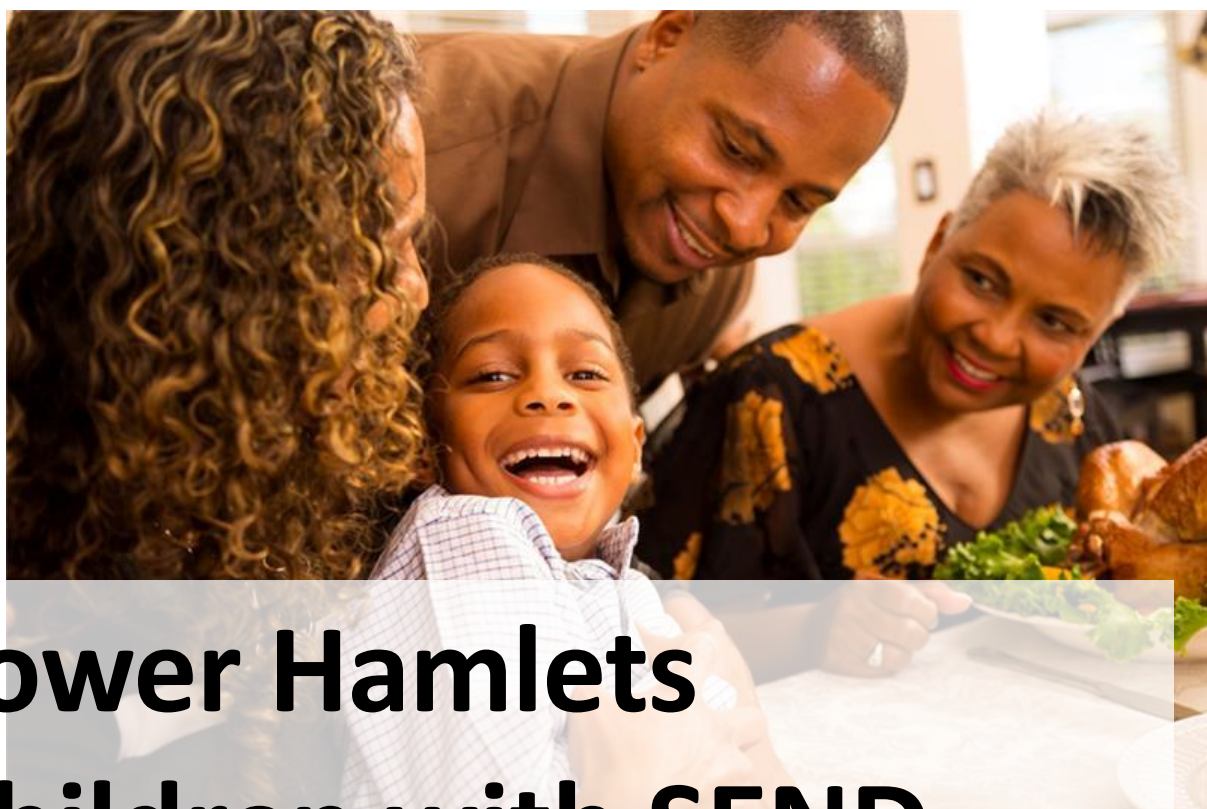




Tower Hamlets Children with SEND Joint Strategic Needs Assessment

Report by Healthy Dialogues
August 2025

Executive Summary

The 2025 Tower Hamlets Joint Strategic Needs Assessment (JSNA) provides a comprehensive analysis of the current and future needs of children and young people with Special Educational Needs and Disabilities (SEND). Developed in partnership with local health, education, social care, youth services, public health and key stakeholders, this JSNA aims to inform strategic planning and support the improvement of health, education and social outcomes.

Key Findings

The Tower Hamlets JSNA emphasises a borough with both notable strengths and critical challenges in supporting children and young people with SEND. As demand grows and complexity deepens, the local system is responding with ambition but faces pressures that require coordinated and long-term solutions. Key findings highlight:

- **Rising SEND prevalence:** Nationally, over 1.7 million pupils are identified with SEND in 2025. Tower Hamlets has the highest proportion of pupils with Education, Health and Care Plans (EHCPs) in England at 6.8%, compared to the national average of 4.8%. This reflects both a rising need and proactive identification, demonstrating Tower Hamlets' commitment to recognising and responding to need early, but also places increased pressure on services and provisions.
- **SEND Primary needs increases:** Speech, language, and communication needs are the most common in Tower Hamlets (40.6%), followed by social, emotional and mental health issues, and autism spectrum disorder (ASD). The latter is also highly prevalent especially amongst those with EHCPs. This reflects the borough's demographic complexity and underlines the importance of early language support and neurodevelopmental pathways.
- **Early years:** The borough has made strides in early identification and intervention. However, children still show below-average outcomes in key developmental domains. This suggests that whilst screening systems are effective, the scale and complexity of early needs are significant.
- **Educational outcomes:** Tower Hamlets ranks amongst the best in England for Key Stage 2 and 4 outcomes for SEND pupils, but Key Stage 5 (post-16) attainment is lower, underscoring a gap in tailored academic and vocational pathways for older SEND learners.
- **Inequalities and deprivation:** SEND in Tower Hamlets is closely intertwined with poverty, ethnicity, language and gender. Tower Hamlets has the highest child poverty rate in England (47%) and over half of pupils with EHCPs are eligible for free school meals, compared to 43.3% of all pupils in Tower Hamlets and about 25% nationally who are FSM-eligible. This highlights how SEND is disproportionately concentrated among disadvantaged groups.
- **Service access and capacity:** While access to speech and language therapy is strong, services face growing demand and limited capacity. Waiting times for ASD assessments can exceed 20 months, specialist school placements are limited, and mainstream schools often struggle to accommodate children with complex needs. Families report falling into a "grey area," where children's support needs are too complex for mainstream school but do not meet the thresholds for specialist support.

- **System-wide commitment:** Tower Hamlets demonstrates a strong dedication to SEND, which is evident in its comprehensive service provision, engagement strategies, and ongoing efforts to enhance support for children and young people with SEND and their families.

Methodology

The JSNA used a multi-method approach to build a rich and balanced understanding of the needs and experiences of children and young people with SEND in Tower Hamlets. This allowed the findings to be grounded in both robust data and lived experience. The key components included:

- **Quantitative data analysis:** Data from sources such as the School Census, the Tower Hamlets SEND Dashboard, Department for Education statistics, and the Office for Health Improvement and Disparities (OHID) Public Health profiles were analysed to understand trends in prevalence, educational outcomes, and inequalities.
- **Qualitative insights:** Voices of children, young people, parents/carers, and professionals were captured as part of the assessment. Semi-structured interviews and engagement events captured first-hand experiences of navigating the SEND system. Thematic analysis of this input highlighted perceived gaps, system strengths, and opportunities for improvement.
- **Academic literature review:** A structured review of peer-reviewed journals and evidence-based guidelines was undertaken for each category of SEND. This provided insights into effective interventions and models of support, and helped align local strategy with current research and NICE guidance.

This triangulation of methods ensured that the JSNA was both evidence-informed and people-centred, providing a solid foundation for actionable recommendations.

Recommendations

Building on detailed analysis across individual areas of need, the JSNA outlines overarching strategic recommendations to guide the future of SEND support in Tower Hamlets. These recommendations aim to deliver a more inclusive, coordinated, and needs-led system:

Enhancing decision-making through data and evidence

- **Strengthen data-driving planning:** Improve the quality of ethnicity and outcomes data and embed impact evaluation into service design to support smarter, more sustainable decisions.
- **Use evidence-based practice:** Regularly review interventions and frameworks to align with the latest research and best practice, ensuring services evolve to meet emerging needs.
- **Understand demand:** Conduct further research into the drivers of rising assessment demand (e.g., for ASD/ADHD) and build early, preventative support into service planning.

Building capacity and collaboration for consistent support

- **Embed continuous learning:** Invest in ongoing professional development and specialist training for education, health and care staff to maintain high standards of practice.
- **Enhance multi-agency collaboration:** Continue to break down siloed working across education, health and social care, fostering more integrated and creative service models with shared accountability.

- **Clarify cross-borough responsibilities:** Develop formal agreements to ensure children placed in or out of borough receive consistent, high-quality support regardless of location.

Advancing equitable, needs-led support

- **Prioritise a needs-led model:** Deliver support based on presenting needs rather than diagnosis alone, enabling early intervention and avoiding delays for those awaiting formal assessments.
- **Maintain a balanced focus across needs:** Ensure growing demand for children and young people with autism does not overshadow support for other needs, promoting equity across all SEND categories.
- **Adopt a holistic approach to neurodiversity:** Develop borough-wide, needs-led approaches that move beyond diagnostic labels, with integrated support for overlapping conditions like ADHD and ASD.

Expanding pathways and improving transitions

- **Improve transition pathways:** Strengthen post-16 and post-19 support for young people with SEND, ensuring clear, coordinated transitions between services and life stages.

Broaden education pathways: Support alternative and flexible learning models that better meet the needs of neurodivergent pupils, especially those who struggle in traditional classroom settings.

Enhancing accessibility, early support and empowerment for families and young people

- **Expand inclusive community opportunities:** Improve accessibility in youth and community spaces, particularly for those with moderate or personal care needs to promote social inclusion.
- **Promote early support for families:** Strengthen early years, pre-natal and maternity support, so that families can access help without needing to wait for an EHCP, laying a foundation for better long-term outcomes.
- **Improve access to information:** Enhance visibility and clarity of support services, particularly for families in mainstream settings, through targeted outreach, inclusive communication, and a more navigable Local Offer.
- **Empower young people:** Shift some focus directly to children and young people, supporting them to understand their needs, develop self-management skills, and gain confidence.

Conclusion

Amid the pressures, Tower Hamlets demonstrates a system-wide commitment to improving outcomes for children and young people with SEND. Investment in early years, the development of strong partnerships, innovative speech and language pathways, and co-produced strategies form building blocks for future transformation. However, rising demand, entrenched inequalities, and service capacity challenges require sustained strategic focus. By addressing these gaps, the borough can build a more equitable and responsive system where every child and young person with SEND is supported to thrive.

Contents

Executive Summary.....	2
Glossary	6
Glossary	6
1. About this Joint Strategic Needs Assessment.....	8
2. SEND Population Overview	17
3. Education	23
4. Communication and Interaction: Autism Spectrum Disorder (ASD).....	34
5. Attention Deficit Hyperactivity Disorder (ADHD).....	49
6. Communication and Interaction: Speech Language and Communication Needs (SLCN)	58
7. Cognition and Learning: Specific Learning Difficulty (SpLD)	70
8. Social, Emotional and Mental Health	77
9. Sensory impairment.....	83
10. Physical Needs	99
11. Community Insights	110
12. Recommendations	118
13. References	123

Glossary

ADHD – Attention Deficit Hyperactivity Disorder
AOAE – Automated Otoacoustic Emission
AABR – Automated Auditory Brainstem Response
AP – Alternative Provision
APS – Average Point Score
ASD – Autism Spectrum Disorder
ASDAS – Autism Spectrum Disorder Assessment Service
ASQ – Ages and Stages Questionnaire
ASQ:SE-2 – Ages and Stages Questionnaire: Social-Emotional, 2nd edition
BATOD – British Association of Teachers of the Deaf
BSL – British Sign Language
CAMHS – Child and Adolescent Mental Health Services
CBT – Cognitive Behavioural Therapy
CQC – Care Quality Commission
CLDS – Community, Learning and Disability Service
CWD – Children with Disabilities
DCOS – Disabled Children’s Outreach Service
DS – Down Syndrome
DLD – Developmental Language Disorder
EET – Education, Employment or Training
EHCP – Education, Health and Care Plan
EPS – Educational Psychology Service
EYFS – Early Years Foundation Stage
EYFSP – Early Years Foundation Stage Profile
FSM – Free School Meals
GP – General Practitioner
GI – Gastrointestinal
HCP – Healthcare Professional
HI – Hearing Impairment
IASS – Information, Advice and Support Service
JSNA – Joint Strategic Needs Assessment
KS2 – Key Stage 2
KS4 – Key Stage 4
KS5 – Key Stage 5
LEA – Local Education Authority
LBTH – London Borough of Tower Hamlets
MAST – Multi-Agency Safeguarding Team
MDT – Multidisciplinary Team
NAS – National Autistic Society
NEET – Not in Education, Employment, or Training
NICE – National Institute for Health and Care Excellence
NIPE – Newborn and Infant Physical Examination

NIPT – Non-Invasive Prenatal Testing
OHID – Office for Health Improvement and Disparities
Ofsted – Office for Standards in Education, Children’s Services and Skills
OT – Occupational Therapy / Therapist
PE – Physical Education
PD – Physical Disability
PH – Public Health (in NICE guideline codes)
QToD – Qualified Teacher of the Deaf
QTMSI – Qualified Teacher of Multi-Sensory Impairments
QTVI – Qualified Teacher of the Visually Impaired
RNIB – Royal National Institute of Blind People
SES – Socio-Economic Status
SEND – Special Educational Needs and Disabilities
SEND IASS – Special Educational Needs and Disabilities Information, Advice and Support Service
SEN – Special Educational Needs
SENCO – Special Educational Needs Coordinator
SEMH – Social, Emotional and Mental Health
SLD – Severe Learning Difficulties
SLT – Speech and Language Therapy / Therapist
SLCN – Speech, Language and Communication Needs
SpLD – Specific Learning Difficulty
SPD – Sensory Processing Disorder
STAG – Special Transport Advisory Group
UK – United Kingdom
VI – Visual Impairment
YP – Young People

1. About this Joint Strategic Needs Assessment

1.1 Aims and Purpose

The Special Educational Needs and Disability (SEND) Code of Practice¹ states that a Joint Strategic Needs Assessment (JSNA) must be produced to analyse the needs of the local community. It must be regularly reviewed and updated to reflect the needs of children and young people with SEND.

This JSNA is sponsored by the Tower Hamlets SEND Improvement Board and has been developed in collaboration with partners from health, education, social care and the voluntary sector in the borough. Its primary aim is to assess the current and future needs of children and young people with SEND, with a focus on identifying specific challenges across each category of need. The JSNA will propose recommendations to improve outcomes and guide strategic planning and resource allocation, to ensure timely, high-quality, and personalised support for children and young people with SEND.

The JSNA should be considered alongside the Tower Hamlets SEND and Inclusion Strategy 2024², as both documents work together to enhance the health, educational achievement, and overall well-being of children and young people with SEND.

The London Borough of Tower Hamlets has a strong commitment to supporting children and young people with SEND and has previously published two JSNAs on SEND in 2015 and 2019. This updated JSNA builds on past progress, providing a current analysis of the SEND population and undertaking a review into each category of need. This approach ensures that the unique needs of all children are effectively addressed.

1.2 Methodology

This JSNA adopted a multi-method design, incorporating four key components: desk-based research, literature synthesis, data analysis and qualitative insights. This approach enables a comprehensive understanding through the triangulation of sources and methods. By combining literature-based analysis with real-world data and human perspectives, the JSNA provides a robust foundation for analysis, discussion, and conclusions.

Desk-based research

This initial phase involved extensive desk-based research to map the existing landscape of SEND service and support. This included the systematic review of information from a wide array of sources, including statutory policy documents, organisational reports, strategic frameworks, relevant government publications, and grey literature from academic and non-academic settings. The goal of this phase was to gather robust contextual information on the current provision, challenges, and best practices in SEND. This foundational evidence base was critical in framing the key areas of focus for subsequent stages of the JSNA, ensuring alignment with local priorities and national policy directives.

Literature synthesis

A structured synthesis of academic literature was undertaken for each identified category of need. This involved targeted searches of peer-reviewed journals, systematic reviews, and evidence-based guidelines. The literature synthesis aimed to identify evidence-based practices in supporting children and young people with SEND, as well as families and professionals who work with them. Any emerging

evidence that provided insights into scalable and contextually appropriate strategies were documented. The purpose of this exercise was not only to inform local strategy development but also to embed a culture of continuous learning and reflective practice within the Tower Hamlets' SEND provision.

Data analysis

This phase involved the systematic examination of quantitative data to build a clear picture of the local SEND landscape. Data sources included publicly available datasets such as:

- The School Census (processed and analysed by LBTH)³
- Department for Education statistics³
- Tower Hamlets SEND Dashboard⁴
- OHID Fingertips⁵

These allowed for the analysis of demographic trends, prevalence rates, service utilisation, and outcomes for children and young people with SEND, and included analysis of key characteristics such as age, gender, ethnicity and type of need, to identify disparities and inform targeted recommendations.

Qualitative insights

To deepen understanding and ensure the voices of stakeholders were central to the needs assessment, qualitative insights were gathered through a variety of methods. These included semi-structured interviews, focus groups, and informal or opportunistic conversations at SEND-related events and engagement forums. Participants included parents and carers, children and young people, frontline practitioners, education staff, voluntary sector representatives, and strategic leads.

The qualitative data was analysed using thematic analysis, guided by Braun and Clarke's⁶ approach. This rigorous process allowed for the extraction of nuanced insights from lived experiences and professional perspectives. Themes emerging from this qualitative analysis provided valuable depth and context to the quantitative findings, highlighting areas such as unmet needs, barriers to access, perceived gaps in support, and suggestions for service improvement.

1.3 Structure of the document

The following sections of this document (Chapters 4 onwards) are structured to explore each category of need in detail. For each area, we outline the key causal factors, examine the local picture within Tower Hamlets, and describe current approaches to diagnosis and pathways into support. We also consider how these needs impact access to a healthy lifestyle and shape experiences within school life. Each chapter includes a review of evidence-based practice, highlights the support services currently available in Tower Hamlets, and concludes with relevant recommendations to inform future planning and provision.

This structure was co-developed and endorsed by Tower Hamlets SEND leads as the key lines of enquiry for assessing the health needs of children with SEND. Each chapter is intended to be self-contained so practitioners and families can access the full picture for a specific SEND categories of interest with

ease. As a result, some content is intentionally repeated across chapters when the document is read from start to finish.

1.4 Definitions

According to the SEND Code of Practice (2015)¹, a child or young person has special educational needs (SEN) if they have a learning difficulty or disability which requires special educational provision. This includes those who have a significantly greater difficulty in learning than the majority of others of the same age, or a disability that prevents them from accessing facilities generally available in mainstream schools or post-16 institutions.

The Equality Act (2010)⁷ defines disability as a physical or mental impairment that has a long-term and substantial adverse effect on day-to-day activities. While many children with SEN may also meet the legal definition of disability, not all children with disabilities have SEN. To reflect this overlap and ensure inclusive support, the term Special Educational Needs and Disabilities (SEND) is commonly used.

Long-term conditions such as asthma, diabetes, epilepsy, or cancer fall under the legal definition of disability, but do not automatically result in SEN unless they also impact learning in a way that requires special provision. For this reason, these conditions are outside the scope of this JSNA.

The SEND Code of Practice groups needs into four broad areas:

Communication and Interaction: This area covers children and young people who have difficulty communicating with others. This can include problems with:

- Understanding what others say
- Expressing themselves
- Social communication, such as understanding the rules of conversation or body language

It includes conditions such as:

- Speech, Language and Communication Needs (SLCN)
- Autism Spectrum Disorder (ASD), including Asperger Syndrome

Cognition and Learning: Children in this category learn at a slower pace than their peers, even with appropriate differentiation. Their needs can vary widely in severity and may include:

- Mild learning difficulties (MLD)
- Severe learning difficulties (SLD)

It also includes Specific Learning Difficulties (SpLD), which affect aspects of learning such as:

- Dyslexia (reading and spelling)
- Dyscalculia (maths)
- Dyspraxia (coordination and motor skills)

Social, Emotional and Mental Health (SEMH): This area covers difficulties in managing emotions, forming relationships, and behaviours. These can include:

- Being withdrawn or isolated

- Displaying challenging or disruptive behaviour

The code states these behaviours may reflect underlying mental health difficulties which might include:

- Anxiety or depression
- Self-harming
- Eating disorders
- Substance use

Nationally, Attention Deficit Hyperactivity Disorder (ADHD) prevalence in assessment and diagnosis has increased significantly⁸. As a result, an ADHD chapter has been incorporated into this review.

Sensory and/or Physical Needs: This category includes children with physical or sensory impairments that make it harder to access the curriculum or physical environment. Children may need specialist equipment, adaptations, or ongoing support to participate fully in education.

It can include:

- Visual impairment (VI)
- Hearing impairment (HI)
- Multi-sensory impairment (MSI)
- Physical Disability (PD) – including conditions that limit mobility, coordination, or access to learning environments

A child may have needs spanning more than one category, and needs may evolve over time. Early identification is vital to avoid compounding or unmet needs.

Support for children and young people with SEND is delivered via two pathways: SEN Support, available within mainstream settings without a formal plan, and Education, Health and Care Plans (EHCPs) for those with more complex need. EHCPs are legally binding and outline a coordinated package of educational, health, and social care provisions.

In this document, *primary need* refers to the main category of difficulty identified for a child or young person (e.g. Autism Spectrum Disorder), while *secondary need* refers to additional areas of difficulty that may coexist but are not the primary reason for support.

1.5 Disability Models

Attitudes towards disability shape how individuals behave towards people living with disabilities. These attitudes can then influence opportunities, treatment, and ability for people living with disabilities to participate fully in society. These attitudes are often informed by underlying beliefs about the nature of disability itself.

Disability is commonly understood through two primary conceptual frameworks: the Medical Model and the Social Model:

- The **Medical Model** views disability primarily as a result of an individual's physical or mental impairments. It emphasises diagnosis, treatment and care, placing the source of problem within the individual, rather than considering the influence of environmental or social factors.
- The **Social Model**, in contrast, understands disability as the result of social, environmental, and attitudinal barriers that restrict participation and inclusion.

This JSNA adopts the Social Model of disability, in line with the approach recommended by the Government Equalities Office (now part of the Equality Hub under the Department for Education) in 2014⁹. The Office recommended that all government departments adopt the Social Model in their engagement with people who have disabilities, acknowledging that removing barriers, rather than 'fixing' individuals, is key to enabling full societal participation.

1.6 National legislation and guidance

The development of the approach to SEND has been shaped by a number of key legislative and policy documents. These set out the statutory duties and responsibilities of local authorities, schools, and other agencies in identifying, assessing, and supporting children and young people with SEND.

The framework reflects a shift towards inclusive education, early intervention, and person-centred support, and is underpinned by principles of equality, participation, and joined up working across education, health, and social care.

Below is a non-exhaustive list of significant national legislation and policy documents that have influenced the current SEND system in England.

