

Holistically bridging the gap between education and healthcare

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ORIGINAL ARTICLE

Holistically bridging the gap between education and healthcare: A case study model of assessment

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Abstract

In today's special educational needs and disability system, children spend an incomprehensible amount of time on waiting lists to see specialists, and teachers and parents spend an inordinate amount of time trying to target support when a child's needs are unidentified and unclear. This case study looks at the current pathway to support for children with neurodiversities in UK mainstream schools, considering in detail the role of the professionals around the child, in particular the SENCo. In this case study, three children are discussed; in these cases, an additional layer of assessment was included in the referral system, using Frith's causal modelling. This resulted in a more accurate and timely diagnosis of neurodiversities, whether singular or co-occurring, in each case. The additional assessment level was undertaken by a developmental psychologist (DP) who acted as a catalyst for the assessment process and an advisor to target intervention. Following a holistic assessment by the DP, one child was diagnosed with autism on the NHS within three months of the assessment, one child was diagnosed with attention deficit/hyperactivity disorder on the NHS within six months of the assessment, and one child had a dual diagnosis of dyslexia and dyspraxia. Moreover, importantly, only one child's outcomes matched the SENCo's initial diagnostic hypothesis. Two possible, and probably controversial, assessment models are proposed, that take the guesswork out of the referral process for the SENCo, saving time and money across all sectors, while considering a child's needs holistically and wholly.

KEY WORDS

assessment, children, education, neurodiversity, psychology

Key Points

- SENCos and teachers have limited training, if any, in the identification and support of neurodiversities, yet SENCos are the gatekeepers to referral for children with special educational needs, disability and neurodiversities.
- Current systems require SENCos to decide on the appropriate referral pathway for children who make less than expected progress or have decreased emotional well-being.
- Ensuing specialist involvement may then echo SENCo concerns, diagnose and make targeted recommendations; or may be a costly experience leading to an impasse with little direction; wholly depending on the match of specialist to referral.
- This study proposes, through case study, two new routes to specialist support, proposing that SENCos and/or specialist teachers are upskilled, to enable a

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clearer and more targeted referral system in the first instance, ultimately taking children's needs and support into account holistically and saving specialist services time and money.

INTRODUCTION

When a child makes less progress than expected, shows concerning behaviours, or appears to have decreased self-esteem and/or emotional well-being, a school should follow a protocol that first recognises and acknowledges strengths, and then identifies difficulties, differences and areas of need. Following this, the school can then put into place an approach that draws on successive cycles of assessment, intervention and review: the graduated approach (DfE, 2015, p. 5.38). Where this approach makes insufficient progress, schools, with parents, have an obligation and moral duty to seek guidance from external professionals with special expertise to support the child in their learning and socio-emotional development (DfE, 2015, p. 5.48). Such professionals could include, among others, speech and language therapists, specialist teachers, educational psychologists, occupational therapists, community paediatricians, clinical psychologists and general practitioners. However, to refer to the correct expert effectively, the teacher and SENCo in the educational setting would be supported by having a well-founded rationale as to the cause of the child's needs.

This article argues that the decision made by the SENCo, at this point, at school level, is crucial to optimise the decision-making process about whom to involve to support the young person, as errors in judgement can be both costly and counterproductive. The task of determining the ideal referral pathway, in the first instance, can undeniably be challenging for school staff. This process requires a deep level of knowledge as to how to observe behaviours, and in turn how these might be associated, at a multi-faceted level, with cognitive, developmental and environmental differences or influences (Frith, 1999). Teacher training, including Initial Teacher Training and Early Career Frameworks (DfE, 2019) and SENCo training, does not (National Award for SEN Co-ordination) and will not (SENCo National Professional Qualification) include guidance or instruction on such complex interactional analyses.

