mean exposure to fewer peer models, reduced curriculum breadth, and a perception — internal or external — of being 'different' or 'less capable'. These trade-offs need to be openly considered and not bypassed due to diagnostic assumptions.

The meta-analysis by Ruijs and Peetsma (2009) found that students with additional needs placed in inclusive settings had more positive social outcomes and, in some cases, stronger academic trajectories than those educated separately. Notably, this applied even to children without a confirmed diagnosis — further supporting the case for holding inclusion as a default, rather than an exception requiring justification.

Longer-Term Consequences Across the Life Course

The developmental implications of being removed from emotionally and socially rich environments are not confined to childhood. Gaps in emotional regulation, social competence, and identity formation can persist into adolescence and adulthood—shaping future relationships, employment, and parenting capacity.

Research shows that children who do not have consistent opportunities to co-regulate, manage peer relationships, or encounter developmentally appropriate challenge may carry these unpractised skills forward. This is not merely a matter of missed milestones, but of altered developmental trajectories. Children managed predominantly through behaviour control or diagnostic labelling can internalise a sense of fixed limitation—developing identities rooted in deficit rather than growth.

Morris et al. (2022) provide compelling evidence that parental emotional regulation is significantly associated with children's emotional adjustment and behaviour. When adults have not developed robust regulation capacities themselves—often due to gaps earlier in life—the result can be patterns of inconsistent caregiving, heightened stress responses, and difficulty maintaining healthy boundaries. These patterns, in turn, increase the risk of adverse outcomes for the next generation.

From a systems perspective, the cumulative effect of unmet developmental needs can be far-reaching. Poor adult regulation and unresolved relational patterns can lead to increased use of public services, lower employment retention, higher rates of family breakdown, and challenges in engaging with community structures. These are not inevitable outcomes, but they are predictable when developmental needs are sidelined in favour of narrow diagnostic pathways or exclusion-based management approaches.

The imperative, then, is early and inclusive developmental support—not simply to avoid immediate distress, but to lay the groundwork for relational stability, educational engagement, and emotional resilience throughout the life course. Investing in inclusive, developmentally informed support now is an act of long-term prevention as much as it is a response to present needs.

It's also worth stepping back and reflecting on what we want childhood to prepare young people for. Children who are autistic, have ADHD, learning difficulties, or any other form of difference—will grow into adults who deserve the same opportunities for relationships, employment, and community as anyone else. In adulthood, we expect people to work alongside others with a wide range of personalities, communication styles, and life experiences. That variety is not only normal but essential in any healthy workplace or community. So by separating children early on—whether physically, socially, or via the narratives we build around them—are we unintentionally creating adults less able to live, work and relate alongside others?

Inclusive, Non-Diagnostic Support Models

In recent years, a growing number of schools, local authorities and integrated systems have begun trialling more flexible support models that do not rely on diagnosis to access help. These approaches reflect a shift away from threshold-based or diagnostic gatekeeping, towards inclusive practices that meet children's needs early—before labels are applied or entrenched. When used well, these approaches can help preserve children's access to mainstream developmental experiences while still offering tailored support where needed.

Common features of these inclusive models include:

- Trauma-informed environments that recognise the impact of adversity on behaviour and learning.
- Nurture groups and dedicated emotional literacy interventions that help children build regulation and resilience in small, relationally secure settings.
- The Zones of Regulation and other structured tools to support emotional awareness, communication and self-control.
- Peer mentoring and social-emotional learning (SEL) curricula embedded across the school day.
- Whole-school behaviour policies that prioritise relational repair over exclusion or withdrawal.

Crucially, these approaches do not require a formal diagnosis to be activated. They assume that all children benefit from consistent relationships, clear boundaries, emotional vocabulary, and structured opportunities to co-regulate and try again. Rather than placing the onus on a label to unlock support, these systems offer help as part of the standard developmental scaffold of school life. They reflect a shift from "what's wrong with this child?" to "what does this child need — and how can we help them access it now?"

Research supports their impact. The Education Endowment Foundation (2023) found that many of these strategies—particularly when embedded school-wide—are both cost-effective and scalable, producing measurable gains in emotional readiness, behaviour, and engagement for a broad spectrum of learners. Importantly, they can be implemented without waiting for referrals, panels, or clinical thresholds to be met. By reducing reliance on overstretched diagnostic services and helping prevent children being placed on referral pathways where they may wait years for clarity — or never receive it; they help preserve what matters most: the child's right to feel safe, understood, and included within their everyday environments.