- **Education Act 1981**¹⁰: This was the first major piece of legislation in the UK to formally recognise and define special educational needs. It required Local Education Authorities (LEAs) to identify, assess, and make provisions for children with SEN. The Act introduced the concept of statements of SEN, which later evolved into EHCPs under the 2014 reforms.
- **Every Child Matters 2003**¹¹: A landmark governmental initiative following the Laming Report into the death of Victoria Climbié. It aimed to improve outcomes for all children and young people (aged 0–19), with a focus on five key outcomes: being healthy, staying safe, enjoying and achieving, making a positive contribution, and achieving economic well-being. While not legislation, it strongly influenced the direction of inclusive education and multi-agency working.
- **The Equality Act 2010**⁷: This consolidated and strengthened previous anti-discrimination laws, providing legal protection for individuals with disabilities, including those with SEN, against direct and indirect discrimination, harassment, and victimisation in education, employment, and wider society.
- **Children and Families Act 2014**¹²: A pivotal reform of the SEND system in England. It introduced EHCPs to replace statements of SEN and extended statutory support to young people up to age 25. The Act placed duties on local authorities to work jointly with health and social care partners, and to identify all children and young people who have or may have SEN or disabilities. It placed an emphasis on person-centred planning and family engagement.

- **SEND Code of Practice: 0-25 Years 2015¹¹:** Statutory guidance issued under the Children and Families Act 2014 sets out the duties of local authorities, schools, early years providers, and other professionals in identifying, assessing, and supporting children and young people with SEND. The Code highlights the importance of early identification, high-quality teaching, and co-production with families and young people.
- **SEND and AP Green Paper: “SEND Review: Right Support, Right Place, Right Time” 2022¹³:** This policy consultation paper was launched in response to growing concerns about inconsistency, inefficiency, and delays in the SEND system. It proposes reforms to ensure earlier identification of need, clearer national standards, stronger accountability, and better alignment between mainstream, special, and alternative provision (AP). The green paper forms part of an ongoing reform process.

In addition to legislation, the National Institute for Health and Care Excellence (NICE) provides several evidence-based guidelines relevant to the care and support of children and young people with SEND. These guidelines provide best-practice recommendations for professionals across health, education, and social care, and cover topics such as:

- **Autism spectrum disorder in under 19s: support and management – NICE guideline [NG170] (2021)¹⁴:** This guideline covers the recognition, referral, diagnosis, and management of autism in children and young people under 19. It promotes early identification, multidisciplinary assessment, and tailored interventions, including support for communication, behaviour, and education.
- **Attention deficit hyperactivity disorder (ADHD): diagnosis and management – NICE guideline [NG87] (2018, updated 2023)¹⁵:** This guideline provides evidence-based recommendations on the diagnosis and management of ADHD in children, young people and adults. It covers clinical assessment, pharmacological and non-pharmacological interventions, and support in education, social care, and family contexts.
- **Learning disabilities and behaviour that challenges: service design and delivery – NICE guideline [NG93] (2018)¹⁶:** This guideline focuses on services for people with a learning disability and behaviours that challenge, including children and young people. It outlines principles for person-centred planning, early intervention, and collaborative working across health, education, and care settings.
- **Social and emotional wellbeing in primary education – NICE public health guideline [PH12] (2008) and Social and emotional wellbeing in secondary education – NICE public health guideline [PH20] (2009)¹⁷:** These guidelines promote social and emotional wellbeing in schools by recommending whole-school approaches, including positive behaviour policies, staff training, and targeted interventions. While not SEND-specific, they are relevant for preventing emotional and behavioural difficulties, particularly for those at-risk.
- **Developmental follow-up of children and young people born preterm – NICE guideline [NG72] (2017)¹⁸:** This guidance addresses the long-term developmental needs of preterm infants. It provides recommendations for monitoring to identify and respond early to potential cognitive, behavioural, or physical developments, many of which overlap with SEND.

- **Mental health problems in people with learning disabilities: prevention, assessment and management – NICE guideline [NG54] (2016)¹⁹:** This guideline provides a framework for recognising, assessing, and treating mental health conditions in people with a learning disability, including children and young people. It supports a person-centred, holistic approach, and emphasises making reasonable adjustments in healthcare and education.

NICE guidelines are not legally binding, but they are widely recognised as authoritative standards that inform commissioning, service delivery, and quality assurance across the system.

1.7 Local Strategies

Tower Hamlets has developed a range of local strategies aimed at improving outcomes for children and young people with Special Educational Needs and Disabilities (SEND). These strategies align with national policy and are shaped by local priorities, data, and lived experiences. Together, they provide a framework for delivering coordinated, inclusive, and effective support across education, health, and care services.

Tower Hamlets Special Educational Needs, Disabilities and Inclusion Strategy 2024-29²: This strategy outlines the boroughs approach to supporting children and young people with SEND. It presents the evidence base and consultation feedback that informed its development, highlighting key data trends and a co-produced vision. The strategy focuses on building an inclusive, coordinated, and supportive local system and identifies six priorities:

- Timely, effective and well-coordinated support for children and young people with SEND.
- User-friendly services for children and young people with SEND and their families.
- Early identification and support for the under-fives.
- Effective education and support for school-age children with SEND and additional needs.
- Opportunities and support for young adults with SEND and additional needs.
- Children and young people with SEND and neurodiversity are valued, celebrated and supported to thrive.

TH_IS Accelerate! Strategy (2024 -2029)²⁰: The Accelerate! Strategy is a six-year plan developed by the Tower Hamlets Children and Families Partnership. It outlines eight key ambitions co-produced with children, young people, families, and partners, and acts as a strategic vehicle for delivering improvements in child and family outcomes. It places a strong emphasis on equity, early intervention, and partnership working.

Tower Hamlets Early Help Strategy 2023-2025²¹: This strategy outlines a collaborative, locality-based approach via Family Hubs to provide early, coordinated support to families before issues escalate. Co-produced with families and partners, it focuses on improving child and maternal health, education, employment, wellbeing, and safety. The strategy sets shared outcomes, guiding principles (e.g., relational, trauma-informed practice), and eight key priorities to build an integrated workforce and streamlined pathways. Governance is led by a new Early Help Partnership Board, which will track progress through a Quality Assurance Framework and active stakeholder feedback.

Tower Hamlets Health and Wellbeing Strategy (2021-2025)²²: This strategy focuses on improving population health and reducing inequalities. A key priority is giving every child the best start in life, which includes improving outcomes for children with SEND. The strategy promotes early intervention, integrated working across services, and addressing the wider determinants of health that impact children's development and well-being.

Youth Justice Plan (2023-2025)²³: Developed collaboratively with young people, professionals, and strategic partners, this plan outlines Tower Hamlets' approach to youth justice. It focuses on four cross-cutting themes: adopting a "Child First" approach, improving practice standards, expanding access to health services, and increasing participation in education, employment, and training. The plan aligns closely with other local strategies to ensure joined-up support for young people, including those with SEND.

Tower Hamlets Local Offer²⁴: In line with the Children and Families Act 2014, Tower Hamlets publishes a Local Offer, that sets out the education, health, and care services available for children and young people with SEND. This helps families understanding what support is available locally and how to access it.

1.8 Care Quality Commission – SEND Inspection Summary (2025)

At the time this needs assessment was undertaken, Tower Hamlets were inspected by the Care Quality Commission (CQC). This ran in parallel to but in isolation of the JSNA. The CQC assessment report was issued August 2025.

The report indicated that since the last inspection, provision for children and young people with SEND in Tower Hamlets has improved, but experiences remain inconsistent. Progress was evident in co-production with children and young people, early years, alternative provisions and partnership working. However, delays, inconsistencies in EHCPs, gaps in transition support for older youths and continued challenges with the speech and language provision for school-aged children require improvement.

It highlighted a variety of areas the Tower Hamlets SEND Partnership is doing well within the borough including:

- Ambitious leaders with a clear SEND strategy which provides effective governance and accountability, with noted improvements made on previous inspections.
- A positive relationship with Parent Forums with parents influencing commissioning and strategy, with leaders learning from complaints.
- Prompt referrals and effective support for children with complex needs were highlighted within early identification and care.
- A comprehensive Healthy Child Programme with close work between health professionals and family hubs, specialist nurses and GPs.
- Broad emotional wellbeing support was clear, with CAMHS risk assessment / signposting and crisis teams available for urgent needs.

Overall, leaders, practitioners and services are working effectively together, with strong early help, health, therapies, mental health and inclusive education support, underpinned by an ambitious strategy and genuine parent partnership.

The report also indicated several areas for improvement highlighting:

- A lack of coordinated approach for learning disability diagnosis with some young people missing annual health checks limiting access to service and benefits.
- EHCPs/reviews are not used consistently, with timeliness and quality still inconsistent.
- Too few families know about or use the local offer that is available.
- Delays in equipment provision and unsuitable housing still affect some children and families.

Overall, it emphasised that improvements were needed in diagnosis, preparation for adulthood, EHCP timeliness/quality, communication, staff expertise and practical support to ensure children and young people consistently get the right help at the right time.

These observations led to a series of areas of improvement which are summarised below:

- **EHCPs and preparation for adulthood:** Plans should be timely, accurate, up to date, and accessible to all relevant practitioners, with earlier and better planning from Year 9.
- **Transitions and post-16/19 support:** Improve diagnosis consistency, expand local education options, start planning for adulthood earlier and strengthen support for those 19+ to prevent them from falling out of education, employment or training.
- **Oversight and staff capacity:** Strengthen monitoring of out-of-school provision and develop staff knowledge, accessibility, and signposting for families.
- **Health services:** Cut waiting times for neurodevelopmental assessments and improve timely, consistent access to speech and language therapy.

The full Inspection Report can be found here: [Partnership inspection finds children and young people with SEND are valued in Tower Hamlets](#)

2. SEND Population Overview

This chapter presents an in-depth overview of key statistics related to children and young people with SEND in Tower Hamlets, set within the wider national context of England.

2.1 Key statistics

In recent years, the number of children and young people in England identified with SEND has steadily increased. In 2025, that number surpassed 1.7 million pupils, an increase of over 93,000 compared to the previous year³. This ongoing rise has continued a trend that has been building since 2016, reflecting the growing complexity and visibility of young people's needs in schools.

Table 3.1: 'Pupils in all schools, by type of SEN provision - 2016 to 2025' in England between 2015/16 and 2024/25

Year	EHCPs	EHCPs (percent)	SEN support/SEN without an EHCP	SEN support/SEN without an EHCP (percent)
2015/16	236,806	2.8	991,981	11.6
2016/17	242,184	2.8	1,002,069	11.6
2017/18	253,679	2.9	1,022,537	11.7
2018/19	271,165	3.1	1,047,163	11.9
2019/20	294,758	3.3	1,079,000	12.1
2020/21	325,618	3.7	1,083,083	12.2
2021/22	355,566	4.0	1,129,843	12.6
2022/23	389,171	4.3	1,183,384	13.0
2023/24	434,354	4.8	1,238,851	13.6
2024/25	482,640	5.3	1,284,284	14.2

This national figure includes children with formal EHCPs, as well as those receiving SEN support in schools without a formal plan. In 2025 alone, 482,640 pupils in England had an EHCP, an 11.1% increase from 2024, while more than 1.28 million pupils were receiving SEN support. Together, they represented nearly 1 in 5 school-aged children.

In Tower Hamlets, these national trends are clearly reflected, and in some cases, more pronounced. In January 2024, nearly 9,000 children and young people aged 0–25 with SEND were living in or attending school in the borough. Of these, 3,109 had an EHCP and 5,778 were receiving SEN support without one³.

Tower Hamlets had the highest proportion of school pupils with an EHCP in the entire country, 6.8%, compared to the national average of 4.8%. Conversely, the percentage of pupils receiving SEN support without a plan was 12.6%, slightly below the national average of 13.6%³.

2.2 Gender

In the UK, males are consistently more likely than females to be identified with SEND and to receive support. This pattern holds true for those with EHCPs and those receiving SEN support, and is observed across different regions, age groups, ethnicities, and types of need.

However, the degree of gender disproportionality varies substantially depending on the type of disability, geographic location, and the child's developmental stage. For example, conditions such as ASD have historically shown a strong male skew, but recent changes in identification patterns suggest evolving diagnostic practices. These shifts may reflect improved recognition and diagnosis of females, who have traditionally been under-identified, particularly in conditions where presentation differs by gender.

In recent years, there are signs that this gender gap is beginning to narrow. An increasing proportion of females are now being identified with SEND, indicating progress toward greater awareness and possibly improved identification practices for girls²⁵.

In Tower Hamlets, the proportion of males with EHCPs and SEN support rose between 2022/23 and 2023/24, reflecting a trend seen across England. However, in 2024/25, the percentage of males receiving support decreased slightly both locally and nationally.

Looking at the gender breakdown for 2024/25 in Tower Hamlets:

- **27%** of those with an EHCP were female, below the national figure of **28.6%**.
- For those receiving SEN support, **40.4%** were female, higher than the national rate of **38.8%** (see Table 3.2).

These figures highlight ongoing disparities in SEND identification between genders, while also pointing to a gradual increase in female identification, particularly at the SEN support level. The shifting patterns in conditions like ASD further suggest that the landscape of SEND identification is evolving, likely due to greater awareness of how different needs may present in girls.

Table 3.2: 'Age and Gender, by type of SEN provision and type of need - 2016 to 2025' for EHCPs and SEN support / SEN without an EHCP in England and Tower Hamlets between 2022/23 and 2024/25

		England			Tower Hamlets		
		2024/25	2023/24	2022/23	2024/25	2023/24	2022/23
EHCPs	Female	127,217	112,269	99,343	915	813	709
	Female (%)	28.6	28.0	27.6	27.0	26.1	25.5
	Male	317,202	288,144	260,994	2,479	2,296	2,075
	Male (%)	71.4	72.0	72.4	73.0	73.9	74.5
SEN support / SEN without an EHCP	Female	458,677	433,501	406,585	2,382	2,270	2,230
	Female (%)	38.8	38.0	37.2	40.4	39.3	38.2
	Male	722,988	706,245	686,641	3,519	3,508	3,605
	Male (%)	61.2	62.0	62.8	59.6	60.7	61.8

Note – This data includes state-funded nursery, primary, secondary and special schools, non-maintained special schools and state-funded alternative provision schools. It does not include independent schools.

2.3 Ethnicity

Tower Hamlets, is one of the most ethnically diverse areas in the UK, has a distinctive SEND profile shaped by its population characteristics. The largest ethnic group is Bangladeshi, accounting for 34.6% of residents, and the borough is home to one-sixth of all Bangladeshis living in England and Wales. The second largest group is White British, who make up 22.9% of the population.

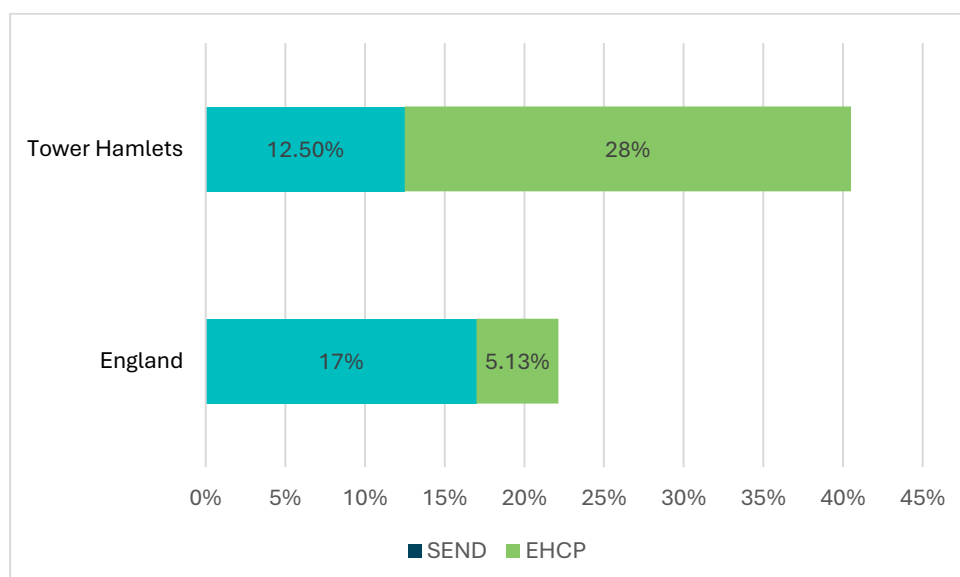
This diversity is reflected in the composition of pupils receiving SEND support. Earlier analysis of SEN data by the LBTH public health team found that among those with an EHCP, 60% are Bangladeshi, while 54% of pupils receiving SEN support also identify as Bangladeshi. These figures align with the overall population profile of the borough.

Other ethnic groups with notable representation include:

- White British: 10.6% (EHCPs), 13.7% (SEN support)
- Black African: 8.5% (EHCPs), 7% (SEN support)

However, a significant portion of the SEND population lacks recorded ethnicity, which affects accurate representation and service planning. Nationally, 17% of SEN cases lack ethnicity data, compared to 12.5% in Tower Hamlets. In Tower Hamlets 28% of Tower Hamlets pupils with an EHCP had no recorded ethnicity in 2023/24, compared to just 5.13% in England.

Figure 3.1: Proportion of pupils with SEND and EHCP missing ethnicity data in England vs. Tower Hamlets 2023/24.



Source: January 2024 School Census [LBTH Data, March 2024]

National research has consistently shown disproportional identification of SEN amongst certain ethnic groups, particularly Bangladeshi, Pakistani, Black Caribbean and Gypsy Roma communities. If left unaddressed, there is a risk, that through inadequate or inappropriate provision, unequal outcomes in the future may be reinforced²⁶.

Nationally, the highest proportions of SEND are observed in the Traveller of Irish Heritage (33.3%), Gypsy Roma (27.8%), White and Black Caribbean (24.1%) and Black Caribbean (23.6%). In Tower Hamlets, this is even more pronounced, with White and Black Caribbean (39.9%), Gypsy Roma (38.9%), White British (38.2%) and Black Caribbean (27.9%).

By contrast, Chinese pupils have the lowest proportion of SEND both nationally (7.4%) and locally (11%).

Table 3.3. Ethnic groups with the highest rates of SEND, by comparing the proportion of all pupils by ethnicity, with the proportion of pupils in each ethnic group with SEND.

		Black Caribbean	Gypsy Roma	Traveller of Irish Heritage	White and Black Caribbean	White British	Asian-Chinese
England	Number of pupils in ethnic group	78,817	28,594	6,798	134,384	5,215,524	63,774
	% of pupils in ethnic groups with SEND	23.60%	27.80%	33.30%	24.10%	20.20%	7.40%
Tower Hamlets	Number of pupils in ethnic group	545	18	-	596	3,536	263
	% of pupils in ethnic groups with SEND	27.90%	38.90%	-	39.90%	38.20%	11%

Amongst pupils with any SEND in Tower Hamlets, the most prevalent primary need within the school population is SLCN accounting for 40.6% of the cohort. This represents the highest percentage among all local authorities when compared to statistical neighbours (30.1%). When compared nationally, it is also ranked first – and is considerably higher than the national rate of 24%.

Figure 3.2: Identification: Prevalence & primary need – School population

		Tower Hamlets					Statistical Neighbours			England							Note
		2021	2022	2023	2024	Trend	Latest Avg.	Rank	Latest Diff.	2021	2022	2023	2024	Rank	Latest Diff.	Trend	
Prevalence & characteristics	Incidence of SEND																
	Pupils with EHCP (all schools)	5.2%	5.4%	5.9%	6.8%		5.2%	1st	+1.6%	3.7%	4.0%	4.3%	4.8%	1st	+2.0%	---	3
	Pupils with SEN Support (all schools)	11.6%	11.6%	12.4%	12.4%		13.8%	10th	-1.4%	12.2%	12.6%	13.0%	13.6%	116th	-1.2%	---	
	Primary school pupils with EHCP (state-funded mainstream)	3.6%	3.7%	4.5%	5.4%		4.1%	1st	+1.3%	2.1%	2.3%	2.5%	3.0%	1st	+2.4%	---	
	Primary school pupils with SEN Support (sfm)	13.3%	13.7%	14.1%	14.6%		14.7%	6th	-0.1%	12.6%	13.0%	13.5%	14.1%	62nd	-0.5%	---	
	Secondary school pupils with EHCP (sfm)	4.1%	4.2%	4.4%	4.7%		3.2%	1st	+1.5%	2.0%	2.2%	2.4%	2.7%	3rd	+2.0%	---	
	Secondary school pupils with SEN Support (sfm)	10.0%	9.8%	10.8%	10.5%		12.5%	10th	-2.0%	11.5%	11.9%	12.4%	12.9%	126th	-2.4%	---	4
Primary need	State-funded AP/PRU pupils with EHCP	11.0%	14.4%	14.2%	14.6%		23.2%	8th	-8.6%	24.0%	28.2%	25.5%	24.2%	86th	-9.6%	---	
	State-funded AP/PRU pupils with SEN Support	87.6%	68.6%	61.2%	40.6%		63.7%	11th	-23.1%	58.7%	54.0%	57.0%	58.1%	107th	-7.5%	---	
	Specific learning difficulty	6.0%	5.4%	6.1%	7.0%		8.8%	8th	-1.8%	12.1%	12.0%	11.8%	11.6%	134th	-4.6%	---	
	Moderate learning difficulty	9.6%	8.1%	6.4%	5.5%		10.4%	9th	-4.9%	18.1%	16.8%	15.4%	14.0%	148th	-8.5%	---	
	Severe learning difficulty	1.4%	1.4%	1.2%	1.5%		2.1%	5th	-0.6%	2.6%	2.5%	2.3%	2.2%	110th	-0.7%	---	
	Profound & multiple learning difficulty	2.2%	2.1%	2.1%	1.9%		1.1%	2nd	+0.8%	0.8%	0.8%	0.8%	0.7%	2nd	+1.2%	---	
	Speech, language & communications needs	39.5%	40.3%	40.7%	40.6%		30.1%	1st	+10.5%	22.6%	23.2%	23.7%	24.0%	1st	+56.6%	---	
	Autistic spectrum disorder	14.1%	14.7%	14.8%	16.3%		19.0%	9th	-2.7%	12.5%	13.3%	14.3%	15.5%	66th	-2.8%	---	
	Social, emotional & mental health	16.4%	16.7%	17.7%	17.6%		17.4%	5th	-0.2%	18.0%	18.4%	19.2%	20.1%	120th	-2.5%	---	5
	Hearing impairment	2.3%	2.3%	2.2%	2.3%		1.7%	1st	+0.6%	1.8%	1.7%	1.6%	1.5%	7th	-0.8%	---	
	Visual impairment	0.9%	0.9%	0.8%	0.8%		0.7%	5th	+0.1%	1.0%	1.0%	0.9%	0.9%	77th	-0.1%	---	
	Multi-sensory impairment	0.2%	0.2%	0.2%	0.2%		0.2%	5th	-	0.3%	0.3%	0.3%	0.3%	88th	-0.1%	---	
	Physical disability	1.9%	1.8%	1.7%	1.7%		2.0%	7th	-0.3%	2.8%	2.7%	2.5%	2.4%	129th	-0.7%	---	
	Other difficulty/disability	3.3%	2.8%	2.2%	2.1%		3.6%	9th	-1.5%	4.0%	3.9%	3.6%	3.3%	120th	-1.2%	---	
	SEN Support but no specialist assessment	2.2%	3.3%	3.9%	2.6%		3.1%	9th	-0.5%	3.2%	3.4%	3.5%	3.5%	103rd	-0.9%	---	

Source: SEND Analysis Dashboard 2024

This is followed by SEMH (17.6%), which is similar to the rate among statistical neighbours (17.4%). ASD ranked third at 16.3%, which is below the average for statistical neighbours (19%) but above the national rate of 15.5%.