In addition to being able to hypothesise the underlying determinants of a child's learning or social, emotional and mental health needs, a SENCo also needs to consider the areas of expertise, service delivery and type of analysis and support offered by each specialist field, an area of much variation across local authorities. Examples include knowing that 'Educational psychologists look at how children and young people experience life within the context of their school and home environment and how different factors in these environments interact with each other' (BPS, n.d.). The educational

psychologist's focus may be on a child's learning and well-being, identifying strengths and difficulties. Using an approach based mainly on constructivist psychology, education psychologists have a fluid view, using contextualised assessments that are also informed by consultations and observations of classroom behaviours and interactions with the environment. Specialist teachers, on the other hand, have a more circumscribed focus, with expertise in cognition and learning, for example, in dyslexia or dyscalculia, acquired from direct teaching and practitioner training in the chosen specific learning difficulty (BDA, n.d.). Referrals to CAMHS (Child and Adolescent Mental Health Services) may lead to involvement from well-being practitioners, or a consultation with a clinical psychologist, trained to reduce psychological stress and promote psychological well-being in children and adolescents (NI Direct, n.d.), and with additional top-up specialist training and supervision, clinical psychologists might also choose to diagnose autism and attention deficit/hyperactivity disorder (ADHD). Community paediatricians are specifically trained to acquire the key capabilities to diagnose and support childhood developmental conditions such as developmental co-ordination disorder (DCD/dyspraxia), autism and ADHD (RCPCH, 2021), but in a number of authorities they only diagnose a child with such difficulties up to the age of five (Derbyshire Healthcare, n.d.; Midlands Partnership University, n.d.). Understanding and appreciating fully the foci of the training and services provided by each specialist is therefore a necessity for the SENCo.

When deciding on the most suitable professional to refer to, a SENCo must also consider the cost of the referral, value for money and impact on the total SEND budget. With fees for specialist teachers and educational psychologists being around £90 to £150 per hour (Staufenberg, 2022) (a price often exceeding an annual core subject budget in small schools), and soaring waiting times for specialist involvement (Tidman, 2022), the importance of this decision cannot be underestimated.

Accordingly, the conclusion made at the point of referral to external agencies, by the SENCo, can be pivotal in attaining the necessary assessment and targeted support. To this end, SENCos often revert to screening children for the difficulties they suspect a child may have using published screening tools, such as the dyslexia screener from GL Assessment and the QbCheck (Ulberstad, 2016). However, such tools are a long way from being diagnostic and are not endorsed as such. Screening tools are just that, demanding an adept understanding of the outcomes, with current guidelines clearly stating that screeners should not be used for diagnostic purposes (BDA, n.d.; Hult et al., 2018; NICE, 2023).

Figure 1 is a simplified illustration of the current approach to the diagnostic and support route. In this figure showing the current pathway, a difference in behaviour is observed by the teacher and reported to the (non-specialist) SENCo, who then makes the relevant observations and assigns the child to the specialist professional considered relevant, based solely on the SENCo's knowledge. The professional then may, or may not, diagnose the suspected difficulty; if not, the cycle begins again.

This assessment system could be described as intensely channelled and compartmentalised. A child's well-being and attainment, and in essence life chances, thus depend heavily on the SENCo as a gatekeeper. Yet, even with an understanding of preliminary assessment data, and of agency roles, the SENCo's choices risk becoming a speculative process and at times a gamble, involving constant and unnecessary pressure on the SENCo.

This article considers a case study where an additional, more generalised, level of assessment was included within the referral system, resulting in a more timely and valid assessment of need for all the children involved. The additional assessment layer was undertaken by a developmental psychologist (DP) who acted both as a catalyst for the assessment process, and as an advisor to targeted intervention. The DP was affiliated with a trust of schools and supported SENCos and teachers with SEND and inclusion work, while also having a close relationship with community paediatricians in the locality. The DP had a PhD in developmental psychology, specialising in sensorimotor differences, a Master's degree in psychology, and qualifications to assess and teach specific learning difficulties. The DP was an Associate Member of the British Dyslexia Association (AMBDA), a Chartered

Psychologist with the British Psychological Society (BPS) (CPsychol) and an Associate Fellow of the BPS (AFBPsS), and held a relevant Assessment Practicing Certificate (APC), had experience of teaching, and was trained in using standardised diagnostic assessments for autism, ADHD and dyspraxia for research and clinical purposes (Autism Diagnostic Observation Schedule 2nd Edition (ADOS-2; Lord et al., 2012); Autism Diagnostic Interview – Revised (ADI-R; Lord et al., 1994); QbCheck (Ulberstad, 2016); and Movement Assessment Battery for Children (Movement ABC; Henderson et al., 2008)).