This is not about bypassing specialist assessment or minimising the importance of diagnostic clarity where appropriate. Rather, it is about ensuring that developmentally appropriate help is not delayed. These inclusive models create space for children's strengths to emerge, for behaviour to be understood in context, and for systems to respond with curiosity rather than categorisation. For children whose difficulties are situational or short-lived, this may be enough. For those with enduring neurodevelopmental differences, such environments are still the best foundation on which to build.

Support should not be a reward for a diagnosis. These inclusive models remind us that many of the most effective forms of help are those that meet children where they are — before their needs become entrenched, medicalised, or misunderstood.

Lived Experience and Reflective Practice

While policy, referral data, and academic research provide important context, the most meaningful insights often come from those living and working within the system. Children, families, and practitioners consistently describe the emotional and practical toll of navigating diagnostic pathways—not because diagnosis itself is harmful, but because access to meaningful support is often dependent on it.

Families repeatedly report feeling forced to frame their child’s behaviour as a medical problem in order to be taken seriously. The Children’s Commissioner (2022) highlights this concern, noting that many parents feel they have no choice but to pursue labels that may or may not reflect the full story, simply to access help. This pressure can distort both how children are seen and how they see themselves. Being told—directly or indirectly—that one is different, broken, or deficient can shape self-concept in ways that affect confidence, motivation, and identity for years to come.

Children internalise the narratives that surround them. Before adolescence in particular, their developing sense of self is highly shaped by adult perception and peer feedback. When that narrative is primarily deficit-based—focused on what's "wrong" with them, or “different” about them; rather than what they need to thrive—it can limit agency, reduce aspiration, and increase the risk of learned helplessness. This is not just a question of language, but of opportunity: when the support on offer reinforces separation or pathology, children are less likely to experience themselves as capable, included, or expected to grow.

Professionals, too, often feel the strain of this dynamic. Many describe ethical discomfort with a system that prioritises referral and labelling over developmental support. Teachers, SENCOs, and health professionals report feeling they must frame need as neurodevelopmental—even when they believe other contextual or emotional explanations better fit—because this is what secures resources. These compromises wear down reflective practice. Over time, they can contribute to burnout, role confusion, and diminished trust between sectors.

Supervision, peer discussion, and structured time for reflection are often lacking in overstretched services, yet they are vital if practitioners are to resist reductive narratives and maintain a clear, values-based approach to support. Making space to ask, “What do I really think is going on here?” is not a luxury—it’s a necessity for ethical and effective practice.

Conclusion

The rising volume of neurodevelopmental referrals reflects multiple realities at once: growing awareness, unmet need, and pressures within systems that link support to diagnosis. For some children, referral leads to timely recognition and helpful intervention. For others, it may result in exclusion from developmental opportunities, prolonged uncertainty, or assumptions that narrow the lens through which their behaviour is understood.

This paper has outlined how diagnostic framing can, in some cases, overshadow relational, contextual or situational explanations. It has shown that pathways intended to help can unintentionally delay access to support, particularly when diagnostic criteria are used as gatekeepers rather than guides.

Children develop social and emotional skills through experience — by being with others, managing challenges, and building trust in relationships. When those opportunities are limited, either by system design or by the assumptions we make about difference, development itself can be disrupted.

There is no single solution. But there is space — within education, health, and community systems — to strengthen needs-led support that does not depend on diagnosis. Inclusive environments, early relational help, and flexible pathways all have a role to play in ensuring that children can access the support they need while still participating in the settings where development happens.

Reflective practice, careful interpretation, and attention to lived experience remain central. So too does the ability to hold complexity — to respond to behaviour without rushing to label it, and to support development without first requiring evidence of disorder.

Final thought

The increasing volume of neurodevelopmental referrals reflects a system under strain — one that too often requires a diagnosis in order to act. While diagnosis has a role, it should not be the sole route to support. Many children need help long before their difficulties are fully understood, and not all require a clinical label to thrive.

What children need most are consistent relationships, access to developmentally rich environments, and systems that respond to their behaviour with curiosity and care.

Inclusive, needs-led approaches can:

- Protect children’s access to social and emotional learning opportunities
- Reduce reliance on stretched diagnostic pathways
- Help prevent the long-term consequences of exclusion or misinterpretation
- Enable professionals to work with integrity, without compromising values to navigate a broken system

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