In Tower Hamlets, the most common type of need of pupils with an EHCP was ASD, accounting for 32% of pupils across all settings. This was followed by SLCN (31%).

Those with multi.-sensory impairments (0.4%), visual impairments (1%) and severe learning difficulties (1.5%) are among the least common primary needs for both EHCP and SEN support, according to the local data. However, despite their lower prevalence, it is important to recognise that these conditions can profoundly impact the lives of children and young people and may require significant lifelong resources.

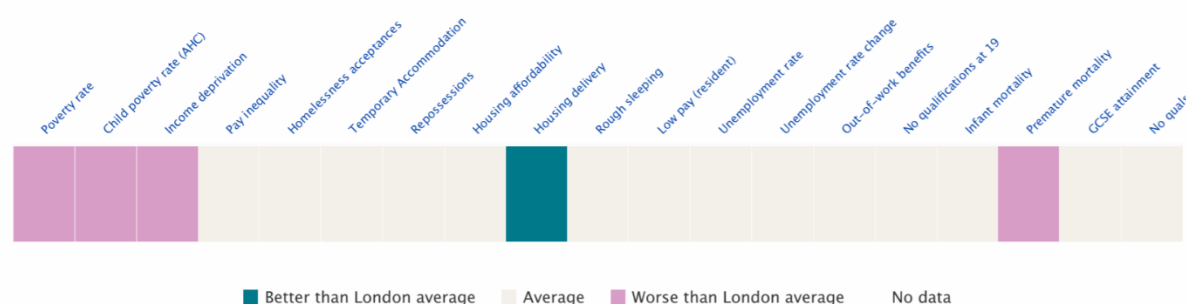
2.4 Deprivation

London has the highest poverty rate of all regions of England with one in four Londoners living in poverty. Although poverty varies across the city, more than half of boroughs also have higher levels of poverty than England as a whole.

According to London's Poverty Profile (2024)²⁷, Tower Hamlets has 47% of children living in poverty, the highest rate within England. Children born in the borough (and those who also experience high levels of child poverty) and more than twice as likely to be growing up in poverty than those in wealthier boroughs (e.g. Richmond or Kingston).

Figure 3.3: Tower Hamlets poverty rates across key indicators

Tower Hamlets ratings across key indicators



Source: Trust for London

Across all borough-level indicators in the *London Poverty Profile*, Tower Hamlets ranked worst for income deprivation, reflecting deep structural inequalities for the area. Conversely, it ranked best for average annual net housing completions, showing significant investment in infrastructure despite ongoing challenges²⁸.

Free school meal (FSM) eligibility is widely recognised as a proxy indicator of deprivation. In 2023/24, 40.1% of children in Tower Hamlets were eligible for FSM, almost double the national average of 24.6%. At the start of the 2023 academic year, Tower Hamlets Council became the first local authority in England to implement universal free school meals for all primary and secondary pupils up to the age of 16.

Children with SEND are disproportionately affected by deprivation, as reflected in their higher rates of FSM eligibility compared to their non-SEND peers. Within the SEND population in Tower Hamlets, 53.2% of children with an EHCP and 49.2% of those receiving SEN support were eligible for FSM. These rates are significantly higher than those observed across both London and England overall,

underscoring how SEND and socioeconomic disadvantage frequently overlap, thus compounding the challenges children and families face³.

2.5 Summary

This chapter explored the rising prevalence of SEND both nationally and in Tower Hamlets, where rates are amongst the highest in the country. In 2025, nearly one in five pupils in England had SEND, and Tower Hamlets recorded the highest proportion of pupils with an EHCP at 6.8%.

Gender disparities remain evident, with boys more likely to be identified with SEND. However, recent trends suggest a gradual increase in female identification, particularly at the SEN support level, which may reflect a better awareness of how needs like autism may present differently in girls.

Ethnicity plays a significant role in the local SEND profile, with Bangladeshi pupils forming the majority of those identified in Tower Hamlets. However, a large proportion of cases lack recorded ethnicity, limiting full insight into disparities.

SLCN is the most common primary need in the borough, with rates far above the national average. Amongst EHCP holders, ASD is the most frequently recorded need.

Finally, the chapter highlighted the strong link between SEND and deprivation. Tower Hamlets has the highest child poverty rate in England, and children with SEND are disproportionately affected, with over half eligible for free school meals.

3. Education

This chapter on Education provides a comprehensive overview of support for children and young people with SEND in Tower Hamlets. It covers key stages from early years through post-16 education, including identification, provision, outcomes, challenges, and safeguarding. The chapter also incorporates local data, service insights, and stakeholder perspectives to highlight both achievements and areas for improvement within the borough's education system.

3.1 Early Years

Section 23 of the Children and Families Act 2014 places a legal duty on health bodies to inform the local authority when they identify a child under compulsory school age who may have SEND. This duty is crucial in ensuring that children with emerging or diagnosed needs are identified early, enabling timely assessment and intervention to support their development and learning. Effective implementation of Section 23 requires strong multi-agency collaboration between health, education, and social care partners, as well as robust local systems for monitoring, planning, and delivering services.

In Tower Hamlets, early identification and support for children with SEND is a significant priority, given the borough's high levels of need and diverse population. Despite excellent service engagement rates, local data shows that children in Tower Hamlets continue to experience higher rates of developmental delay and complex SEND compared to regional and national averages.

3.2 Early Identification and Developmental Screening

All children in Tower Hamlets undergo newborn screening, including the newborn blood spot test, which identifies nine serious conditions early in life. As part of the Healthy Child Programme, every family is offered five mandated contacts with health visitors, with vulnerable families receiving additional visits and tailored support. In Tower Hamlets, the health visiting service has been restructured, with some responsibilities shifting from health visitors to community nursery nurses. This change is part of a broader strategy to implement the Healthy Child Programme²⁹. However, stakeholders have reported challenges related to this shift, particularly in ensuring that community nursery nurses receive adequate and appropriate training to provide the comprehensive knowledge required to support children's development.

3.2.1. Newborn and Infant Physical Examination (NIPE)

Coverage of the mandated newborn screening and early-infant physical examinations in Tower Hamlets is broadly in line with London but statistically 'worse' than England averages. Fingertips data show that in 2023/24, 95% of newborns in Tower Hamlets received their NIPE within 72 hours of birth (London 95.3%, England 96.1%). 98.5% received their newborn hearing screening in 2023/24 (London 98.8%, England 99.0%).⁵

3.2.2. Ages and Stages Questionnaire

The two-year health and development review, during which children are assessed using the Ages and Stages Questionnaire (ASQ) to monitor progress across key developmental domains. If delays are

suspected, an ASQ:SE-2 (Social-Emotional) assessment is undertaken, triggering referrals to specialist services where appropriate.

In 2023-24, 99% of children in Tower Hamlets received their 2–2.5-year review including an ASQ by age 2.5, the highest proportion in London⁵. However, children in Tower Hamlets performed worse than the national average across several domains⁵:

- 81.5% achieved the expected level in communication skills with 86.6% achieving nationally.
- 91.4% achieved the expected level in gross motor skills, compared to the national average of 93.3%.
- 82.9% achieved the expected level in fine motor skills – the fourth lowest figure in London and significantly below the England rate of 93.3%.
- 91.5% achieved the expected level in problem-solving skills with 92.5% achieving nationally.
- 87.2% achieved the expected level in personal-social skills, compared to 91.2% nationally.

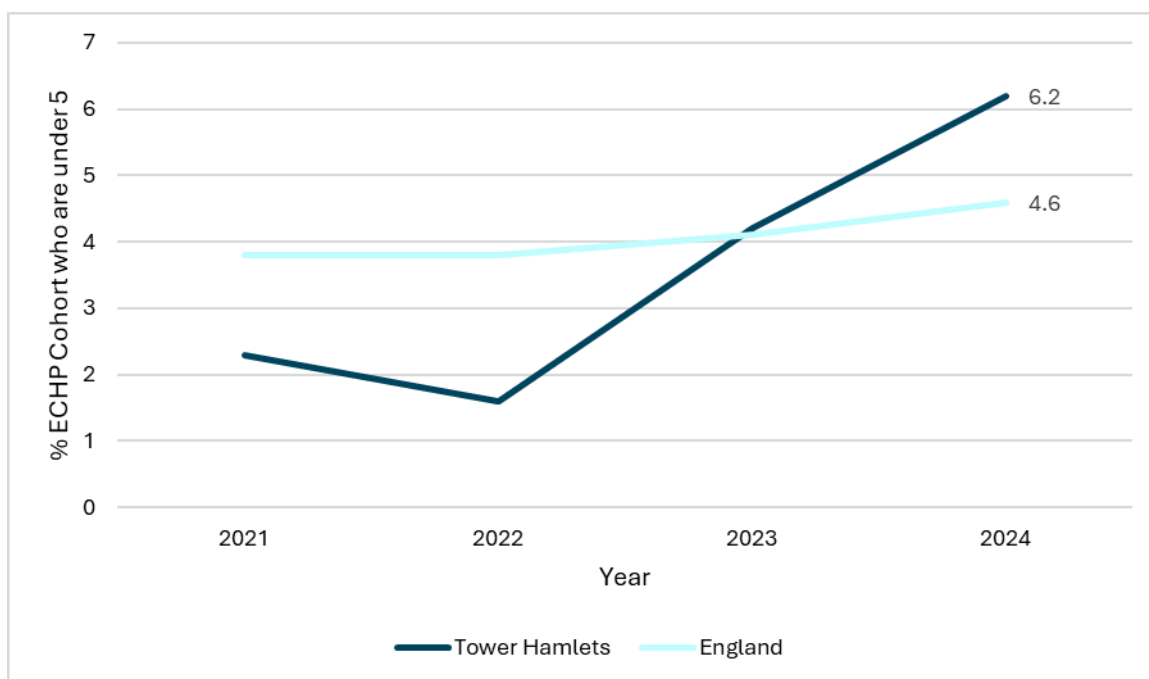
3.3 Early Education

Early education plays a critical role in promoting school readiness, particularly for children with SEND. Ensuring that children develop key communication, social, and self-care skills before starting school is a major focus in Tower Hamlets, supported through targeted interventions and partnerships with early years settings.³⁰

In England, all 3 and 4-year-olds are entitled to 15 hours of free early education per week for 38 weeks a year (570 hours in total annually). Working parents are now eligible for up to 30 hours of free childcare per week from the term after their child turns nine months, continuing until the child starts school. Some 2-year-olds remain entitled to 15 hours a week if their families meet specific criteria such as being on a low income, receiving qualifying benefits, or where the child has SEND, an EHCP, or is looked-after or adopted.

In 2024, 276 Tower Hamlets children aged below five had an Education, Health and Care Plan (EHCP), representing 6.2% of the borough's EHCP cohort, a higher proportion than both the England average (4.6%) and statistical neighbours (5.1%). This figure has more than doubled since 2022, indicating rising levels of complex need (Figure 4.1).

Figure 4.1: Percentage EHCP cohort



Source: SEND Analysis Dashboard, 2024

There were 6,029 4-year-olds and under attending government funded early education in Tower Hamlets in 2024.

- 0.7% of children aged two and under were receiving SEN support, and 0.3% had an EHCP, rates slightly above both London (0.5% and 0.1%) and England (0.4% and 0.0%).
- 4.8% of 3-year-olds were receiving SEN support and 2.2% had an EHCP, higher than London averages (3.1% and 0.6%) and England averages (2.0% and 0.5%).
- 7.2% of 4-year-olds were receiving SEN support and 5.5% had an EHCP, exceeding London (5.9% and 5.3%) and England (5.3% and 4.9%) averages³.

Table 4.1: Percent of pupils for Age, by type of SEN provision and type of need - 2016 to 2024¹ for Age 2 and under, Age 3, Age 4, EHCPs, No SEN and SEN support in England, London and Tower Hamlets for 2023/24

Age Group	Area	EHCPs (%)	No SEN (%)	SEN support (%)
Age 2 and under	England	0.0	1.0	0.4
	London	0.1	1.0	0.5
	Tower Hamlets	0.3	1.1	0.7
Age 3	England	0.5	3.0	2.0
	London	0.6	3.9	3.1
	Tower Hamlets	2.2	5.9	4.8
Age 4	England	4.9	7.5	5.3
	London	5.3	7.2	5.9
	Tower Hamlets	5.5	6.8	7.2

Source: Special educational needs in England.

Among nursery-aged children with SEND (SEN or EHCP), SLCN were the most common primary need, affecting a total of 49 children³.

Languages

Data from the Tower Hamlets School Census indicates that over 70% of nursery children with SEND spoke a language other than English, compared to 60% of the overall pupil population in the borough. This higher proportion of children with SEND in nursery who speak languages other than English may contribute to the increased speech and language needs observed⁴. children exposed to more than one language may develop spoken language later than peers exposed to only one.

3.4 Pathway

Tower Hamlets continues to invest in early identification and support for children with SEND. A Start for Life bid has been secured to fund a workforce pilot programme, enabling screening for social communication differences and speech and language needs from as early as 12 months of age. This proactive approach aims to identify emerging needs sooner, allowing families to access timely support.

A Speech and Language Therapy (SLT) treatment pathway for children aged 3 to 5 years has been launched in Tower Hamlets, transforming access to specialist services. Waiting times for assessment have significantly improved, falling from 35 weeks in 2022 to just over 10 weeks in 2024, enabling earlier intervention and reducing the risk of long-term language and communication difficulties.

In addition, early support is provided to children awaiting assessment through targeted interventions in early years settings and by health visiting teams, ensuring that emerging needs are addressed without delay.

Attainment

In 2024, the percentage of both SEN support (24%) and EHCP (4%) pupils achieving Early Years Foundation Stage 'Good Level of Development' returned to 2019 levels, bringing Tower Hamlets in line with the England average of 24% for SEN support and 4% for EHCP, and just below the statistical neighbour average for both groups (27% - SEN support, 5% EHCP)⁴ (Table 4.2).

Table 4.2: EYFSP Good level of development - SEN Support and EHCP in 2023 for Tower Hamlets, Statistical Neighbours and England

	SEN Support	EHCP
Tower Hamlets	25%	4%
Statistical Neighbours	27%	5%
England	24%	4%

Source: SEND Analysis Dashboard, 2024

3.4.1. Impact of COVID-19

It is important to note that some educational outcomes, particularly at Early Years Foundation Stage (EYFS), reflect the ongoing impact of the COVID-19 pandemic. In 2022, 0% of children with an EHCP and 18% of children with SEN Support achieved a Good Level of Development in the EYFS, compared to national averages of 4% and 23% respectively. These figures suggest significant disruption to early childhood development and learning due to pandemic restrictions.

3.5 School Age

Educational settings play a vital role in the development and well-being of children with SEND. They provide tailored support, inclusive environments, and access to specialist resources that help children thrive both academically and socially.

In Tower Hamlets, 90.3% of pupils with SEND attend mainstream schools, while 9.1% are supported in the borough's five special schools. Overall, Tower Hamlets' schools are highly successful, with 97% rated good or better by Ofsted.

Tower Hamlets has the highest proportion of pupils with an EHCP in England. By 2024, 6.8% of all pupils across school phases held an EHCP. This reflects a sustained increase from 2021 in the proportion of mainstream primary and secondary pupils requiring significant support⁴.

Primary needs among pupils with SEND

Speech, language and communication needs and ASD are the two most common primary needs among pupils with SEND. The January 2024 School Census shows that in the primary phase ASD accounted for 40% and SLCN 37%, while in the secondary phase SLCN accounted for 39% and ASD 22%.

A breakdown by primary and secondary school years is presented below.

Table 4.3: Percentage of pupils with an EHCP by primary type of need, Tower Hamlets primary and secondary schools, 2023/24.

EHCP Pupils	Primary	Secondary
Not Recorded	0%	0%
Autistic spectrum disorder	40%	22%
Hearing impairment	4%	2%
Moderate learning difficulty	4%	6%
Multi-sensory impairment	0%	0%
Other difficulty	2%	2%
Physical disability	3%	3%
Profound and multiple learning difficulty	1%	1%
Severe learning difficulty	2%	2%
Social, emotional and mental health	5%	14%
Specific learning difficulty	2%	4%
Speech, language and communication needs	37%	39%
Vision impairment	1%	2%
Total	100%	100%

Source: January 2024 School Census [LBTH Data, March 2024]

Educational outcomes

Tower Hamlets ranks among the best local authorities in England for educational outcomes for pupils with SEND. In Key Stage 2 (KS2), outcomes in Reading, Writing and Mathematics (RWM) are particularly strong:

- Tower Hamlets ranks 8th highest nationally, with 14.5% of EHCP pupils achieving the expected or higher standard in KS2 RWM, compared to 8.2% nationally.
- The borough ranks 12th nationally for the proportion of SEN Support pupils achieving the expected standard⁴.

Reasonable adjustments

Most children and young people with SEND attend mainstream schools. Under the Equality Act 2010, these pupils are recognised as having disabilities and are therefore entitled to request reasonable adjustments to support their learning and participation. Such adjustments can include additional time in tests and examinations, the use of assistive technology (e.g., computers or text-to-speech software), and the option to record information in alternative formats beyond traditional writing. These measures are designed to reduce barriers to learning, promote inclusion, and ensure that pupils with SEND can access the curriculum on an equitable basis alongside their peers.

Attendance and absence

Frequent absence among children with SEND can compound educational disadvantage, leading to poorer long-term outcomes. Conversely, regular school attendance offers structure and routine that is particularly beneficial for many children and young people with SEND.

Attendance patterns for pupils with SEND in Tower Hamlets show both strengths and challenges. Across all school phases, unauthorised absence rates remain low for SEND pupils, at only 2.6% for EHCP pupils and 2.7% for those on SEN Support, placing Tower Hamlets first among its statistical neighbours and in the top quartile nationally.

However, challenges persist in primary and special schools:

- The overall absence rate for SEN Support pupils in mainstream primary schools was 8.3%, placing Tower Hamlets in the worst-performing quarter of local authorities in England.
- In mainstream primary schools, 35% of EHCP pupils and 30.3% of SEN Support pupils were persistent absentees (defined by the Department for Education as pupils who miss 10% or more of possible school sessions in an academic year), among the highest rates nationally.
- In contrast, Tower Hamlets' secondary schools have particularly low absence rates: the overall absence rate in state-funded secondary schools is just 6.2%, with 18.6% of pupils (all pupils) classed as persistently absent, placing the borough among the best in England for secondary attendance. For pupils with an EHCP or SEN, the borough-level overall absence rate is 9.9%.
- Overall and persistent absence rates in Tower Hamlets' special schools remain above both statistical neighbour and England averages⁴.

Exclusions and suspensions

Tower Hamlets continues to perform well in minimising suspensions and permanent exclusions among pupils with SEND. The borough remains in the best-performing quartile nationally for exclusion rates:

- Ranked 4th in England for the suspension (fixed-term exclusion) rate of EHCP pupils in secondary schools.
- Ranked 8th in England for the permanent exclusion rate among SEN Support pupils.

3.6 Post-16

3.6.1. Overview of Post-16 SEND Population

The population of young people with SEND in Tower Hamlets continues to grow, with an increasing proportion of EHCPs extending into adulthood. By 2024, Tower Hamlets ranked 3rd highest in England for the proportion of its EHCP population aged 20–25 years.

Overall, the proportion of 0–24-year-olds with an EHCP in Tower Hamlets continues to rise, reflecting greater identification and sustained support for young people with complex needs as they transition to adulthood.

3.6.2. Educational Attainment

Key Stage 4 (GCSE) Outcomes

In 2022, pupils with SEND in Tower Hamlets achieved above-average GCSE outcomes compared to national figures:

Attainment 8 scores:

- EHCP pupils: 16.4%, compared to 14.3% nationally (ranked 48th in England).
- SEN Support pupils: 39.2%, compared to 34.9% nationally (ranked 25th in England).

English and Maths (Grades 9–4):

- EHCP pupils: 14%, similar to the national average of 14% (ranked 75th).
- SEN Support pupils: 48%, significantly outperforming the national average of 39% (ranked 28th).

Key Stage 5 (Post-16) Outcomes

Despite strong performance at GCSE, challenges emerge for SEND learners in post-16 education:

- At Key Stage 5 (A-level and equivalent), average point scores per academic entry for SEND students remain below the national average.
- Tower Hamlets ranks 11th among its statistical neighbours for the academic Average Point Score (APS) per entry for SEN Support students, indicating room for improvement in post-16 attainment outcomes.

There remain gaps in the provision of post-16 learning opportunities for those who are achieving a level 2 qualification or below at this age (unless for those with complex needs) and who would benefit from continued education within an appropriate environment.

Qualifications by age 19

Nonetheless, qualification rates by age 19 for SEND students are a significant strength in Tower Hamlets.

- Tower Hamlets is ranked 12th in England for the proportion of EHCP students achieving a Level 3 qualification (e.g. A-levels, BTEC Nationals) by age 19⁴.

This suggests that while post-16 attainment per entry may be lower, many young people with SEND are successfully completing full qualifications by age 19.

Participation in Education, Employment or Training (EET)

Participation in education, employment or training (EET) among young people with SEND in Tower Hamlets shows a mixed picture:

- Among 16- and 17-year-olds with an EHCP, Tower Hamlets performs strongly, with 94.6% in education or training in 2022, significantly above the national average of 88.7%. This places Tower Hamlets in the top quartile nationally for EET rates for this group.