It is important to understand here the difference between the role of the DP and that of other psychologists in assessing special educational needs in schools, such as educational psychologists (EPs). In this instance, the DP was able to apply knowledge grounded in cognitive and biopsychological development to profiling a child's needs, by using targeted norm-based psychometric assessment batteries, such as that utilised by specialist teachers to assess specific learning difficulties, as well as criterion-based diagnostic assessments, such as those used by paediatricians, in addition to understanding contextualised differences in a child's presentation through interviews and observation. EPs, on the other hand, support children in schools using a more constructivist approach, based broadly on the belief of pioneering psychologists such as Vygotsky (1978), that children essentially construct their own realities. EPs therefore consider children's needs in a more fluid fashion, for example looking at motivational factors to encourage mastery of goals (Castelló & Botella, 2006) and environmental contingencies that may impact on behaviour. Research also indicates that partial psychometric evaluations of aptitude are commonly featured in EP involvement, due to the primary aim of assessment, which often



FIGURE 1 Current cycle, behaviour reported and SENCo makes the decision as to what the difficulty might be and which professional to refer to.

high-quality teaching strategies, in addition to the ability to access autism groups in the local area based on the detailed assessment carried out.

In this instance, support was given in timely manner, as John did not have to wait two to three years to be diagnosed with autism following repeated visits and ‘ping pong’ between services and school. Cost was minimal as, in addition to school and parent support, John saw only the DP attached to the trust and then the paediatrician on the NHS. In this instance the school SENCo had suspected autism, which was supported quickly and fully.

STUDY 2: NISHAL

No professionals were previously involved in Nishal's case, with the exception of those providing regular eye tests and a hearing assessment. [Table 2](#) specifies the assessments and observations completed for Nishal.

This information, again collated through background history and assessment, was given as a detailed narrative to the parents and the school. In this instance, the school SENCo had suspected dyslexia due to Nishal's slow reading and spelling difficulties. However, Nishal did not demonstrate any difficulties with phonological awareness, his reading was accurate and in some areas above average, and his spelling difficulties were only apparent during prolonged writing and not during spelling tests. However, the pervasive slowness of working, low to below-average symbolic, non-symbolic and visual processing, high levels of reported inattention by observation and subjectively by questionnaire, in addition to objective measures on the QbCheck, created a profile indicative of ADHD, predominantly inattentive. This profile was given to the school and Nishal was diagnosed and treated for ADHD within six months, following a consultation with a community paediatrician. The DP also signposted the parents, the school and Nishal to a number of interventions and high-quality teaching strategies.

Support was given in timely manner and cost was minimal, as Nishal saw only the DP attached to the trust and then the paediatrician on the NHS. In this instance, the school SENCo had suspected dyslexia; this was not the final outcome for Nishal. If the school had engaged a dyslexia specialist, the outcome of this assessment would probably have been ‘not at risk of dyslexia’, and Nishal's school and parents would not have known how to target support.

CASE STUDY 3: MAJA

Professionals previously involved in Maja's case were speech and language professionals due to difficulties with pronunciation, and professionals providing regular

eye tests and a hearing assessment. [Table 3](#) specifies the assessments and observations completed for Maja.

This information, collated through background history and assessment, was given as a detailed narrative to the parents and the school. In this instance, the school SENCo had suspected dyslexia and this was given as a diagnosis due to Maja's phonological awareness, phonological memory and phonological processing difficulties, in addition to her persistent and pervasive difficulties with literacy. However, in addition to this background history, a co-ordination screener, a questionnaire and two standardised assessments for fine motor and gross motor co-ordination, a sensory profile and difficulties with processing were also highly indicative of co-occurring dyspraxia. Consequently, Maja was signposted to a community paediatrician who confirmed the diagnosis, and an occupational therapist was able to support Maja within four months of the initial assessment by the DP. In class, strategies were also signposted with regard to the co-occurring diagnoses.