However, for young people on SEN Support, outcomes are less favourable. In 2022, 89.4% of 16- and 17-year-olds with SEN Support were in education or training, which, while higher than the national rate of 86.9%, ranks Tower Hamlets 8th among its statistical neighbours and suggests lower participation relative to local peers. This leaves around 10.6% of SEN Support young people potentially not engaged in education, training, or employment (NEET) or with unknown activity.

The *Preparing for Adulthood team* in Tower Hamlets provides oversight of young people who are NEET, working closely with key partners such as the Youth Justice Service and the Careers Service. There are positive efforts to engage young people and support their transition into further opportunities. A range of local options are available, supported by promotional activities, such as the "Let's Work" event, to encourage awareness and participation.

3.7 Challenges and Risks

While the borough's educational performance for SEND learners is strong overall, significant challenges remain:

- Although GCSE outcomes are above average, the lower Key Stage 5 APS scores point to potential barriers faced by SEND students in sustaining higher levels of attainment through post-16 education.
- The high proportion of EHCP holders aged 20–25 reflects growing demand for specialist support into adulthood. This has implications for education, health and social care services, particularly as more young adults remain in education settings beyond age 19.
- Persistent absence remains a concern, as frequent school absence in earlier years can limit future qualifications and progression into employment or training.

3.8 Safeguarding

As outlined in the Education Act (2002)³¹, all schools have a legal duty to safeguard and promote the welfare of children. This duty includes creating a safe learning environment, making appropriate

referrals to social care, and ensuring that all staff are trained in safeguarding practices. The statutory guidance 'Keeping Children Safe in Education'³² emphasises that safeguarding is everyone's responsibility and clearly outlines the roles of schools and staff in fulfilling this duty.

In Tower Hamlets, children and young people with SEND are recognised as being more vulnerable to abuse and neglect. However, when engaging with the safeguarding team, there is limited visibility of whether a child or young person has SEND needs. While stakeholders generally demonstrate a good understanding of SEND, a more differentiated approach is recognised as critical to ensure safeguarding practices are adapted appropriately to meet the needs of this vulnerable group, ultimately optimising child safety.

Local safeguarding services and support

The following safeguarding services and support are available within Tower Hamlets:

- **Tower Hamlets Safeguarding Children Partnership:** A statutory body responsible for coordinating local work to safeguard and promote the welfare of children. Led by the three statutory safeguarding partners (Local Authority, Health and Police) and work with a wide range of organisations to keep children safe.
- **The Multi-Agency Safeguarding Team (MAST):** This team brings together professionals from various agencies to share information and identify risks to children at the earliest possible stage. This service is available to schools, children's centres, education support staff, parents/carers, pupils, and voluntary/community organisations.
- **MAST Early help and children and families' services:** A single point of access for the public and all those working with children, young people and their families within the local community, offering advice and recommending support across a variety of issues (i.e., housing problems, drug or alcohol addiction).

3.9 Education insights

Significant efforts were made to engage with schools, head teachers, and wider teaching staff within Tower Hamlets; however, within the timeline of the JSNA, responses were limited. Continued engagement with schools and the importance of this to help shape a holistic understanding and strategy towards support for children and young people with SEND has been noted within the recommendations. Further insights have been developed through stakeholder engagement:

- **Waiting lists:** Whilst specialist schools were seen as strong, it was felt that there were not enough provisions for pupils with complex SEN. Long waiting lists for specialised schools were observed, and when the need is urgent, this is acutely felt by parents / carers, and children and young people. It is sometimes the case that the specialist school provision isn't necessarily the right fit for the young person and consequently, outcomes may not necessarily be met. Additionally, it is acknowledged that all specialist schools face capacity constraints, with little to no ability to expand. This presents a critical challenge, especially considering the increasing number of assessments and diagnoses being made.

- **Accessibility to speech and language provisions:** This was considered to be strong and provided a good source of support to the child or young person, as well as reassurance for the parent or carer. However, capacity and availability remained a central challenge.
- **Attendance rates in secondary schools:** Strong partnership approaches have been instrumental in supporting good attendance rates in secondary schools, with a combination of resources and support services contributing to this success. However, there are still opportunities to strengthen these partnerships and strategies in the primary years to ensure consistent attendance from an early age.
- **Independent schools:** It is acknowledged that independent schools are generally less equipped to support children and young people with additional needs. There is often limited understanding of these needs and a lack of appropriate support provision. As a result, children and young people who perform well academically but have social or emotional difficulties may not be identified for additional support in these settings.
- **Fair access arrangements:** Stakeholders spoke of strong partnerships with all schools, enabling support to children when things are not working as they should, i.e., through a transfer to another school.
- **Exclusions:** Whilst it is observed Tower Hamlets performs well in this area, increases in exclusions have been acknowledged within the latest national data and continue to indicate that there is a disproportionate impact on children and young people with SEN

Additional insights and research related to education which are captured across individual categories of need and from the perspectives of parents, carers, and children and young people with SEND, help to build a more comprehensive and contextualised picture of the educational landscape in Tower Hamlets.

3.10 Recommendations

Following analysis, the following recommendations are presented to guide future actions and decision-making for children and young people with SEND in education:

- **School readiness:** School readiness should remain a high priority for the borough, as the early years present a critical window to influence and shape the long-term health and wellbeing outcomes of children and young people with SEND.
- **Strengthen attendance support:** Tower Hamlets has high persistent absence rates among SEND pupils in primary and special schools. A targeted attendance improvement strategy, possibly involving family outreach workers and flexible support plans could reduce absenteeism and its long-term impact on learning outcomes.
- **Strengthen mainstream SEND support:** Phoenix has provided valuable expertise to several mainstream schools across the borough, helping them develop more specialised support for pupils with SEND. Given the rising levels of need and the limited capacity within specialist schools, these initiatives should be expanded and strategically leveraged to make mainstream education more accessible and inclusive for children and young people with SEND. It should be expected that all classrooms include neurodivergent children.

- **Monitoring and mitigation:** While Tower Hamlets performs well in minimising exclusions, recent national trends indicate both suspensions and exclusions are increasing³³. Both can impact on academic, social and emotional wellbeing. Ongoing monitoring and targeted support for schools with higher exclusion rates, especially for pupils with social, emotional, and mental health needs can help sustain equitable outcomes.
- **Independent Schools:** It is important to review how independent schools identify children and young people with SEND. In addition, there should be a clear process for assessing the capability of newly established schools to identify students with SEND as part of their registration and quality assurance procedures.
- **Post-16 support pathway:** Though GCSE results are strong, lower Key Stage 5 outcomes suggest the need for improved academic and vocational pathways for SEND learners. This could include better tailored college support, inclusive apprenticeships, and revisiting transitional planning for young people working below Level 3.
- **Post-19 transitions:** With Tower Hamlets ranking 3rd in England for EHCP holders aged 20–25, there is a need for a clear multi-agency transition strategy that supports education, employment, and independent living outcomes for young adults with SEND.

3.11 Summary

Tower Hamlets demonstrates significant strengths in its early identification and support systems for children and young people with SEND, reflected in high screening coverage, proactive investment in early years pathways, and above-average educational outcomes in several key stages. However, persistent challenges remain. Local children continue to present higher rates of speech, language, and communication needs, as well as rising numbers of complex cases requiring EHCPs, particularly in the early years. Attendance and persistent absence remain areas of concern, especially in primary and special schools, while lower attainment at Key Stage 5 suggests barriers to sustaining progress into further education. The borough's diverse linguistic profile also intersects with SEND needs, increasing demand for specialist support. As more young people with SEND remain in education into adulthood, planning for transition and adult services will be critical to ensure that gains achieved in earlier years are maintained and that no young person is left behind.

4. Communication and Interaction: Autism Spectrum Disorder (ASD)

According to the National Autistic Society, ASD is a neurological and developmental disability that affects how people communicate and interact with the world around them. The effects and severity of symptoms vary widely across the spectrum.

Although autism can be diagnosed at any age, symptoms typically emerge within the first two years of life, affecting approximately one in 100 people (WHO 2023).

4.1 Causal Factors

Various factors contribute to the development of ASD, some of which are particularly relevant to the local communities in Tower Hamlets.

Genetic influences play a significant role, as ASD can run in families, making children with older siblings with ASD more likely to develop the condition³⁴. Additionally, children with certain rare genetic conditions, such as Down syndrome and Fragile X syndrome, have a higher likelihood of presenting with ASD³⁵.

Environmental factors also contribute to the risk of ASD. Research has suggested a potential association between exposure to air pollution especially during the third trimester of pregnancy or early childhood, increases the likelihood of ASD³⁶ however, the extent and mechanisms of this relationship remain unclear, a concerning issue given that Tower Hamlets ranks among London's top five worst boroughs for air pollution⁵.

Other risk factors include being an older parent, experiencing pregnancy and birthing complications, and having closely spaced pregnancies (less than one year apart). Prenatal and maternal stress and trauma have also been linked to ASD³⁷.

Moreover, Some studies have identified higher rates of ASD among children of mothers with recent migration experience, potentially reflecting the impact of social and environmental factors such as stress, trauma, socioeconomic disadvantage, or barriers to healthcare access. However, these associations are complex and not fully understood³⁸.

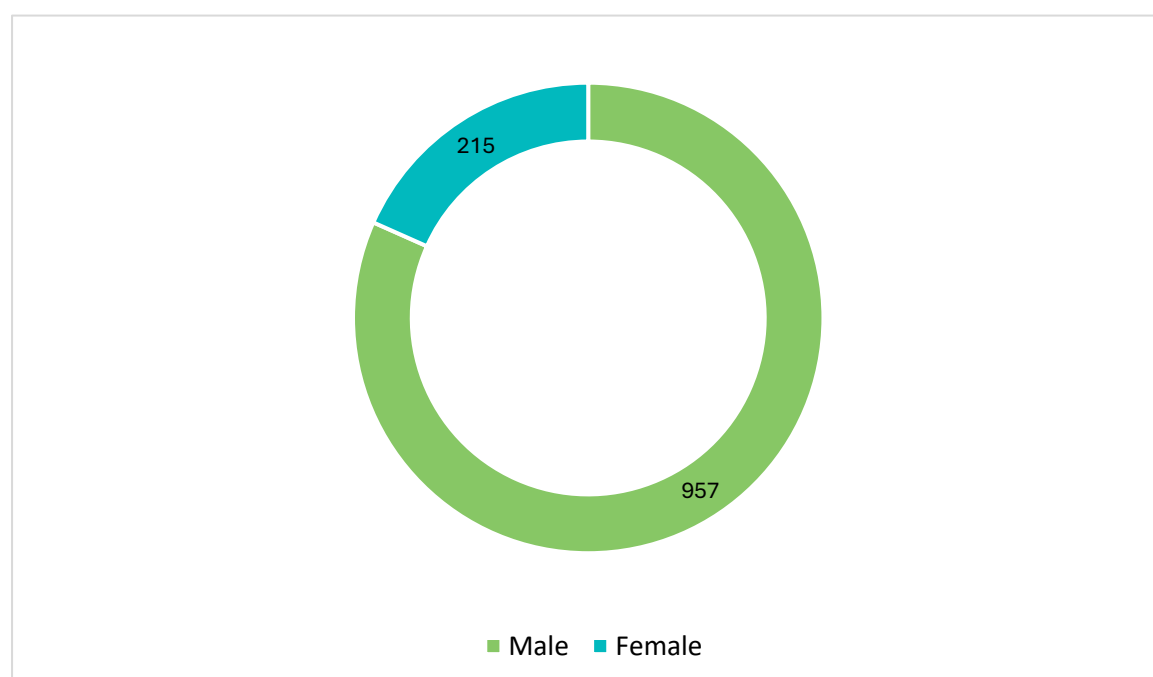
4.2 Local Picture

ASD is one of the most prevalent conditions affecting children and young people in Tower Hamlets, with 39% of all pupils with EHCPs having an ASD diagnosis. This is the second-highest proportion for any SEND category in the borough. Additionally, children with ASD often need additional support for speech, language, and communication, as well as social, emotional, and mental health challenges, which are the most frequent secondary needs, representing 21% and 3% of secondary needs among children with autism. ASD is also the most common secondary need for children with speech, language, and communication difficulties.

Referrals for ASD diagnosis have risen by 300% since 2021³⁹. The condition is more commonly diagnosed in boys than girls, at a ratio of 4:1 in Tower Hamlets, suggesting an under-identification of

ASD in girls. This underdiagnosis is widely documented, as girls often exhibit different signs and symptoms than boys and may be more likely to mask their challenges due to socialisation⁴⁰.

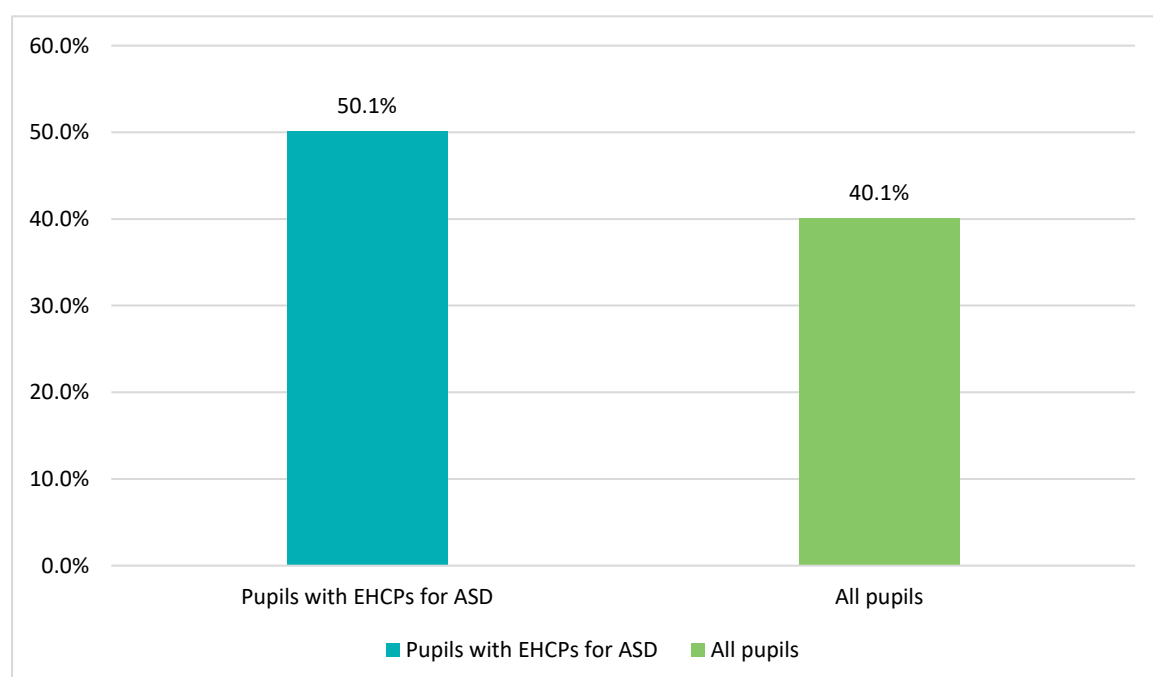
Figure 5.1. SEND ASD prevalence by gender in 2024



Source: Data Sources: LBTH SEN2 Return 2024 and IDACI 2019 Postcode Checker [MHCLG 2019]

Poverty remains a significant factor for children and young people with autism in Tower Hamlets. Around half (50.1%) of pupils with an Education, Health and Care Plan (EHCP) for ASD are eligible for free school meals, compared with 40.1% of the wider school population (Figure 5.2).

Figure 5.2. Percentage of Free school meal eligibility among pupils with EHCP's for ASD, 2023/4



Source: Special educational needs in England, GOV.UK

Additionally, the majority (61%) of pupils with an EHCP for ASD speak a first language other than English, a figure that mirrors the overall linguistic diversity of Tower Hamlets' school population. This suggests that pupils with ASD are not over-represented among children who speak English as an additional language.

Ethnic disparities are also evident in ASD identification and support. Local data from 2023 suggests that while the overall distribution of pupils with EHCPs for ASD broadly reflects the ethnic composition of the borough's school population, certain groups are over- or under-represented.

Pupils of Black Somali heritage are notably and disproportionately represented in ASD diagnoses, with 5.6% of Somali pupils having an EHCP for ASD, higher than the 3.6% representation of Somali pupils in the school population. In contrast, pupils from 'Any other ethnic group' and 'Any other white background' are under-represented in EHCPs for ASD. This pattern is not unique to Tower Hamlets; similar trends have been observed nationally, such as in Bristol, and internationally, including studies from Sweden, where children of Somali heritage have been found to have higher rates of ASD diagnosis. Community feedback suggests Somali families may face additional barriers to accessing assessment and support, such as limited awareness of available services and cultural differences in understanding autism.

Disparities are also observed at the level of SEN support (i.e. without an EHCP). White British pupils are significantly over-represented, accounting for 18.7% of those receiving SEN support for ASD despite representing only 7.7% of the school population. Conversely, Bangladeshi pupils are under-represented, comprising 48.7% of those receiving SEN support for ASD, while making up 62.4% of the overall school population (table 7).

Table 5.1: Percentage of pupils receiving EHCP or SEN Support by ethnic group, 2023.

	Bangl adesh i	Black Africa n	Black Somal i	White British	Any other ethnic group	Any other mixed backgr ound	Any other white background
Total % of all pupil s in ethni c grou p	62.4%	3.7%	3.6%	7.7%	3%	4.8%	4.9%
% of pupil s in ethni c grou	62.8%	4.3%	↑ 5.6%	8.2%	↓ 1.4%	4.9%	↓ 2.8%

p with EHCP for ASD							
% of pupils in ethnic group receivi ng SEN suppor t for ASD	↓ 48.7%	3%	2.2%	↑ 18.7%	1.7%	↑ 9.1%	↓ 3%

Note: This table includes a selection of the most prominent ethnic groups in Tower Hamlets to illustrate key differences. Data for all ethnic groups are available on request.

4.3 Diagnosis

Accessing a paediatric ASD assessment in Tower Hamlets can be complex due to the fragmented nature of local services, which poses challenges for both families and professionals. Parents or carers who notice signs of ASD in their child can seek referral assistance from various professionals, including health visitors, nursery staff, school staff (teachers and SENCOs), speech and language therapists, and occupational therapists. Accessing a referral through a GP is not advisable, as they may not be able to provide the detailed information required.

Two distinct services in Tower Hamlets offer ASD assessments for children and young people, each with its referral process and eligibility criteria:

- The Autism Spectrum Disorder Assessment Service (ASDAS): This service is provided by a multidisciplinary team that includes community paediatricians, a clinical psychologist, an occupational therapist, a speech and language therapist, and a social worker. It is an "assessment-only" service funded by the NHS and delivered by Barts Health NHS Trust. Parents awaiting an assessment for their child receive an information support pack from the Community Paediatric Service, where ASDAS is based.
- Child and Adolescent Mental Health Services (CAMHS): CAMHS in Tower Hamlets conducts ASD assessments for children and young people referred for mental health issues who also display signs of ASD. Parents awaiting an assessment through CAMHS can access engagement and support sessions.

Although there have been improvements in the coordination between these two services, stakeholders indicate that further improvement is needed. Post-diagnostic support for children with ASD and their families is available through the Phoenix Outreach Service and the Autism Support Tower Hamlets Service, delivered by the National Autistic Society (NAS). Additionally, the Children's Disability Team offers a 'stay and play' service, which includes support for children awaiting diagnosis, who are often overlooked.

4.4 Pathway

The demand for ASD assessments has increased nationwide, exceeding available resources^{41 42}. Tower Hamlets has been particularly affected, with the number of accepted referrals for ASD assessments at the Autism Spectrum Disorder Assessment Service (ASDAS) tripling since 2020, reaching over 600 referrals in 2023. Local data from ASDAS, covering January to July 2023, indicates that the service receives an average of 88 new referrals each month. Of those assessed, over 90% are diagnosed with ASD, equating to about 32 diagnoses per month. However, the average wait-time for a diagnosis is 20 months, with some families waiting up to 30 months (2.5 years).

This rising demand is putting a significant strain on Tower Hamlets' services, which are increasingly understaffed and underfunded. Key stakeholders have identified several contributing issues, including long waiting times, limited interim support for families, and overly complex assessment processes. There is a growing need for streamlined referral and assessment procedures, prioritising children with the highest need, enhanced support for professionals involved in the process, and improved service integration.

4.5 Healthy Lifestyle

Children with ASD often face unique challenges in maintaining a healthy lifestyle. Dietary issues are common, such as the need for routine at mealtimes, preferences for eating alone, sensory sensitivities, and gastrointestinal distress, which can lead to limited food choices⁴³.

Additionally, research suggests children with ASD tend to be less active than their peers⁴⁴. A recent meta-analysis of nine studies found that children with ASD spend 30 minutes less per day in moderate-to-vigorous physical activity than their peers⁴⁵. This is partly due to barriers like delayed movement skills, sensory sensitivities, social and communication challenges, and the need for increased parental involvement.

Sleep problems, including insomnia and sleep apnoea, are twice as common among children with ASD when compared to their non-ASD peers, which can impact their appetite, metabolism, and physical activity levels during the day⁴⁶.

Young people with ASD have similar desires for sexual and personal relationships as their peers without ASD. However, they often face limitations in sexual health education and encounter challenges in accessing sexual health services. These challenges may include difficulties in obtaining contraception due to communication barriers, sensory sensitivities, and social anxiety⁴⁷.

4.6 School Life

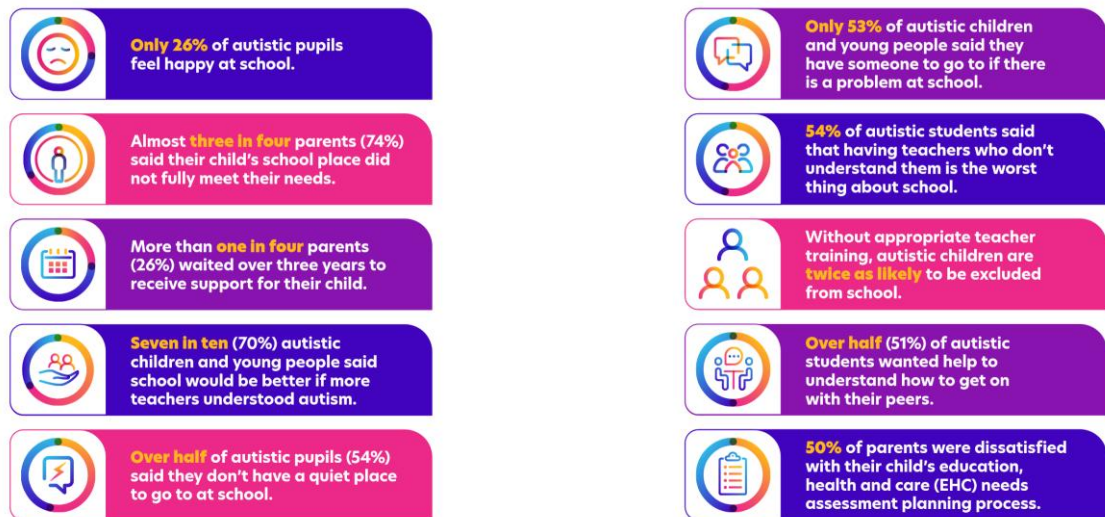
A national survey by the National Autistic Society (2021) reveals significant challenges faced by children with ASD in mainstream education. The survey found that only one in four pupils with ASD were happy at school, and 70% of children and young people believe that their school experience would improve if more teachers had a better understanding of ASD⁴⁸.

Figure 5.3: National Autistic Society — Education Report 2023, Key findings from 2021 report

Key findings from the 2021 report¹⁰



Research we conducted in 2021 showed the extent of how schools are failing autistic children and young people, as well as their parents.



Source: National Autistic Society

The voices of young people with ASD in Tower Hamlets highlight these challenges vividly. Members of the Our Time Youth Forum describe experiencing significant challenges in mainstream education. They express a lack of immediate support, particularly for those targeted by bullying or dealing with anger management issues. Many felt that there was not enough understanding or inclusion of ASD within the education system, both from teachers and peers. They highlight the need for better training for educators and greater awareness and acceptance in schools. Additionally, they emphasise the importance of fostering connections and encouraging those who struggle to engage with others, which could improve their school experience.

Autism has been compared to a fingerprint, each person has their own version, yet no two are alike. This uniqueness makes it essential for parents, teachers, peers and healthcare professionals to recognise and understand individual differences in order to provide effective support and inclusion.

4.7 Outcomes

Children and young people with ASD frequently experience significant challenges relating to both physical and mental health. Research indicates that adolescents with ASD may face particular difficulties in understanding and navigating sexual health, due in part to social communication differences and a lack of sexual education tailored to their specific needs. These challenges can increase vulnerability to sexual exploitation and engagement in risky sexual behaviours^{49 50}.

Evidence suggests that substance misuse is generally less prevalent among children and young people with ASD compared to their neurotypical peers. However, the risk can increase during adolescence and adulthood, particularly as individuals with ASD may use substances as a means of coping with anxiety, depression, or social isolation⁵¹.

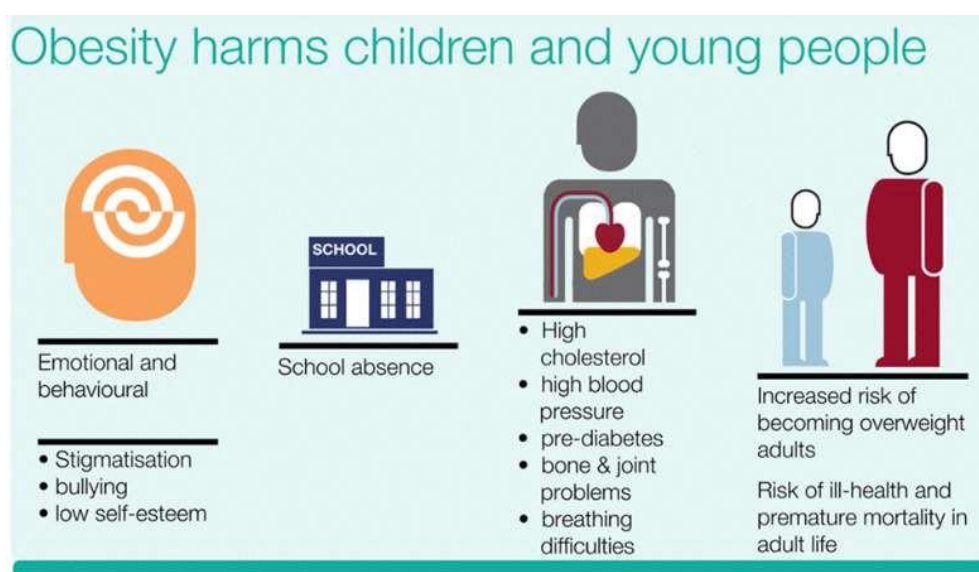
Mental health issues are significantly more common among children and young people with ASD, with conditions such as anxiety, and obsessive-compulsive disorder occurring at higher rates than in the general population⁵². A large-scale UK study found that around 70% of children with ASD have at least one co-occurring mental health condition, with approximately 40% experiencing two or more^{53 54}. These co-occurring mental health difficulties can further exacerbate challenges in areas such as social relationships, education, and overall well-being.

Research indicates that gender-diverse identities, including transgender⁵⁵ and gender non-conforming identities, are more prevalent among individuals with ASD than in the general population. Although the exact reasons for this association remain unclear, several contributing factors are currently being explored. These include potential differences in how gender identity develops and is expressed in individuals with ASD. Some evidence suggests a link between autism and gender dysphoria⁵⁶, with individuals with ASD appearing more likely to experience gender dysphoria compared to neurotypical individuals. However, the underlying causes of this connection are not yet well understood, and further research is needed to clarify the nature of this relationship.

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Children and young people with ASD also commonly experience gastrointestinal (GI) issues, including abdominal pain, constipation, and diarrhoea. Studies indicate that GI problems are significantly more prevalent among individuals with ASD than among the general population and can substantially impact daily life, including sleep, behaviour, and overall quality of life⁵⁹.

Figure 5.4: OHID, Childhood obesity: applying All Our Health, April 2022



Source: GOV.UK Office for Health Improvement & Disparities

In Tower Hamlets, children in Reception and Year 6 in mainstream schools are weighed annually, as part of the National Child Measurement Programme. However, the results are not adjusted for special educational needs, making it difficult to monitor the weight status of children with ASD locally. Living with excess weight increases the risk of developing Type 2 diabetes and cardiovascular disease⁶⁰, as well as a range of social impacts outlined by the Office of Health Improvement and Disparities (Figure 4).

4.8 What works (evidence-based practice)

Supporting children and young people with ASD requires a holistic, person-centred approach that considers the individual's strengths, needs, and preferences. Interventions should be tailored rather than "one size fits all," as autism presents differently in each individual. UK guidance emphasises early intervention, multidisciplinary support, and meaningful involvement of families and young people in planning and decision-making.

Early identification and assessment

Early recognition and assessment of autism are associated with improved outcomes, including better communication skills, social engagement, and family wellbeing. NICE guidelines recommend structured assessments are undertaken by professionals trained in recognising autism in children and young people¹⁴. Early identification allows families to access targeted support, including educational adjustments and family interventions.

Communication support

Many children with ASD experience differences in how they communicate and understand social interactions. Effective support aims to reduce barriers and enhance participation, with interventions tailored to the individual's goals and needs. Speech and language therapy, play-based programmes to build understanding among families and teachers, and alternative communication tools for children who use little, or no speech can all be helpful. Some children with ASD develop personal strategies, such as preparing for social situations or choosing activities that feel manageable. Good practice also involves neurotypical people allowing extra time for processing, respecting all forms of communication, and recognising that behaviour can be a means of expression. Professionals should be mindful of cultural differences and the tendency of some girls and young women with ASD to mask social communication difficulties⁶¹.

Evidence-based communication strategies include structured social communication programmes (e.g. Social Stories™, PECS), speech and language therapy focused on functional communication, and approaches that build joint attention and interaction skills, such as the Early Start Denver Model. NICE guidance⁶² also emphasises supporting alternative or augmentative communication methods for minimally verbal children.

Sensory and environmental adaptations

Sensory processing differences are common. Adjustments such as creating quiet spaces, reducing noise and light levels, and using sensory tools can help children feel comfortable and participate more fully at home, school, and in the community⁶³.

Education and learning

Children with ASD often benefit from tailored support in education, including visual timetables, clear instructions, additional processing time, and regular movement breaks. Adapting teaching strategies and collaborating closely with families are key to helping children engage and succeed¹.

Family support and mental health

Families of children with ASD benefit from clear, accessible information about autism, practical strategies for managing daily challenges, and emotional support to reduce stress and improve wellbeing. Peer support groups and parent networks offer valuable opportunities for sharing experiences and reducing feelings of isolation¹⁴.

Supporting parents and carers to understand their child's communication and sensory needs, as well as helping them navigate education and health services, empowers them to advocate effectively. Children and young people with ASD are more likely to experience anxiety, depression, and other mental health difficulties. All children and young people with ASD should have full access to health and social care services, including mental health services, regardless of their intellectual ability or any coexisting diagnosis. Health and social care professionals working with children and young people with ASD in any setting should have training in autism awareness and skills in managing autism,

Shared decision making

It is good practice to involve children and young people with ASD in decisions about their care and support wherever possible. This helps ensure interventions reflect their strengths, preferences and goals.

4.9 Support services (ASD services available across 0-25 life course)

Local Offer (universal offer): The Tower Hamlets Local Offer website provides dedicated information and guidance for families around autism, including support available before and after a diagnosis. The Local Offer signposts to services such as parent support groups, autism-specific short breaks, educational support, and local community activities for children and young people with ASD.

Figure 5.5: Example Parenting Classes provided by the Tower Hamlets Family Hubs to support families with children and young people with autism⁶⁴.

Parenting Classes



Supporting Autistic Children and teens

Complete the enquiry form to apply:
[Parenting adult education enquiry form](#)

Understanding your child with additional needs 0-19+yrs (online)

Open to all Tower Hamlets parents with children 0-19, 25 with SEND)
[Solihull Approach](#)

Understanding Autism (in person)

[Apply via link here](#)

Speak to staff at Family Hubs/Children and Family Centres further information
[Family Hubs website](#)

Source: Tower Hamlets Family Hubs – Family Wellbeing & Support Services

Tower Hamlets Autism Services: Several services in Tower Hamlets support children and young people with autism. The Phoenix Outreach Service offers specialist advice to schools and families to help pupils with ASD thrive in education. The Tower Project runs the First Start Autism Service, supporting children and young people aged 5–25 with ASD with life skills, social inclusion, and community access.

CAMHS Neurodevelopmental Service: The Child and Adolescent Mental Health Service (CAMHS) in Tower Hamlets includes a neurodevelopmental team that provides assessment, treatment, and support for children and young people with ASD who also have mental health needs. The service offers individual interventions as well as workshops for parents.

Short Breaks and Community Support: Short breaks specifically for children with ASD are available through services such as the Tower Project and the Children with Disabilities Team. These provide respite care and structured activities tailored to children's sensory and communication needs. Community-based activities, including autism-friendly leisure sessions, are also offered locally. Stakeholders report in comparison to other boroughs, the short breaks offer provides variance and choice, without the need for complex assessments process which often cause stress. Example offers include overnight respite, childcare schemes, befriending or direct payment options.

Disabled Children's Outreach Service (DCOS): A community based, therapeutic interventions team supporting children and young people with behaviour that is challenging to understand and manage due to diagnosed developmental difficulties, disabilities and/or complex lifelong physical health needs. Eligibility for this includes children and young people with ASD (who also have severe learning disabilities or behaviour which is challenged) or children and young people with complex health needs (physical and /or learning disabilities, who require palliative care and those with sensory impairments).

Phoenix School: Phoenix School is the main specialist school in Tower Hamlets for children and young people with ASD. It caters for pupils aged 3–19 with autism and severe learning difficulties. The school offers a highly individualised curriculum focusing on communication, independence, and life skills, supported by a multidisciplinary team including speech and language therapists, occupational

therapists, and behaviour support staff. Phoenix also provides outreach services to mainstream schools to help support pupils with ASD in inclusive settings.

Specialist Classes in Mainstream Schools: In addition to Phoenix School, some mainstream primary schools in Tower Hamlets host specialist autism classes. These classes, sometimes supported by Phoenix's outreach service, provide targeted support within a mainstream environment. Pupils remain enrolled in the mainstream school but receive specialist teaching in smaller groups to address their specific communication, sensory, and learning needs. However, stakeholders report that capacity for these classes is limited, and families have raised concerns about a lack of clear information and choice around placements.

Other Special Schools: While not exclusively for pupils with ASD, other special schools in Tower Hamlets, such as Beatrice Tate School and Stephen Hawking School, support children and young people with autism alongside a broader range of learning needs. These schools provide structured environments and specialist teaching approaches suitable for pupils with complex needs.

Tower Hamlets Transition Team: This team supports young people with disabilities, including those with ASD, in transitioning from children to adult services. They provide guidance on education, employment, and independent living.

These services work together to ensure that individuals with ASD in Tower Hamlets have the support they need during critical transitions in their lives.

4.10 Gaps

A number of gaps were identified by stakeholders:

Gaps in provision and system fragmentation

There are significant service gaps for children with ASD in Tower Hamlets. Stakeholders report a clear divide between specialist and mainstream provision. Children who do not meet the threshold for specialist services but struggle in mainstream settings often fall through the cracks, receiving little or no support.

This issue is compounded by limited early interventions and insufficient pathways for children with emerging needs. Services are often reactive rather than preventative, and parents frequently feel that support is only accessible after a formal diagnosis or when needs become acute.

Limitations of EHCPs and academic focus

EHCPs are viewed as too narrowly focused on academic attainment. This approach fails to capture the broader challenges faced by many children with ASD, particularly those who are academically capable but struggle with daily functioning, such as social communication, emotional regulation, and life skills.

Crucial areas of need, such as sleep hygiene, feeding, toilet training, and bedtime routines, are under-supported. While the Occupational Therapy (OT) service is praised for its holistic, independence-focused approach, access remains limited due to demand and resourcing constraints.

Reduced services for feeding and eating issues

Specialist support for children with restrictive eating or feeding difficulties has declined. A previously commissioned six-week programme run by Educational Psychologists to support families around fussy eating was decommissioned in 2022. This has left a gap for families dealing with complex feeding issues, which are often co-occurring with ASD.

Underdiagnosis and inequities in identification

Although ASD is generally more prevalent among boys, research suggests that part of this gender gap reflects underdiagnosis in girls, who may present differently or mask their difficulties. This may lead to missed opportunities for timely intervention and tailored support. This disparity has lifelong consequences, particularly as girls transition into adolescence and adulthood.

Certain ethnic groups are also disproportionately impacted. While both White British and Somali children are more likely to be affected by ASD, Somali families face additional barriers, such as lack of culturally sensitive services and limited community awareness of autism. Cultural differences in understanding and identifying ASD may contribute to reduced engagement with services.

Lengthy waiting times and lack of interim support

Families often wait up to two and a half years for a diagnosis. During this long waiting period, there is minimal interim support. Even post-diagnosis, many families report receiving little help in understanding what the diagnosis means, how to support their child, or how to navigate the complex SEND system.



Tower Hamlets and City
SEND IASS

SENDIASS (Special Educational Needs and Disabilities Information, Advice and Support Service) is highlighted as a helpful resource, but awareness of such support is inconsistent among professionals and families.

Insufficient awareness and training in schools

Stakeholders and education partners report that there is a low level of autism awareness among school staff and pupils, which contributes to the social isolation of children with ASD. This lack of understanding can exacerbate behavioural issues, mislabel children's needs, and undermine inclusion efforts. Furthermore, professionals themselves often lack knowledge of local SEND services, creating additional barriers to effective support.

Capacity and choice in specialist provision

There are concerns about the current capacity of autism-specific classrooms in Tower Hamlets. While approximately 200 children are supported in these settings, demand is rapidly increasing, and provision is not expanding to match. These classrooms, often located in mainstream schools and supported by Phoenix School, are not officially designated as SEN units or resource bases, leading to inconsistencies in access and provision.

Parents report a lack of real choice when it comes to placements, and the system struggles to adapt to growing numbers of children with social communication difficulties, many of whom may be awaiting diagnosis or operating in a pre-diagnosis space.

Shifting towards a needs-based approach

Stakeholders express a strong desire to move away from a diagnosis-driven model towards a needs-based approach. Currently, ASD diagnosis is often seen as a "gateway" to support, particularly for unlocking EHCPs or other statutory interventions. This can delay essential help for children who have clear needs but are stuck waiting for formal assessment.

There is a call for a more graduated response model that identifies and addresses needs without the prerequisite of diagnosis. This would enable earlier, more responsive interventions and better match support to individual children and families.

Empowering families and making better use of existing resources

Many families feel disempowered in the current system. There is an opportunity to strengthen and better utilise services such as Family Hubs, which could offer practical support around emotional wellbeing, toilet training, and parenting strategies.

Tower Hamlets is a comparatively well-resourced borough, but there is a recurring challenge around "what exists, where, and when." Families and professionals alike struggle to navigate the landscape of services, suggesting the need for clearer pathways and joined-up information.

4.11 Recommendations

Following the analysis conducted, the recommendations outlined below are proposed to address the key findings:

- **Bridge the gap between mainstream and specialist provision:** Establish a graduated support framework that ensures children with ASD who do not meet thresholds for specialist services, still receive timely and appropriate help within mainstream settings. This should include, targeted early interventions, flexible school-based support and clear referral/ escalation pathways to avoid children falling through the cracks between mainstream and specialist provision.
- **Adopting a needs-based approach:** A shift towards a needs-led approach rather than relying on formal diagnosis as a gateway to support would allow earlier identification of and response to individual needs, strengthening support for children and young people and leading to improved outcomes across education, health, and wellbeing. A more flexible, responsive system would also reduce delays in access and ensure that support is matched to need rather than diagnostic status.
- **Strengthen EHCPs:** Continue to build on established relationships between health, social and education to develop a more holistic approach to the health and wellbeing of children and young with ASD. An MDT approach will enable practices of broader areas of functioning (emotional, social) to be understood and better supported.
- **Complex feeding support:** Develop a multidisciplinary approach involving dieticians, psychologists, OTs and autism specialists to address and support complex feeding needs. Offering accessible resources and training for parents and early years can further support efforts in this area.

- **Improving equity:** Introduce targeted awareness approaches to reduce gender and cultural disparities in ASD identification, with a focus on improving early recognition in girls and ethnic diverse communities. Additionally, work with Somali and other underrepresented communities to co-design culturally sensitive outreach and support materials around neurodiversity.
- **Increased awareness, access and equity:** Whilst progress continues to be made, gaps remain in understanding what services and support are available. Assessing the effectiveness of existing mechanisms aimed at raising awareness can help inform the development of more targeted approaches. Additionally, collaboration with parents, carers, and professionals can help identify specific gaps and determine how best to address them.
- **Training:** For education professionals, implement a consistent, borough-wide approach to training for education professionals to strengthen understanding of ASD. This should include developing knowledge of ASD behaviours, individual needs, and available local services. A standardised approach will help reduce barriers to support, promote inclusive practice, and improve outcomes for pupils with ASD.
- **Pathway support:** Whilst navigating the pathway for diagnosis, provisioning of interim support packages can be strengthened through clear, accessible guides and resources that help families navigate each step. Increasing awareness of local services such as SENDIASS, Family Hubs, and Parent Carer Forums will further empower families and improve access to early help.
- **Strengthen information-seeking behaviours:** Promote proactive engagement with services by encouraging families and carers to take ownership of information-seeking behaviours. Techniques such as motivational interviewing can be used to build trust, enhance motivation, and support families in accessing relevant information, resources, and support networks.
- **Service capacity and resource planning:** Explore opportunities to expand assessment capacity, recruit additional multidisciplinary staff, and increase places in specialist ASD classes to meet growing demand.
- **Address disproportionality:** Undertake targeted analysis and community engagement to understand and address the over-representation of Black Somali pupils in ASD EHCPs and White British pupils at SEN Support level. Co-produce culturally sensitive outreach, awareness, and early support strategies with affected communities.

4.12 Summary

The increase in capacity to undertake assessments has enabled greater identification and provisioning of support. However, rising demand, long waits for diagnosis, and fragmented services make it difficult for families to access timely support for children and young people. Many children fall through the cracks, particularly girls and those from minority backgrounds, due to underdiagnosis and a system that often requires a diagnosis before formal help is provided.

Furthermore, schools struggle to meet the diverse needs of students and whilst specialist services like Phoenix School and local outreach efforts exist, capacity is limited, and information is often unclear. Despite this, there is a growing movement toward more holistic support and observed increases in

support provisions whilst navigating ASD diagnosis pathways. The recommendations focus on creating a more inclusive, needs-led system by improving early intervention, reducing reliance on formal diagnosis, strengthening support in schools, addressing inequalities in identification, enhancing service awareness and empowering families through clearer pathways and accessible resources.

5. Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a childhood-onset condition with characteristics of inattention, impulsivity and hyperactivity. A child or young person may show signs of being inattentive, such as:

- Being easily distracted.
- Finding it hard to listen to what people are saying or to follow instructions.
- Forgetting everyday tasks, like brushing their teeth or putting on socks.

They may show signs of being hyperactive and impulsive, including:

- Having high energy levels.
- Fidgeting or tapping their hands and feet.
- Talking noisily.
- Feeling restless, or getting up and moving around, when they are supposed to sit still.
- Finding it hard to wait their turn, or interrupting conversations.

Most children and young people with ADHD have symptoms of both the inattentive and hyperactive-impulsive type ⁶⁵.

5.1 Causal Factors

The causes of ADHD are complex and therefore not fully understood or always known. However, it is most likely to include a combination of both genetic and environmental factors ⁶⁶. Research highlights a strong hereditary component, while certain prenatal conditions and brain injuries may also increase the risk. Though no single cause has been identified, these factors collectively contribute to the complexity of ADHD's development and are outlined below:

Genetic influences

Research indicates a strong genetic component to ADHD. Studies suggest that if a parent has ADHD, their child has more than a 50% likelihood of also having the condition⁶⁷. Twin and family studies estimate ADHD heritability at approximately 70–80%, indicating that while genetics play a major role, environmental factors also contribute to its development⁶⁸.

Pregnancy and birth risks

Whilst ADHD does not necessarily have a direct cause associated with pregnancy, exposure to certain factors during pregnancy may increase the risk of the child being diagnosed with ADHD. For example, smoking during pregnancy, alcohol exposure, exposure to toxins, maternal stress, children born with a low birth weight or born premature have a higher risk of having ADHD ⁶⁶.

A high fat, high sugar diet during pregnancy may also be linked to symptoms of ADHD in children who show conduct problems early in life ⁶⁹.

Brain injury

A recent meta-analysis found that children with severe traumatic brain injuries are around three times more likely to develop ADHD symptoms compared with those without brain injury, while the risk was not significantly elevated for mild or moderate injuries⁷⁰.