Support was given in timely manner and cost was minimal, as Maja was assessed by the DP attached to the school trust, and then by the NHS paediatrician. In this instance the school SENCo had suspected dyslexia. If the school had engaged a dyslexia specialist, the outcome would probably have been a single dyslexia diagnosis, and Maja's co-occurring needs, which would impact her co-ordination, planning, sensory needs, punctuation, handwriting, social interaction and emotional regulation in additional ways, would have been missed.

DISCUSSION

In each of these cases, the additional level of assessment given by the DP built a crucial bridge between health and education, collating background history, observations, and cognitive and developmental assessments, detailing outcomes of each child's strengths and difficulties, and signposting to an appropriate specialist. This ensured that a profile of the children involved was completed in a timely, yet detailed manner, thus enabling a holistic view of each child's needs.

Thus, instead of the current approach to the diagnostic and support route shown in [Figure 1](#), a new assessment route is proposed. [Figure 2](#) outlines the new assessment route suggested by this study, whereby, after the behaviour is reported by the teacher to the SENCo, the SENCo makes the relevant observations and passes the information on to an in-house DP. The DP then, having worked closely with the school and community healthcare, is able to obtain background history from parents/carers and the school, and diagnose and/or recommend a likely cause of the child's difficulties, learning and/or emotional, based on in-depth training

TABLE 2 Observations and assessments completed for Nishal by the developmental psychologist using the causal model as a framework.

Frith's causal model level	Description	Test
Biological	Male 8 years and 8 months First of three children Born at term with no concerns during pregnancy or birth History of developmental conditions in family (autism)	
Cognitive	Verbal ability: above average Non-verbal ability: above average Short-term memory: mid average Working memory: mid average Visual sequential memory: high average Elision: high average Blending: mid average Sound isolation: high average Rapid digit naming: low average Rapid letter naming: low average Rapid colour naming: below average Rapid object naming: below average Visual processing speed: below average Seeks sensory input less than others Shows hyposensitivity to touch and body position	Wide Range Intelligence Test (WRIT) (Glutting et al., 2000) Test of Memory and Learning (TOMAL2) (Reynolds & Voress, 2007) Comprehensive Test of Phonological Processing (CTOPP2) Phonological Awareness, CTOPP2 Rapid Symbolic Naming (Wagner et al., 2013) Rapid Automatized Naming and Rapid Alternating Stimulus (RAN/RAS) Rapid Non-symbolic Naming (Wolf & Denckla, 2005) Symbol Digit Modalities Test (SDMT) (Smith, 2000) Sensory Profile 2 (Dunn, 2014)
Behavioural	All developmental milestones met Ability to read is meeting expected targets Shows creative flair, enjoys construction Has a caring nature and a great imagination but sometimes struggles to see boundaries with reality Requires much more time than others to complete work Instructions need repeating several times Reported to have difficulties 'processing information' Is very disorganised and often forgets equipment/ homework Leaves seat regularly in class Is easily distracted Is working towards expectations in maths and writing Spelling is weak and phonetic Struggles to focus, especially during written tasks Finds it hard to start a piece of work Staff report lowered self-esteem Reading efficiency: low average Single word reading: mid average Reading comprehension: above average Single word spelling: mid average Spelling within writing 30% error rate Writing composition simple and markedly different to verbal ability Unable to sustain writing beyond six minutes Inattention: very elevated Learning problems: very elevated Executive functioning difficulties: very elevated Peer relations: very elevated Underlying activity: average 0.1 Q-score Impulsivity: average 0.4 Q-score Omission errors: significant 1.5 Q-score Reaction time: significant 2.2 Q-score Reaction time variation: significant 1.8 Q-score	Observation and school voice Test of Word Reading Efficiency (TOWRE2) (Torgesen et al., 2012), Wechsler Individual Achievement Test (WIAT III) (UK) (Wechsler, 2017) Conners-3 DSM-5 scales for ADHD, parent and teacher (Conners, 2008) QbCheck (Ulberstad, 2016)