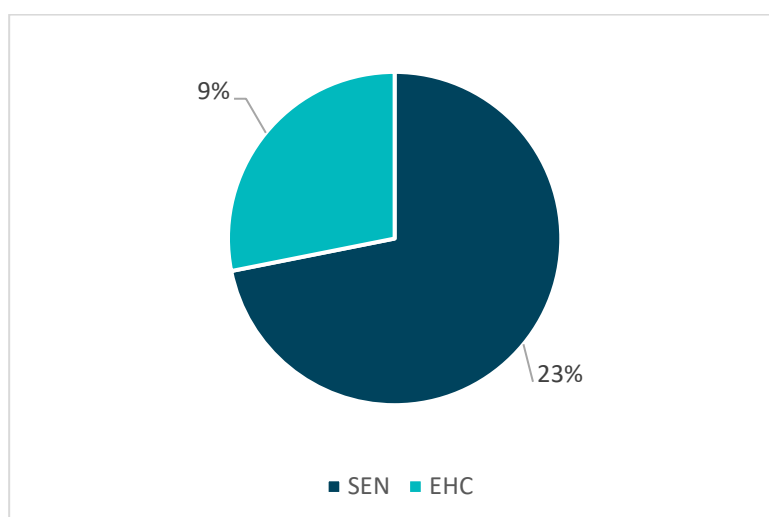
5.2 Local Picture

Due to limitations in local data on ADHD, this section draws on national and international data, with local insights included where possible. Recent research estimates the global prevalence of childhood ADHD (in children aged 3 to 12 years) as 7.6% and adolescent ADHD (young people aged 12 to 18 years) as 5.6%⁷¹.

ADHD is typically categorised under SEMH SEND needs. This is because ADHD often presents with difficulties in social interaction, emotional regulation, and mental well-being.

In 2024, within Tower Hamlets, 1,303 pupils in schools were identified as having a *primary need* of SEMH. This category includes a range of conditions, including ADHD (but does not mean all pupils identified with SEMH have ADHD). These pupils represent 23% of all pupils receiving SEN support across Tower Hamlets schools. See figure 6.1.

Figure 6.1: Receipt of SEN support type for the primary need of SEMH



Source: January 2024 School Census [LBTH Data, March 2024]

In England, there has been a significant increase in referrals in ADHD assessments and treatments, alongside a rise in ADHD diagnoses. This has been partly attributed to greater public awareness of ADHD and other neurodevelopmental conditions which has driven more people to seek support. This trend has also been observed internationally⁸ and locally. This has recently reduced from 78 weeks following an increase in assessment capacity⁷². However, there remains significant gaps in the reporting of ADHD, reflected as a national challenge.

5.3 Diagnosis and pathway

There is no definitive clinical test of ADHD and therefore diagnosis can be difficult. The GP is the primary referral point, however, schools or other professionals (e.g. health visitors, social care provider) can also initiate referrals. For those aged 18 and older, referrals are made to the ADHD service

at East London NHS Foundation Trust.. For those under the age of 18, diagnosis for children and young people with ADHD are commonly undertaken within CAMHS. These are specialist services for children and young people.

CAMHS teams often include psychiatrists, psychologists, and other specialists who, as a multi-disciplinary team conduct assessments to evaluate the child's symptoms and functioning. This involves gathering information and supporting evidence from multiple sources, including the child, parent, teachers and other caregivers. Alongside this, professionals may use standardised screening, behavioural observations and other diagnostic tools to assess for ADHD symptoms, and, if the child meets the criteria for ADHD, a diagnosis will be made. A diagnosis of ADHD should only be made by a Child and Adolescent Psychiatrist, Paediatrician or other appropriately qualified healthcare professional (HCP) with training and expertise in the diagnosis of ADHD and other mental health conditions.

It's important to note that ADHD can often co-occur with other conditions, such as anxiety, depression, or learning difficulties, so CAMHS may identify these as well. After a diagnosis, CAMHS can provide various forms of treatment and support, including medication management, therapy, and school-based strategies. School-based strategies may include staff consultation and training on supporting students, promoting positive activities or establishing specific support systems within the school environment.

While ADHD can be diagnosed at any age, it usually starts before the age of 12. However, some people do not realise they have ADHD until they are older. ADHD can be different for everyone and can be dependent on age, sex, gender identity and if other neurodevelopment conditions are present ⁷³.

5.4 Healthy Lifestyle

ADHD has been associated with poorer health outcomes with the characteristics of inattention, impulsivity and poor planning are likely to contribute to poorer health behaviours, but ADHD can also be influenced by these same behaviours ⁷⁴.

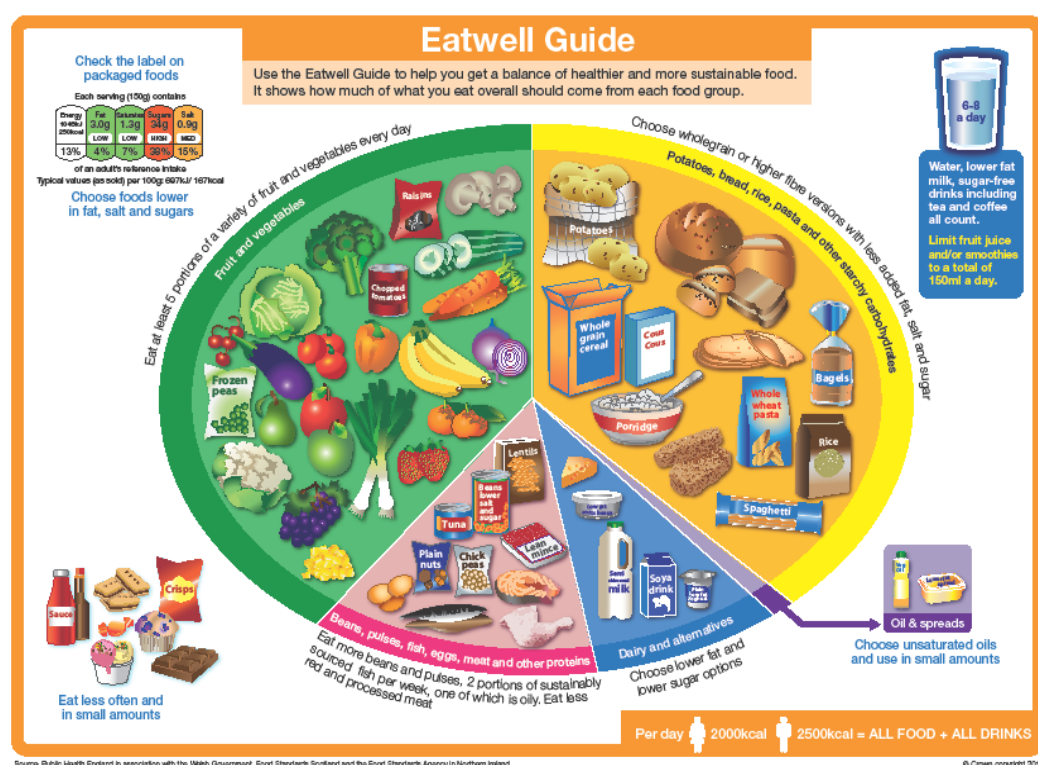
Physical activity

Children and young people with ADHD are often less likely to engage in physical activity compared to their peers without ADHD ⁷⁵. Whilst growing evidence demonstrates that physical activity can improve attention and alleviate symptoms of ADHD, children with inattention symptoms are at increased risk of being less physically active in adolescence ⁷⁶.

Healthy eating habits

Children and young people with ADHD can struggle to eat healthily due to impulsivity, difficulty regulating emotions and challenges with planning and decision-making around food. Additionally, poor sleep, boredom, anxiety, anger and low self-esteem can lead to emotional eating, which can be exacerbated by impulsivity. Furthermore, children and young people with ADHD may struggle to recognise hunger and fullness cues, leading to unpredictable eating patterns. Due to this, it can be difficult to maintain healthy eating habits ⁷⁷.

Figure 6.2: The Eatwell guide defining government recommendations on eating healthily and achieving a balanced diet ⁷⁸.



Source: GOV.UK Office for Health Improvement and Disparities – The Eatwell Guide

Smoking

Children with ADHD are more likely to smoke cigarettes in adolescence and into adulthood ⁷⁹. Furthermore, research suggest that ADHD in childhood confers a risk for earlier daily smoking onset, faster progression from smoking initiation to daily smoking, more attempts to quit at least once, greater likelihood of relapse during quit attempts, and more severe withdrawal ⁸⁰.

Sleep

Young people with ADHD often experience difficulties with sleep, including trouble falling asleep, staying asleep and waking up. It is anticipated that almost 75% of children with ADHD have sleep problems. A lack of good quality sleep can worsen ADHD symptoms and affect children and young people's ability to think and reason. Additionally, it can have an effect on the quality of life of the whole family ⁸¹.

5.5 School Life

Children and young people with ADHD can face significant challenges in educational settings due to inattention, hyperactivity and impulsivity. Young people with ADHD are more likely to experience lower academic attainment and increased school difficulties compared to their peers ⁸².

Emotional and social impact

Children and young people with ADHD often face emotional and social challenges influenced by their interactions with their environment. Difficulties with emotional regulation may result in frequent

frustration or sudden outbursts. Additionally, impulsivity and trouble interpreting social cues can make it challenging for them to build and sustain positive peer relationships.

Traditional academic achievement

Although students with ADHD often possess significant potential, they may have difficulty maintaining focus. This can hinder their ability to complete assignments, meet deadlines, and reach academic goals.

Persistent struggles and underachievement can negatively affect self-esteem and confidence, leading children and young people to feel as though they are not meeting expectations. Providing individualised support and appropriate accommodations is essential to help children and young people realise their strengths, reach their full potential, and experience meaningful success.

Self Esteem

Many young people with ADHD experience low self-esteem, often stemming from academic difficulties, social challenges, and persistent feelings of inadequacy. Furthermore, frequent setbacks and repeated criticism can further erode a sense of self-worth, making it harder to believe in abilities or stay motivated to pursue goals.

However, in all cases, with appropriate strategies and support, children and young people can thrive academically and socially⁸³. Evidence suggests individuals with ADHD may be able to 'hyper-focus' on things that engage their interest, bring energy and fun to group settings, be creative and think outside the box⁸⁴.

5.6 Outcomes

ADHD can have a lifetime impact, with a range of interdependencies with the health, wellbeing, social integration, and quality of life of individuals and families. It is therefore associated with a variety of health outcomes, including mental health problems, physical health issues and reduced lifespan⁸⁵. Whilst ADHD is not directly a cause of reduced life expectancy, the associated challenges and behaviours can increase the risk of accidents and health problems. Compared to those without the condition, men with ADHD have a life expectancy of 6.8 years shorter, whilst women with ADHD experience an 8.6 year reduction⁸⁶.

Mental health: Individuals with ADHD are more likely to experience a mental health problem. These include anxiety, depression, sleep problems, conduct disorder and substance use⁸⁷. Research indicates those with ADHD are at an increased risk of substance use (alcohol and other substance use)

Progression to adulthood: NICE reviewed the diagnostic construct of ADHD across the lifespan and concluded that ADHD in adulthood is often associated with significant impairment¹. Adults with ADHD tend to have fewer academic qualifications, as well as difficulties with organising time, prioritising tasks and meeting deadlines.⁸⁵ Additionally, it is associated with increased rates of criminal convictions, transport incidents, early mortality and suicidal behaviour. It is therefore important to ensure behaviours are appropriately understood in childhood and adolescence. Evidence

¹ NICE, 2019. *Attention deficit hyperactivity disorder: diagnosis and management*. Available here: [Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE](#)

demonstrates individuals living with ADHD, with appropriate support and interventions can live healthy lives.

5.7 Transitions

Transitioning from child to adult ADHD services is critical for ensuring continued support for young people with ADHD and as they move into adulthood. Effective transition requires early planning, collaborating between child and adult services, and tailored support to meet individual needs. In Tower Hamlets, this process is facilitated through:

Local Offer: The Tower Hamlets Local Offer website provides information on services available for young people with SEND, to help navigate transitions at different life stages.

Tower Hamlets Transition Team: From the age of 14, for those on an EHCP, the annual review will include conversations about preparing for adulthood and life after school. Guidance and support to achieve outcomes such as further education, paid employment, community inclusion and health and wellbeing is provided at this stage.

5.8 What works (evidence-based practice)

Supporting a child or young person with ADHD typically requires a combination of medication, behavioural therapy and educational support, with a focus on tailoring interventions to individual needs. It also requires understanding, patience and a proactive approach to help children and young people to manage their symptoms and thrive. This includes creating a structured environment, encouraging healthy habits, providing emotional support and advocating for their needs at school⁸⁸. It is this holistic approach that can significantly improve focus, mood and overall well-being.

Lifestyle: Establishing a routine can help support children and young people, whilst also encourage a healthy lifestyle to include exercise, a balanced diet and sleep. Setting goals and expectations, breaking down instructions into single steps and positive rewards can help support the development of routines. Where young people are struggling with food and drink, utilising a food and drink diary can help identify preferential foods and be used within school and other settings.

Education: Interventions for children and young people with ADHD focus on creating supportive learning environments and implementing strategies that address specific challenges related to inattention, hyperactivity and impulsivity. Modifying the learning environment continues to be reflected in the research. However, this is, and should be, tailored to the child or young person. This might include regular movement breaks, adapting assessments and helping develop self-regulation skills. These decisions should not be made in isolation of, but in collaboration with the child or young person. Involving the children in decision-making can help encourage the individual to participate in setting goals and choosing strategies that can increase their engagement and motivation⁸⁹.

5.9 Support services

Local Offer (universal offer): The SEND Information, Advice and Support Service (SEND IASS) can provide support and guidance for children and young people with SEND, including ADHD, and their families.

The Tower Hamlets ADHD service: A specialist service for adults suspected or diagnosed with ADHD. This covers those aged 18 upwards where assessments and treatment for ADHD are offered. At the time this JSNA was published, there was a national shortage and disruption of ADHD medications, attributed to national and international supply and demand.

Figure 6.3: Docklands Outreach Logo⁹⁰

Docklands Outreach: Docklands Outreach is health and preventative support agency providing practical and therapeutic support to children (2-13 years old) and young (12-25 years old) living in Tower Hamlets, on a range of emotional and mental health difficulties.



Referrals for children and young people are accepted when neurodiversity is not a primary factor.

5.10 Gaps

NHS England commissioned a rapid review in the ADHD service provision within the NHS. This initial work identified a variety of challenges that are outlined below⁹¹. Evidence indicates that a holistic approach can improve health and wellbeing outcomes. In relation to ADHD, this highlights the importance of considering several contextual factors.

- ADHD service provision and interrelated policies need a joined-up approach across health, care, education, and the justice system. Improving access, experience, and outcomes for people cannot be done by health focused work alone.
- The lack of good ADHD data sources means it is difficult to fully understand the size of the problem. There are limitations in existing evidence explaining what is driving recent increases in demand for ADHD services. The drivers are complex, spanning wider societal issues and education policy. There is limited international data and evidence to draw on.
- Services have not kept pace with demand and need; there has been a rapid growth of independent sector provision in the market for ADHD services. There is a need to work with systems and providers (including non-NHS providers) to better understand the different service models being used and the challenges being experienced at different points of the pathway.
- Data suggests that some populations are at increased risk of experiencing inequalities in access, experience, and outcomes. At-risk cohorts include both victims and perpetrators of crime, those facing broader social and economic deprivation, and those from marginalised groups.

Reduce the over-reliance on formal diagnosis as the primary gateway to support: There is an overemphasis on a diagnosis acting as a means to promote understanding and management within ADHD. However, that wait times for assessment / diagnosis remain significantly high. As such, gaps remain in the provision of advice, guidance and information whilst waiting.

Accessibility to information and advice: Although ADHD is mentioned in various materials linked to the Local Offer, it is not clear how someone can access information, advice and guidance for ADHD. Furthermore, understanding the diagnosis pathway for ADHD for children and young people remains

challenging, and this information is not readily available when carrying out a search a parent might undertake.

Overlapping of neurodiverse symptoms: Many neurodiverse conditions share overlapping traits, yet children and young people are often assessed separately for individual conditions. A single-condition focus can result in duplicated professional efforts, for example, a nursery educational psychologist may be assessing a child for suspected ASD, while another practitioner is simultaneously exploring ADHD. This fragmented approach can cause confusion, delays, and increased emotional stress for parents and carers. A more integrated, holistic assessment model would improve efficiency, reduce duplication, and provide clearer pathways for families.

Education support whilst waiting a diagnosis: In many education settings, access to targeted support is often dependent on a formal diagnosis. As a result, children and young people who are awaiting assessment may not receive the level or type of support they need during this critical period. This gap can negatively impact their learning, wellbeing, and behaviour, particularly for those with neurodevelopmental needs such as ADHD or autism.

5.11 Recommendations

Based on the analysis, the following recommendations are made:

- **A holistic approach to identification:** Whilst ADHD is often associated with learning disabilities or mental health disorders, it should be addressed within the broader framework of neurodevelopmental support provision. Given the overlapping of characteristics of ADHD, autism and other neurodiverse conditions, a more integrated, holistic assessment model is needed, one that looks across neurodevelopmental needs rather than focusing on isolated diagnoses. Such a model would improve efficiency, reduce duplication, and provide clearer, more coordinated support pathways for families. All assessment and intervention should remain person-centred, recognising the unique profile of strengths and challenges each child presents, regardless of diagnostic label.
- **Understanding the drivers of ADHD:** It is important to undertake local research to explore the factors contributing to the rising demand for ADHD assessments and support. While this reflects a broader national trend, developing local insights can provide a deeper understanding of the unique challenges within the borough. This knowledge can then be used to inform more targeted interventions, resource planning, and service design.
- **Provision of resources for schools supporting children awaiting a formal diagnosis:** ADHD does not begin the day it is diagnosed, and although SEN support may be given through a school-managed budget, often economic resources are only accessible to schools and families from the point of diagnosis. Schools need additional resourcing to provide individualised and easy-to-access support for the needs of children who are waiting for assessment or who may have impairments that do not meet diagnostic thresholds.
- **Improve clarity and visibility of information:** Review and update the Local Offer to include a clearly defined section on Neurodiversity and ADHD. This should outline how it presents, the local pathway, available support before and after diagnosis, where to access information, advice and guidance.

5.12 Summary

ADHD is a complex, lifelong condition that affects attention, behaviour and emotional regulation from childhood into adulthood. While its causes are multifactorial, its impact can be seen across physical and mental health, education, and social outcomes. In Tower Hamlets, rates of ADHD are rising, with long waits for assessment, fragmented pathways, and gaps in school support for undiagnosed children. A more integrated, holistic model is needed, one that considers overlapping neurodiverse traits, provides equitable support at all stages, and empowers schools and families with timely information and resources. As such, the recommendations focus on developing greater insights on ADHD within the local area, improving clarity, coordination, and access to ADHD-related support across health, education, and social care systems, both before and after diagnosis. They aim to encourage earlier intervention and provide targeted help for children and young people awaiting assessment.

6. Communication and Interaction: Speech Language and Communication Needs (SLCN)

Children and young people with speech, language and communication needs (SLCN) experience difficulties with communication. SLCN is an umbrella term that covers a range of challenges affecting one or more areas, including:

- **Receptive language:** Understanding what other say
- **Expressive language:** Selecting and joining words together in the correct order to convey meaning
- **Social communication and pragmatics:** Interacting with others, including turn-taking and interpreting facial expressions and body language
- **Speech:** Using speech sounds accurately and in the right places
- **Fluency:** The flow and rhythm of speech
- **Voice:** Quality of voice

6.1 Causal Factors

In children, SCLN can be caused by genetic and developmental conditions such as Down Syndrome and ASD. SLCN can arise from socio-economic, genetic, environmental, and developmental factors. Children may have SLCN linked to conditions such as Down Syndrome or ASD. Developmental causes such as stammering and stuttering are also linked with SLCN and 40% of five-year-old children with all cleft types have speech difficulties ⁹². However, many children experience SLCN without an identifiable underlying condition, representing a larger cohort of children with SLCN.

SLCN is more commonly identified among children from socially disadvantaged backgrounds. The odds of having SLCN are 2.3 times greater for pupils entitled to FSM and living in deprived neighbourhoods ⁹³.

Environmental factors can influence language development. Children learning English as an additional language may face challenges in acquiring language proficiency, but this is distinct from SLCN ^{94 95 96}.

Signs and symptoms

Children with SLCN may exhibit:

- Challenges in producing speech sounds accurately.
- Stammering or disruptions to the flow of speech.
- Variations in voice quality.
- Difficulties understanding language, such as interpreting metaphors or abstract concepts.
- Challenges using language, including word-finding difficulties or applying grammar forms.
- Difficulties with social communication, such as interpreting non-verbal cues or using language to clarify meaning.

- Challenges sequencing information for storytelling.
- Difficulties understanding and using words to describe emotions.

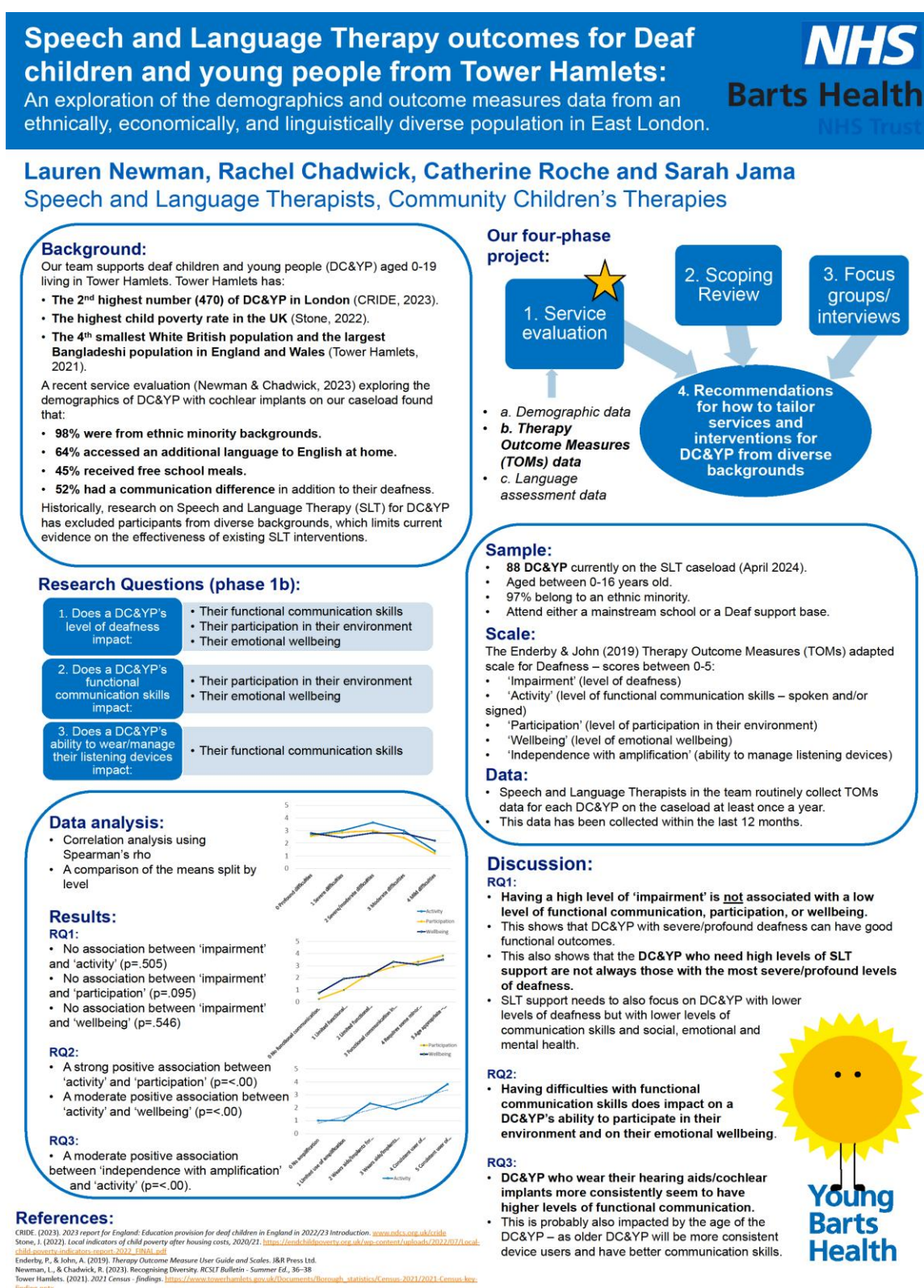
6.2 Local Picture

In 2024, 40.6% of children and young people with SEN within the school population had a primary need of speech, language, and communication. Tower Hamlets had the highest prevalence compared to its statistical neighbours (30.1% on average) and was the 7th highest in England (24%)⁴. Among those receiving SEN support for SLCN, 76.8% were in primary schools, and 19.2% in secondary school settings³.

Of children and young people with an EHCP for SLCN, 46.8% were from the Bangladeshi community. This represents an overrepresentation compared to the overall school population, where Bangladeshi pupils make up a smaller proportion. Ethnicity was not recorded for 27.3% of these pupils, highlighting gaps in data, and a further 7.8% were White-British.

EHCPs for SLCN needs most commonly start at the beginning of primary school, at ages 4, 5, and 6, with the largest proportion starting at age 4 (males 19.7%, females 18%). Overall, more males (74%) than females (26%) hold an EHCP for SLCN, reflecting widely recognised gender differences in prevalence⁹³. In terms of socio-economic context, 94% of children with an EHCP for SLCN were living in areas within the highest deprivation quintiles of the borough³.

Figure 7.1: Speech and language therapy outcomes for deaf children and young people from Tower Hamlets – an exploration of the demographics and outcome measures data from an ethnically, economically and linguistically diverse population.



Source: Newman, L., Chadwick, R., Roche, C., & Jama, S. (2024). *Speech and Language Therapy outcomes for Deaf children and young people from Tower Hamlets*. Poster presented at the BATOD Conference.

6.3 Diagnosis

Identification of SLCN can be complex, particularly when children have co-occurring difficulties or other SEND needs, such as ASD or learning disabilities. Some children may also mask or compensate for their difficulties, which can result in delayed identification. Early recognition of SLCN is critical to ensure children receive timely and appropriate support, optimising health, educational, and social outcomes.

For some children, SLCN is identified early in pre-school, while for others, difficulties may become more apparent after starting school. Signs and symptoms evolve with age and can overlap with other developmental challenges, requiring careful assessment. It is important to note that SLCN refers to difficulties with communication irrespective of the language a child speaks, so children learning English as an additional language should not automatically be considered as having SLCN.

To aid identification, the NHS has developed age-appropriate 'Identification of Needs' checklists covering different domains of speech, language, and communication for Early Years, Primary, and Secondary stages⁹⁷. For example:

Early Warning Signs in Pre-school areas of assessment:

- General signs (e.g. finds it difficult to listen/uses the wrong words when talking).
- Identifies receptive language difficulties (e.g. has poor attention/be the last to finish/be disruptive).
- Identifies expressive language difficulties (e.g. use language typical of much younger child/have word finding difficulties/uses highly inventive words e.g. applepumpkin=pineapple).

Early Warning Signs in School-age areas of assessment:

- Speech (e.g. speech sounds are not clear/stammers).
- Expressive language deficits (e.g. uses language of a much younger child/had difficulty retelling a story or relating news/uses related but incorrect word e.g. shoe for a slipper).
- Receptive language deficits (e.g. confused about routines/poor understanding of abstract concepts/appears to have difficulty managing behaviour).
- Social use of language (poor eye contact/difficult taking turns/tends to talk about the same things).

The NHS has also developed 'Identification of Needs' checklists to be completed for specific scenarios in Early Years, Primary Age and Secondary Age, to help with the identification process.

6.4 Pathway

The pathway for identifying SLCN may be initiated by a variety of people depending on age, including parents/carers, health visitors, GPs, community paediatricians, pre-school staff, school staff, specialist teachers or educational psychologists and is done via an initial assessment. An assessment can be carried out by NHS services, or privately through independent speech and learning therapy providers.

6.5 Healthy Lifestyle

Many children and young people identified with SLCN face mental health and behavioural challenges which can influence their access to a healthy lifestyle.

Mental Health: The ability to develop and use language supports the development of psychological health, and social and emotional wellbeing. Since individuals with SLCN may communicate differently to their peers, this may lead to barriers in forming friendships and having conversations, which can then lead to a sense of exclusion or disconnection. Fostering a sense of belonging is important, as evidence suggests that children with mental health conditions are more likely to have co-occurring speech, language and communication difficulties ⁹⁸.

Poor mental health can adversely affect the overall health outcomes of the individual. People living with mental illness are twice as likely to report experiences of poor physical health and are around 5 times more likely to die prematurely than someone who does not have a mental illness ⁹⁹. Some mental health interventions, particularly those relying heavily on verbal communication, may be less accessible to children with SLCN. Limited research has explored how mental health support is delivered and received by this population, though small studies suggest challenges may arise due to communication barriers and professional understanding of language needs.

Despite this, there is little evidence available on how mental health support is delivered to and received by children with SLCN. A recent study revealed significant barriers accessing support, including a lack of professional knowledge about children's language needs, with interventions considered neither accessible nor delivered in a manner that was appropriate due to a high reliance on language skills ¹⁰⁰.

Physical health, diet and nutrition: Children and young people with SLCN may not be able to effectively communicate their desires and needs e.g. whether they are hungry or whether they are sick. Moreover, delays in the identification and management of eating, drinking and swallowing difficulties (dysphagia) have an impact on nutrition and hydration status, breathing and medication adherence, all of which may result in an increased crisis management for dysphagia and in rare cases, death ¹⁰¹.

Physical Activity: Some evidence from small-scale studies suggests that children with SLCN may face challenges engaging in physical activity, potentially influenced by difficulties with communication and social interaction. However, findings are limited and may be affected by co-occurring conditions such as ADHD¹⁰².

6.6 School Life

Children whose speech, language and communication skills develop more slowly, may be less likely to be 'school ready' than their counterparts. They may experience difficulties with several aspects of school life including:

Making friends: Children with SLCN may experience isolation due to difficulties forming and maintaining friendships. These challenges can be further compounded by co-occurring neurodevelopmental conditions, such as ASD, where social communication and emotional understanding may also be affected.

Understanding and following instructions: Following verbal instructions is a key component of classroom learning, yet children with SLCN may struggle to process and retain spoken information. This

can affect their ability to understand lesson content, complete tasks, and participate fully in class activities.

Participating in conversations/discussions: Children with SLCN may find it challenging to express their thoughts and emotions, which can limit their participation in classroom discussions and group work.

Limitations in access to support and resources: Long waiting lists for assessment services and inadequate training for educators can also hinder educational progress of pupils with SLCN. Tower Hamlets has made progress in this area, for example, speech and language therapy waiting lists have reduced from 36 weeks in 2022 to 12 weeks in 2024. Furthermore, the online app and toolkit 'Verbo' has also been rolled out to 56 primary schools in the borough ¹⁰³, providing resources to support the development of speech and language.

School environments - School environments are viewed by many parents as pivotal to the experiences of the both the child with SLCN and their families. Evidence suggests that increased SEN funding alone does not necessarily lead to better language outcomes for pupils with SLCN. Factors such as staff expertise, whole-school communication culture, and the quality of targeted interventions play a more critical role in supporting progress¹⁰⁴. Although most schools are described as being supportive and understanding by parents, deficits in support are still apparent, with some parents feeling that their school exacerbates their child's mental health problems ¹⁰⁵ Where effective support or early intervention is not achieved, there can be greater impact on literacy, school attainment and emotional wellbeing as the young person ages.

Children with a primary need of SLCN can attend mainstream schools but statistics have shown that the support they receive is not adequate. Research indicates that pupils with SLCN are at higher risk of persistent absence, potentially due to social and communication barriers that affect engagement and confidence at school

6.7 Outcomes

Children and young people with SLCN are at risk of developing a range of social, emotional and physical health and wellbeing outcomes.

Social and Emotional wellbeing: Many children with SLCN, particularly those who also experience social or emotional difficulties, may find it challenging to build and maintain friendships. Difficulties in understanding and expressing emotions can affect relationships and contribute to feelings of frustration or isolation. Research shows that children with language difficulties are at increased risk of developing mental health problems, with around 40% meeting criteria for a diagnosable condition; however, this relationship is complex and bidirectional rather than causal ^{106 107}.

Physical Health: Delays in identification and management of dysphagia may have detrimental effects to nutrition and hydration status and it can also affect breathing and medication adherence (if there is a medicated condition) ¹⁰¹.

Communication: Individuals with SCLN often have difficulty communicating their emotions, desires or needs. This can result in behavioural difficulties, impacting day to day wellbeing, and influencing health in adulthood ¹⁰⁸.

6.8 Transitions

Local Offer: The Tower Hamlets Local Offer website provides information on the provision for children and young people ages 0-19 with speech, language and communication concerns, including ongoing support for the parents and families for children and young people.

Tower Hamlets Transition Team: This team provides advice and assistance to support children and their families during key points of transition. They support with a range of school issues including school admissions processes, managed moves, exclusion and bullying. The Adult Team also assist with creating a transition plan which begins in year 9 (age 14) for those identified by a SENCO as needing ongoing support. To be eligible for care in adulthood, the child has to have a learning disability and 'a critical or substantial risk to independence' as defined by Fair Access to Care ¹⁰⁹.

The team work with partnerships within the community providing support and advice on housing, employment, training and aspects of leisure.

Healthcare transition: This transition is also overseen by the Tower Hamlets Transition Services. A multidisciplinary team called the Community Learning Disability Service (CLDS) provides health services such as physiotherapists, occupational therapists, nurses, SLTs, psychologists and counsellors to those who require it. The provision takes a person-centred approach in order to ensure the young person has the support required for a successful transition into adulthood.

Training and employment: The Hub is a partnership that offers age 14-19 learning in Tower Hamlets. It works in partnership with the transition team to offer a choice of a wide range of courses, which match the young person's interests and needs. Training and Employment opportunities are created with local partnerships e.g. Deaf Plus Employment provides employment support to people with hearing impairments in the form of seeking employment, completing applications and writing CVs as well as applying for Access to Work funds ¹¹⁰.

6.9 What works (evidence-based practice)

There is little evidence available on how support for SLCN is received and the relative outcomes, indicating significant gaps in SLCN research. However, existing research indicates:

Early Intervention for Speech and Language: Early intervention for Speech, Language and Communication Needs (SLCN) is consistently shown to improve long-term educational and social outcomes. Research highlights that supporting children's language development during the early years (ages 0–5) can significantly reduce later difficulties in literacy, learning, and social interaction ¹¹¹.

Early support is most effective when it is delivered across three tiers:

- **Universal interventions** promote language development for all children through high-quality early years provision and involving parents and carers. Examples include modelling back-and-forth communication and shared book reading which builds practitioner skill in supporting speech and language in early education settings^{112 113}.
- **Targeted interventions** are designed for children showing emerging language delay or mild SLCN. Structured group-based activities have demonstrated improvements in expressive and

receptive vocabulary, narrative skills and listening comprehension, particularly when implemented by trained teaching staff (Fricke et al., 2013; Law et al., 2019)^{114 115 116}.

- **Specialist interventions** are provided by speech and language therapists for children with more persistent or complex needs, such as developmental language disorder (DLD) or speech sound disorders. These include individualised therapy plans and close collaboration between therapists, SENCOs and families to ensure strategies are embedded consistently across home and educational settings¹¹⁷.

Delays in identification or intervention can widen developmental gaps, with long-term consequences for educational attainment, self-esteem, and employment outcomes^{118 119}.

Physical Health: There is little evidence available in relation to what is an effective intervention for SLCN in improving health outcomes. Certainly, improvements in language and communication would help children and young people with SCLN engage and communicate with others so as to experience the same level of daily physical activity as their peers¹⁰². Improved language and communication skills will also help to better manage and communicate daily health needs¹⁰⁸. Moreover, establishing a healthy routine, combining a healthy diet with plenty of physical activity are more likely to support healthy behaviours moving forward. Modelling healthy lifestyles remains a significant aspect of learning for children with SLCN.

Mental Health: There is a gap in the evidence base for best practice when working with children and young with SLCN. The language and communication barriers often faced impact the effectiveness of more traditional talking therapies and the evidence for the use of appropriately modified talking therapies associated with SLCN is sparse. However, existing evidence has shown combining the use of positive behavioural support systems, emotional regulation strategies and programmes, effective staff training and the involvement and support of the family were regarded as successful interventions for mental health issues. For example, for younger children, Play Therapy was considered a potentially useful psychological approach for this population in treating mental health difficulties as it supports healthy child/caregiver attachments without the reliance on verbal communication. However, for other children, teaching higher level language associated with comprehension and expression of emotions may also be a useful approach to developing emotion vocabulary and processing and comprehending emotions.

Ultimately, tackling problems early offers a better chance of improvements. The CAHMS in Tower Hamlets provides support and interventions to children with a range of emotional and behavioural issues and suggest involvement and support from the family is very important to treatment outcomes.

6.10 Support services

In Tower Hamlets, in addition to the standard health provisions such as GP and health visitor services, children and young people with SLCN and their families have access to¹²⁰:

The Family Hubs (universal services): These universal Family Hubs provide support in the form of group activities such as Stay and Play, Family workshops, community support sessions and extra help and one-to-one family support. An example is the Early Talk Boost initiative, which is a focused programme for 3-4 years olds in Tower Hamlets who need additional support with language skills (Figure 7.2).

Figure 7.2: Early Talk boost programme information⁶⁴

HLE Interventions: Early Talk Boost



Supporting you,
for a brighter future



Early Talk Boost is a focused programme for 3–4-year-olds who need extra help with language skills, aiming to close the gap with their peers. In just 9 weeks, it can boost progress in language and communication by an average of 5 months.

Children are assessed individually to identify those who would benefit most by pre-school and school settings. Selected children join three weekly sessions of 15–20 minutes during circle/story time, led by an early years practitioner.

Each session includes fun activities to build key skills in speech, language, and communication, helping kids learn new words and engage in conversations.



Source: Tower Hamlets Family Hubs: Child Development and Early Years

Tower Hamlets Children’s SLT Service: This service provides assessment and intervention for children and young people aged 0 – 19 years who present with a range of SLCN. Services are provided in schools, community clinics and special schools and involve speech and language therapists working with children and young people and the adults who care or educate them. It is a free service, and families can self-refer to the service however there is a waiting list ¹²¹.

The toolkit ‘Verbo’, created by NHS SLTs¹²², has also been rolled out to 56 primary schools within Tower Hamlets¹⁰³. It aims to support settings with or without SLT, aiming to complement the existing service. It has tools to upskill education staff including:

- Screening tools.
- Interventions with video modelling and resources.
- Target trackers.
- Staff training.
- Robust impact measures and outcome reports.
- Ability to share information with parents.

The Educational Psychology Services: This service provides consultations, psychological assessments, one-to-one and small group interventions and support for parents.

Tower Hamlet’s Language, Literacy and Communication Team: Provides courses aimed at SENCOs and class teachers interested in deepening their understanding of how language develops and learn more about language difficulties can impact learning.

Figure 7.3: Early social communication differences support provisions through the Speech and Language Therapy teams (under 5s)¹²³.

Early Language Team What we offer



In Tower Hamlets, the NHS and Children and Family Centres and Family Hubs are working together to help children with speech and language difficulties.

The Early Language Team supports children aged 0-5 years old (up to the end of Reception) living in Tower Hamlets who have difficulties with:

- Language (understanding and talking)
- Pronunciation (saying speech sounds and words clearly)
- Situational Mutism (able to talk in some places but do not talk in other places)



Source: Tower Hamlets Local Offer Early Language: Speech and Language Therapy (Under 5s)

Tower Hamlets Community Learning Disabilities Service: This multidisciplinary team provides health services such as physiotherapists, occupational therapists, nurses, SLTs, psychologists and counsellors, amongst many other services, to those with SCLN who require it.

Tower Project: Support children and adults aged 0-25 with SEND to build skills and make friends, as well as offering support to gain employment.

6.11 Gaps

Tower Hamlets provides a comprehensive support programme for children and young people identified with SCLN, with lots of free available support from various sources, some of which are universal and some are dependent on an assessment of needs. There are many children and young people with SCLN who do not have SEN Support or EHCP and therefore may not be able to access many of the targeted support provisions.

In terms of timely provision, whilst progress has been made in the borough, waiting lists are still an issue and the provision of SLTs is not enough to meet demands. It is acknowledged that existing initiatives are aimed at supporting those who may be waiting for assessments.

6.12 Recommendations

Improved provision of resources for schools supporting children awaiting an assessment of need:

As is evident in previous chapters, support is not always provisioned in a timely way for those on waiting lists. Whilst Tower Hamlets continue to increase efforts for support here, there remain gaps in the provision. It is recommended that additional resources and targeted support be made available to schools to meet the needs of children who are awaiting an assessment. A shift toward a needs-based model, rather than one dependent solely on formal assessment / diagnosis can reduce delays and contribute to improved outcomes.

The following recommendations are based on evidence-based research and reflect best practice approaches. While they do not necessarily indicate a gap in support provision within the borough, they highlight areas where best practice can inform and enhance current strategies.

- **Speech and Language** – Early support and intervention for speech and language acquisition is integral to the positive outcomes in many aspects of life. Resources and parental training available for families in English, should be adapted and translated into other languages making the resources and knowledge more accessible.
- **Mental Health** - Increased knowledge about language disorders and access to SLTs and expertise is needed amongst professionals who work in children's mental health. It is recommended that there is more collaboration between SLTs and mental health therapists in order to combine interventions from both fields. More research is needed to understand the extent of the need and how to successfully adapt services to make them accessible to children and young people with language needs, and to ensure that mental health problems are detected in children and young people with language difficulties.
- **Schools and Education** – Formal and regular training should be given to every classroom teacher and teaching assistant in order to both identify and support those with SCLN. This will also target those without an assessment but who still require extra support. It's recommended that Verbo continue to be rolled out to all primary schools within the borough with sufficient training to teaching staff on its use. Schools should also take a more active role in supporting children and young people with SLCN to make and sustain friendships ¹²⁴.
- **Auditory screening** – More regular auditory screening should be offered to children in schools, GP practices and community centres so as to identify auditory deficits much earlier. In Tower Hamlets, only 7% of cochlear implants were fitted under the recommended age of 12 months ¹²⁵.
- **Creating equity** - Since SLCN is strongly related to socio-economic status (SES) background, efforts should continue to be made around addressing the socially disadvantaged within the borough, so that all residents have the knowledge and access to the available healthcare resources. Better advertisement of services in a range of languages could go some way to help the inequalities seen in the borough.

6.13 Summary

Tower Hamlets has a notably high prevalence of SLCN, particularly among primary-aged children and those from the Bangladeshi community. While progress has been made, such as reducing waiting times for assessments and introducing tools like Verbo in schools, access to support remains inconsistent, especially for those without formal diagnoses.

The impact of SLCN is far-reaching, affecting children's ability to build friendships, engage in learning, express emotions, and maintain physical health. Difficulties with communication can also heighten the risk of mental health issues, safeguarding concerns, and long-term challenges to wellbeing. Key transition periods, such as moving through school stages or into adulthood, often intensify these difficulties.

Improving outcomes relies heavily on early identification and timely intervention. This includes equipping both parents and education staff with the training and tools needed to recognise and support children with SLCN effectively. Looking ahead, a shift towards a needs-based approach, supported by stronger cross-agency collaboration, enhanced outreach (particularly for non-English-speaking families), and broader access to inclusive services, will be essential in closing current gaps and securing better long-term outcomes for children and young people with SLCN.

7. Cognition and Learning: Specific Learning Difficulty (SpLD)

Specific learning difficulties (SpLD) are neurological conditions which affect how individuals process information but are independent of the individual's intelligence. They include:

- Dyslexia, which impacts individuals' ability to process information, which makes it difficult to develop reading and writing skills¹²⁶.
- Dyscalculia, which affects how a person reads and understands numbers. This is a more pronounced and long-lasting difficulty than a difficulty with maths, affecting how an individual understands and estimates numbers and quantities.¹²⁷
- Dyspraxia, also known as Developmental Coordination Disorder, which involves issues in co-ordination as well as in planning and carrying out movements¹²⁸.
- Dysgraphia, which is a difficulty in writing and/or spelling¹²⁹.

7.1 Causal Factors

Most SpLD are neurodevelopmental although they may also be acquired through brain injury. The exact causes of neurodevelopmental SpLD are widely unknown, although it is often hypothesised that there is a genetic predisposition for dyslexia¹³⁰, dyspraxia¹³¹ and dyscalculia¹³². There are also physical differences in the brains of those with SpLD compared to those without, suggesting a neurological basis for these conditions.¹³¹⁻¹³² SpLD also frequently present in individuals with ADHD¹³³.

Dyslexia: It is estimated that up to 10% of the population in the UK have dyslexia^{Error! Bookmark not defined.}. Dyslexia is more widely understood with extensive research in the area, for example, it is thought that dyslexia may be triggered by stress in those that already have a genetic risk¹³⁰. A gender difference is also observed in the diagnosis of dyslexia, with more males than females being labelled as dyslexic¹³⁴. It is thought there may be a neurobiological basis to this, with differences in cognition and in how sensory information is processed¹³⁵.