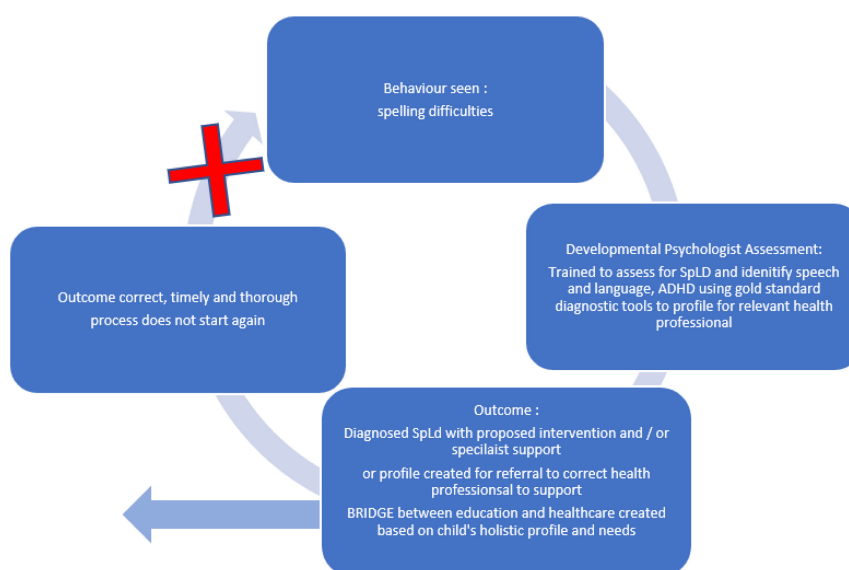
TABLE 3 Observations and assessments completed for Maia by the developmental psychologist using the causal model as a framework.

[illegible]

(Continues)

TABLE 3 (Continued)

Frith's causal model level	Description	Test
	Visual perception: high average Fine motor co-ordination: high average Visual motor integration: below average	Beery–Buktenica Developmental Test of Visual–Motor Integration VI (Beery et al., 2010)
	Marked difficulties with balance and proprioception Hypermobility of upper limbs	Coordination screener (Portwood, 2013)
	Balance: well below average Aiming and catching: below average Manual dexterity: mid average	Movement Assessment Battery for Children (Movement ABC) (Henderson et al., 2008)
	Subjective views on: Control during movement: 20/30 Fine motor control: 16/25 General co-ordination: 51/75	Developmental Coordination Disorder Questionnaire (DCDQ) (Wilson et al., 2007)
	Learning problems: very elevated Executive functioning difficulties: very elevated Peer relations: very elevated	Conners-3 DSM-5 scales for ADHD, parent and teacher (Conners, 2008)
	Underlying activity: average 0.8 Q-score Impulsivity: significant 1.4 Q-score Omission errors: average 0.8 Q-score Reaction time: average 0.9 Q-score Reaction time variation: significant 1.4 Q-score	QbCheck (Ulberstad, 2016)


FIGURE 2 Proposal 1: behaviour reported and SENCo refers to in-house developmental psychologist.

across all areas. Intervention is targeted and next steps are signposted quickly, such as programmes; specialist teachers for dyslexia, dyspraxia and dyscalculia; strategies for inattention; additional specialist support from educational psychology; and signposting to appropriate healthcare professionals, such as community paediatricians, occupational therapists, speech and language therapists or support for mental health (CAMHs). This route aims to optimise and take the guesswork out the referral process.

A further scenario might also be considered, such as that shown in [Figure 3](#) (proposal 2), whereby, following the initial reported behaviour and passing of information on to the in-house DP, *reasons* for the behaviour are considered rather than a *diagnosis* (including, among other things, phonological awareness, manual dexterity difficulties, working memory, auditory filtration and hypermobility), with *each area of need* supported specifically by targeted intervention and/or specialists. This would involve considering every child holistically and wholly,

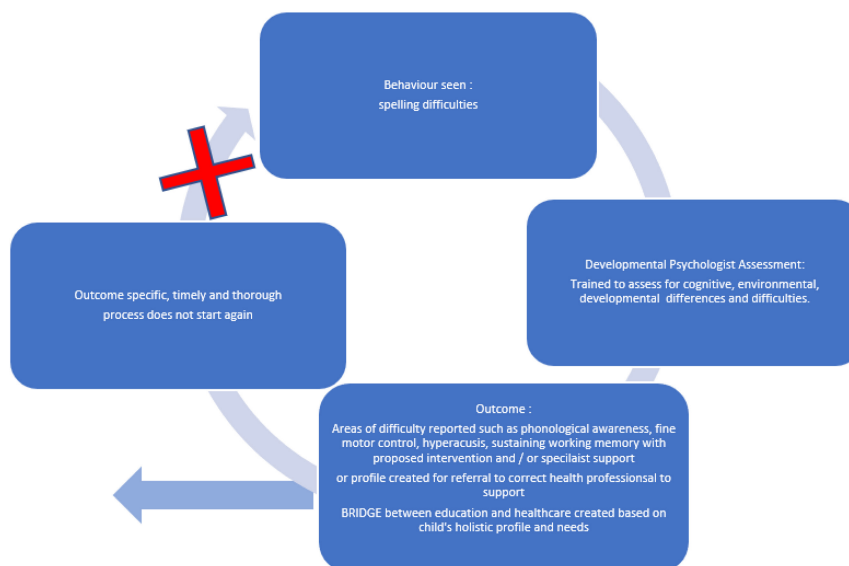


FIGURE 3 Proposal 2: behaviour reported and SENCo refers to in-house developmental psychologist.

and ultimately decrease the need for labels due to a recognition of each child's profile and how to support them.

The value of having a skilled practitioner within schools, who has expertise beyond that currently expected of a SENCo and a triangulation of connections with education, home and health, to support the profiling of a child's needs wholly, is illuminated here. However, the limitations of this role should also be considered, in that such assessment categorically relies on a skilled generalised practitioner to bridge home, health and education, in addition to health and education services working in harmony together. This article proposes that the skilled practitioner need not necessarily be a developmental psychologist, but higher education could be provided to extensively train specialist teachers or SENCos in neurodiversity, since they are already ideally positioned within the school or local authority to act as such a catalyst. Future evolution of existing specialist teaching courses and/or SENCo training could include additional level 7 modules in developmental psychology, thereby incorporating a fundamental and holistic understanding of neurodiversity directly into schools. The cost implications are minimal in comparison to the measurable and immeasurable outcomes of late diagnosis, misdiagnosis or no diagnosis of difficulties in childhood.

Nevertheless, in all cases it should be argued that the optimal further referral route was identified, through this work, as was the optimal support needed. This model has the capacity to enhance preventative work, reducing the demand for specific professionals, and thereby reducing waiting lists and increasing capacity. With this additional in-house layer of assessment, all sectors could save money by accurately targeting need. Furthermore,

anxiety levels in children who are struggling without targeted support could be reduced, the learning gap may be closed and levels of emotional well-being increased, thus positively affecting lives and trajectories.

A final thought: for health concerns, a child would be referred to a general practitioner in the first instance, to review them wholly and refer on if required. Who then is the skilled generalised practitioner to assess additional need holistically at an educational level?

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CONFLICT OF INTEREST STATEMENT

There are no relevant financial or non-financial competing interests to report.

DATA AVAILABILITY STATEMENT

The participants of this study did not give written consent for their data to be shared publicly, so, due to the sensitive nature of the research, supporting data are not available.

ETHICAL APPROVAL

This study was completed by the author as a practitioner and participants cannot be tracked back in any form, due to their complete anonymity. No ethical approval was required.

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