Other environmental risk factors for dyslexia may also include SES and attitudes towards reading in the home¹³⁶. Children with SEND living in more deprived areas are less likely to receive a diagnosis of a SpLD than those living in more affluent areas. In fact, London School of Economics¹³⁷ found that only about 6% of children with SEND in the most deprived areas are recorded as have a SpLD compared to 15% of those in the least deprived areas.

Dyscalculia: It is estimated that approximately 6% of the population in the UK have dyscalculia¹³⁸. Along with genetics, the risk of developing dyscalculia is linked to problems with memory and visual-spatial awareness (the skills needed to understand the space around you based on what you see), with alterations in the parts of the brain that control this¹³⁹.

Dyspraxia: The prevalence of dyspraxia is not yet clear, although it has been estimated that approximately 1.7% of 7-year-olds in the UK have dyspraxia¹⁴⁰. The NHS outline several factors that can increase an individual's risk of dyspraxia including premature birth, low birth weight, genetics (family history of dyspraxia) and consumption of alcohol and/or substance use during pregnancy¹⁴¹.

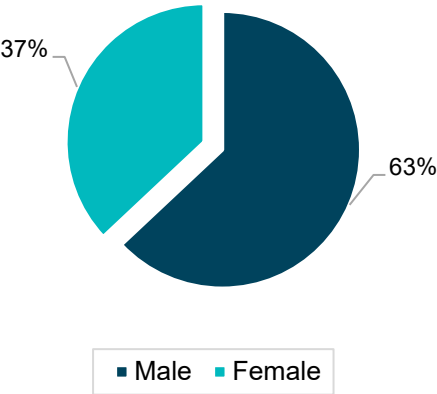
Dysgraphia: Dysgraphia often goes underdiagnosed, or can be misdiagnosed, which can make it difficult to know the true prevalence, although it is estimated that anywhere between 10-30% of children can have difficulties with handwriting¹⁴². Dysgraphia is thought to be linked to impairments in cognitive functions such as memory and ability to understand how sounds of words link to spelling¹⁴³.

7.2 Local Picture

SpLD has been diagnosed in a small proportion of children and young people in Tower Hamlets. Of 3109 children and young people with an EHCP, 122 (3.9%) had an SpLD, with 76 children and young people with an EHCP (2.4%) having this listed as their primary need.

SpLDs appear to be more prevalent among boys with nearly 2 in 3 (63%) of those with a primary need of SpLD in their EHCP identifying as male, and just over a third (37%) identifying as female.

Figure 8,1: The SpLD prevalence in male and female students with an EHCP



Source: January 2024 School Census [LBTH Data, March 2024]

Among pupils with a primary need of SpLD in an EHCP, white ethnic groups are overrepresented, whilst Asian ethnic groups are vastly underrepresented, as outlined in the table below (Table 8.1).

Table 8.1: Pupils with EHCP for SpLD by ethnic group

	White ethnic groups	Asian ethnic groups	Black ethnic groups	Mixed ethnic groups	Other ethnic groups
Total % of all pupils in ethnic group	12.1%	66.6%	9%	8.3%	3%
% of pupils in ethnic group with EHCP for SpLD	30.2%	28.8%	6.8%	8.2%	None

As outlined in Chapter 3, deprivation in Tower Hamlets is high. Given that diagnosis rates of SpLD tend to be lower in more deprived areas,¹³⁷ it may be that the low rate in Tower Hamlets reflects low diagnosis rather than low occurrence of SpLD.

7.3 Diagnosis

SpLD are common, with most classrooms likely having 2 or 3 children with an SpLD, although it can be difficult to identify because, unlike other SEND needs, there is not a distinct separation between those who would be considered 'typical' learners and those who have an SpLD.¹⁴⁴ Children with SpLD do not necessarily need a diagnosis to receive support, although some may find it helpful to better identify what interventions would be most appropriate. As SpLD are a series of conditions, the process of diagnosis and criteria varies slightly.

- **Dyslexia and Dyscalculia:** Dyslexia and dyscalculia are diagnosed through a series of tests by educational psychologists or specialist teachers. In this assessment, the assessor may gather background information from individuals and gain an understanding of their literacy and/or mathematics skills. This information will be used to decide if there is a diagnosis of a specific learning difficulty and/or if any reasonable adjustments are needed.
- **Dysgraphia:** Dysgraphia can be diagnosed by an educational psychologist, who may explore the child's history and academic performance as well as running a series of tests to understand their writing, spelling and overall cognitive abilities.
- **Dyspraxia:** Dyspraxia can be diagnosed by a paediatrician although other healthcare professionals (e.g., Occupational Therapists and Psychologists) may be involved in this. In order for a child to be diagnosed with dyspraxia, they need to have motor skills significantly below what they would be expected to be, and this should be having a considerable impact on their daily activities and school performance.

In Tower Hamlets, the Educational Psychology Service can provide psychological assessments for children and young people, which can help to understand whether the learning difficulties stem from a specific learning disability. Additionally, the Helen Arkell Dyslexia Charity can provide dyslexia assessments at a cost (although there are bursaries available for this).

7.4 Pathway

To reach an assessment for diagnosis and support for SpLD, parents can speak to their child's school or GP, who may provide a referral to another professional such as an educational psychologist or specialist teacher.

The SENCO at the school can work with the teachers, parents and the child to develop a plan to best support the child. Other professionals may also be involved in supporting the child, such as an Occupational Therapist and Educational Psychologist.

7.5 Healthy Lifestyle

To date, there has been a little research examining the health behaviours of individuals with SpLD which makes it difficult to understand the physical health impact of SpLD.

Some research has explored the relationship between health literacy, which is the ability to understand and use information about health, and SpLD. It appears that those with SpLD have a similar level of health literacy as those without¹⁴⁵, indicating that there is no difference in how they can understand and use health information.

7.6 School Life

The way that SpLD affects children and young people can vary greatly, with many having mild difficulties, or struggling in one or two areas, and others having more severe challenges, or experiencing comorbidity of two or more types of SpLD. As a result, the school life for children and young people with SpLD can also vary. The following section outlines some of the literature around school life for children and young people with SpLD, although it is important to note that experiences are likely to differ from child to child.

- **School attainment:** Even though SpLD is not thought to impact on intelligence, children and young people with SpLD, particularly when there is a comorbidity of ADHD, tend to have lower academic achievement than those without SpLD¹⁴⁶. This poor school attainment can lower self-esteem among children with dyslexia, with factors such as grouping classes by ability-level and having negative experiences with teachers also influencing this¹⁴⁷.
- **Motivation:** Students with SpLD have been found to be less motivated in their studies than those without SpLD, which is thought to be linked to feelings of anxiety and/or depression¹⁴⁸.
- **Reasonable adjustments:** Most children and young people with SpLD attend mainstream schools although, as they are recognised as disabilities under the Equality Act 2010 these children are entitled to ask for reasonable adjustments to support their learning. These adjustments could include extra time for tests, providing alternative methods for recording information outside of writing and giving access to assistive technology (e.g., a computer) during lessons.
- **Hidden in plain sight:** Many SpLD go undiagnosed. Children and young people with SpLD may be behind in school, but not necessarily enough to be recognised as needing support. For example, children with dyslexia may be considered 'slow learners' but are expected to catch up eventually leading to a lack of support being provided¹⁴⁹.

Despite the difficulties often faced by people with SpLD at school, many go on to higher education, with 5.6% of higher education students in the UK in 2018/19 declaring that they have SpLD/ADHD, equating to 26,705 people, which has increased since 2007/08¹⁵⁰.

7.7 Outcomes

Overall, it appears that many children with SpLD can expect to live a healthy life, although they may experience poorer psychological and/or social outcomes.

Mental health: Research examining the link between SpLDs and psychological wellbeing has produced mixed findings, with some studies suggesting that those with SpLD experience worse mental health outcomes such as anxiety and depression and others finding their outcomes are similar to those without SpLD¹⁵¹.

Social outcomes: There is some evidence to suggest that people with dyslexia are overrepresented in the criminal justice system as well as among the homeless population, which might be linked to the lower levels of educational attainment seen in this group^{Error! Bookmark not defined.}.

7.8 Transitions

A number of provisions are in place to support the transition of children and young people with SpLD. These are facilitated through:

Local Offer: The Tower Hamlets Local Offer website provides information on services available for young people with SEND, to help navigate transitions at different life stages.

Tower Hamlets Community Learning Disabilities Service: may be able to provide support for those transitioning from child to adult services although do not work with adults with SpLD only.

7.9 What works

Engaging the senses: It has been suggested that teaching approaches for children and young people with specific learning difficulties could draw from a neurodiversity perspective such as multi-sensory techniques which aim to engage more than one sense at a time during learning, although more research is needed to ascertain the effectiveness of this.¹⁵² In particular, music-based interventions seem to support the development and building of literacy skills in children and young people with dyslexia¹⁵³.

Digital interventions: digital interventions (including tutorial-based and video game based) can improve mathematic performance in children who experience mathematical difficulties, such as those with dyscalculia¹⁵⁴. There is also some evidence to suggest that digital interventions (such as audiobooks and video games) can support the development of reading skills among children with dyslexia¹⁵⁵. Furthermore, text-to-speech applications appear to reduce mind-wandering and increase reading comprehension in both children with and without dyslexia, suggesting that this approach may benefit most pupils, not just those with dyslexia¹⁵⁶, although it should be noted that the sample size in this study was small and the findings may therefore not be generalisable.

Occupational therapy: occupational therapists may be able to support children with SpLD with literacy skills and fine motor skills, in particular in improving their handwriting and spelling¹⁵⁷.

Teachers' support: teachers can support the learning of children with SpLD by providing clear instruction, being willing to give guidance with the ability to individualise and adapt teaching to each pupil, as needed¹⁵⁸.

7.10 Support Services

There are several services that can provide support for children with learning disabilities in Tower Hamlets that can also support children with specific learning difficulties. These are outlined on the Tower Hamlets Local Offer website. These include:

- **Children's Occupational Therapy Team:** Provide occupational therapy to young people aged 0-19 years with a developmental disability or medical condition, supporting them to improve their ability to perform everyday tasks.
- **Educational Psychology Service:** Support children and young people through providing consultations, assessments and psychological interventions, can be accessed through educational settings in Tower Hamlets.

- **Family Information Service (universal service):** Provides free information and advice as well as links to a range of services that can support young people and their families, including those with SpLD.
- **Special Educational Needs (SEND) Section:** Manage and issue Educational Healthcare Plans that specify the special needs for each child and the type of education that is needed to meet their needs.
- **Tower Hamlets School Health and Wellbeing 0-19 Service (universal service):** Provides support for children aged 0-19, including those with additional needs. See figure 8.2 for example services available.
- **Tower Project:** Support children and adults aged 0-25 with SEND to build skills and make friends, as well as offering support to gain employment.
- **Helen Arkell Dyslexia Charity:** Providing learning and skills support for all ages for a fee.

Figure 8.2: Example services available for those aged 0-18 years¹⁵⁹.

Services for young people (0-18)		 Supporting you, for a brighter future
Anna Freud Resources aiming to empower young people to make informed choices about their mental health and wellbeing.  Become – Care Advice Line Free help and advice for care-experienced young people. NHS 111 Urgent care mental health service for young people Call the local NHS urgent mental health helpline (England only). To find your local number, use their search bar here.	Tower Hamlets Child and Adolescent Mental Health Service Service is for anyone 0-18 who needs specialist mental health support. Offers assessment, specialist help and support and treatment to children, young people, and their families who are experiencing emotional, behavioural or mental health difficulties. • CAMHS duty line open Monday to Friday 9am – 5pm on 020 7426 2375. • Secondary school-age young person can use online self-referral form.	

Source: Tower Hamlets Family Hubs Health & Wellness Support Services

7.11 Gaps

Identification and diagnosis of SpLD appears to be low in Tower Hamlets, at least among those with EHCPs, indicating there may be children and young people not receiving the appropriate support.

Whilst there is a wide range of services of support available within the borough, it is unclear how easy and accessible they are to access and to therefore assess how effective the support provision is.

7.12 Recommendations

Identification of SpLD: Due to the frequent underdiagnosis of SpLD, a focus on identification to ensure that the appropriate support for learning is received is necessary. It is important that teachers and other school staff feel confident to spot signs that a child's learning may be atypical (for example,

difficulties with reading and writing) so that appropriate provisions can be put in place to support the need. A pathway to diagnosis may also be required to help facilitate this.

Effective support: Where not already implemented, provision of evidence-based support within school settings remain critical, such as using multi-sensory techniques and music-based interventions, as well as remaining adaptable to the needs of the child or young person. Furthermore, opportunities to provide access to digital interventions for reading and writing skills as well as mathematics, should be assessed to ensure that children both with and without a diagnosis of SpLD are able to receive support for reading, writing, spelling and mathematical difficulties.

Assessment of resources: Consider undertaking a review of existing resources for SpLD, in collaboration with parents, carers, and professionals, to evaluate the accessibility and effectiveness of the current available information. This will support a more targeted approach to addressing any gaps in knowledge, understanding, or information.

7.13 Summary

Specific learning difficulties (SpLD) are neurological conditions which affect how individuals process information but are independent of the individual's intelligence. They include dyslexia, dyspraxia, dyscalculia and dysgraphia.

In Tower Hamlets, identification and diagnosis of SpLD appears to be low, which may indicate a gap in children receiving support. However, a formal diagnosis is not necessarily needed for children to access support, including reasonable adjustments and Tower Hamlets provides a wide range of resources and support provisions in the borough.

The recommendations outlined in this chapter focus on increasing teachers' confidence to spot signs of SpLD for earlier identification, adapting approaches in schools to support the learning of all children, including those with SpLD, and assessing current resources to ensure adequate information on SpLD is available.

8. Social, Emotional and Mental Health

Social, emotional, and mental health (SEMH) needs often overlap with other SEND needs, such as SLCN, ASD, and ADHD. Although SEMH is a recognised SEND category in its own right, this chapter focuses on children with SEMH needs alongside another SEND diagnosis, rather than those whose sole need is SEMH as there is a separate, dedicated Mental Health JSNA underway.

8.1 Causal Factors

There is currently limited evidence exploring the link between SEND and SEMH needs. Identifying SEMH difficulties in children with SEND can be challenging due to the overlapping behaviours associated with conditions such as ASD and severe learning disabilities¹⁶⁰. However, research suggests that children with SEND tend to experience poorer overall wellbeing compared to their peers without SEND. They are more likely to feel lonely, more likely to report not knowing how to look after their mental health, and more likely to feel they lack someone to talk to when feeling worried or stressed¹⁶¹. During the COVID-19 pandemic, some mothers reported a worsening of SEMH challenges in their children with SEND, who struggled with re-engaging socially and experienced disruptions to the support services they relied on¹⁶².

An analysis of specific SEND needs has revealed that:

- **ASD:** people with ASD tend to experience a higher prevalence of mental health conditions compared to neurotypical people. These conditions include anxiety, depression, obsessive compulsive disorder, bipolar and schizophrenia¹⁶³. Notably, women, non-binary or transgender people who have ASD often report higher levels of anxiety than men with autism. This disparity may be linked to the additional challenges they face within a patriarchal and heteronormative society¹⁶⁴.
- **ADHD:** according to NHS Digital data, 1 in 3 adults with a common mental health condition also screened positive for ADHD¹⁶⁵. Poor family resilience (a family's abilities to adapt to challenges and stress) has been linked with an increased risk of mental health conditions among children with ADHD¹⁶⁶.
- **SLCN:** children and young people with SLCN needs, such as Developmental Language Disorder, appear to be at a greater risk seem to of developing mental health problems¹⁶⁷. Contributing factors may include frustration related to communication challenges, a lack of understanding and support from others, and academic struggles within the school environment¹⁶⁸.
- **SpLD:** Research on the relationship between SpLD and mental health presents mixed findings. Some studies suggest that individuals with SpLD are more likely to experience mental health issues such as anxiety and depression, while others report outcomes comparable to those without SpLD¹⁶⁹.
- **Sensory impairments:** symptoms of common mental illnesses have been found to be higher in people with sensory impairments than those without, which may be linked to how they feel about their social interactions and relationships¹⁷⁰.

- **Down Syndrome:** depression is the most common mental health condition in people with Down Syndrome¹⁷¹. Its development may be influenced by stressors such as social rejection and social withdrawal. Additionally, women with Down Syndrome are more likely to have depression than men¹⁷².

8.2 Local Picture

In 2024, of the 3,109 children with an EHCP in Tower Hamlets, 405 (13%) were recorded as having a SEMH need. Over one in ten (n=280; 9%) had SEMH listed as their primary need. Among these children and young people, more than three quarters (77%) were male, and less than a quarter (23%) were female, reflecting national trends in the gender distribution of SEMH needs.

The ethnic breakdown of EHCPs demonstrates that white ethnic groups and Mixed ethnic groups are overrepresented, whilst Asian ethnic groups are underrepresented among those with SEMH needs (see Table 9.1). Notably, for 14.1% of children, ethnicity was not listed reflecting challenges with the recording of data.

Table 9.1: Segmentation of SEMH needs by ethnicity in 2024.

	White ethnic groups	Asian ethnic groups	Mixed ethnic groups	Black ethnic groups	Other ethnic groups
Total % of all pupils in ethnic group	12.1%	66.6%	8.3%	9%	3%
% of pupils in ethnic group with EHCP for SEMH	36.3%	20.3%	16%	10.2%	3.2%

In addition to SEMH as a primary need, more than a quarter (n=79; 28.2%) of these children and young people also had a secondary need, most commonly a SLCN (n=43; 15.4%). An additional 125 (4%) children with an EHCP in Tower Hamlets had a secondary need listed as SEMH, with the most common primary need among these children and young people being SLCN (n=69; 55.2%) and ASD (n=40; 32%).

8.3 Diagnosis

Identifying SEMH needs as a SEND is typically carried out by the school's Special Educational Needs Coordinator (SENCo) or through parental referral to the Tower Hamlets SEN team. An Educational Psychologist may also be involved in assessing a child and can identify SEMH needs within the educational context; however, they are not qualified to provide formal mental health diagnoses.

Formal mental health diagnoses are usually made by Child and Adolescent Mental Health Services (CAMHS) Tower Hamlets, following a referral from a GP, another healthcare professional, or a self-referral by parents or carers. It is important to note that not all SEMH needs require a clinical diagnosis in order to receive support.

8.4 Pathway

Children can be referred to mental health services by a range of professionals, including teachers, school nurses, GPs, youth workers, or social workers. In some cases, children and young people may be able to self-refer, or a parent or carer can make a referral on their behalf.

8.5 Healthy Lifestyle

To date, there has been limited research specifically examining health behaviours among children with SEND who also experience co-occurring SEMH needs. However, broader studies have consistently shown that children with SEMH needs are more likely to engage in poorer health behaviours compared to their peers without such needs. These behaviours include inadequate sleep, lower consumption of fruits and vegetables, increased use of social media, as well as higher rates of smoking, alcohol use, drug use, and sexual risk-taking¹⁷³. Such behaviours may be influenced by peer pressure, low self-efficacy regarding health choices, and maladaptive coping strategies.

Although direct evidence is sparse, it is reasonable to infer that similar patterns are likely to be observed among children with other types of SEND, potentially placing them at greater risk of developing preventable health conditions later in life.

8.6 School Life

Children with SEND often face challenging school experiences, which may impact their social, emotional and mental health. In particular, children with SEND tend to have worse academic achievement than their peers¹⁷⁴ and may struggle to form and maintain social relationships at school. A qualitative study¹⁷⁵ found that children with SEND often reported poor relationships with teachers, particularly when educators lacked empathy or understanding, were unfriendly, or failed to appropriately adapt their teaching methods (e.g., not allowing sufficient time to complete tasks). Additionally, children with SEND described experiencing difficulties with peer relationships, including bullying. Despite these challenges, some were able to form strong friendships which may serve as a protective factor for mental health. Bullying, however, is widely recognised as having impact on children and young people's mental health and wellbeing which can persist into adulthood¹⁷⁶.

For children and young people with SEMH needs, stigma can further compound these difficulties. Being labelled as 'different' by teachers, school staff, or peers can lead to feelings of exclusion and reinforce negative self-perceptions¹⁷⁷.

Interviews with local stakeholders revealed growing concerns about the rise in emotionally based school avoidance, where children are increasingly absent from school due to anxiety. One stakeholder outlined that this anxiety may be linked to autism. This local trend mirrors national findings, with recent literature suggesting that the increase in emotional-based school avoidance across England may be driven by a rise in mental health issues among children and young people, particularly those who are neurodivergent, following the COVID-19 pandemic¹⁷⁸.

8.7 Outcomes

Whilst there has been limited literature exploring the outcomes of SEMH needs among people with SEND, both SEMH and SEND needs increase risk of some negative outcomes, including:

- **Crime:** people with mental health conditions have historically been overrepresented in the criminal justice system, with many proposed explanations for this including a lack of available support and social exclusion¹⁷⁹. There is a complex relationship between crime and SEND, with people with ADHD having an increased risk of arrest, convictions and incarcerations¹⁸⁰ whilst people with ASD are at higher risk of engaging with the criminal justice system, although do not appear to be at higher risk of offending behaviours than the general population¹⁸¹. Furthermore, there is a high prevalence of SLCN among young people in the youth justice system¹⁸² and of people with dyslexia in the criminal justice system^{Error! Bookmark not defined.}.
- **Homelessness:** it is widely known that most people experiencing homelessness have a mental health condition¹⁸³, but research has found that SEND needs can lead to homelessness as well. For example, it has been found that ADHD increases risk of homelessness¹⁸⁴ as does dyslexia. Furthermore, it has been found that having an intellectual disability increases risk of homelessness¹⁸⁵.
- **Employment:** people with mental health problems can have difficulty in finding and retaining employment, tend to earn less than those without mental health problems and can struggle to grow in their careers¹⁸⁶. Employment can vary across SEND need, but there is a clear gap in education, employment and training between those with and those without SEND¹⁸⁷.

From this, it is clear that both SEMH and SEND needs can lead to certain negative outcomes independently of each other and therefore, the possible cumulative effect of having co-existing SEMH and SEND needs should be considered and acknowledged when planning support and interventions for children with SEND.

8.8 Transitions

Children receiving support from CAMHS can transition to the Adult Mental Health Service. This process should begin six months prior to the child's 18th birthday, with a referral made by CAMHS to the Adult Mental Health Service. During these six months, several meetings should take place to transfer care. Where necessary, CAMHS can continue to provide joint support for up to six months following the child's 18th birthday.

For children with a learning disability receiving support from CAMHS, if appropriate, they can be transitioned to the Community Learning Disability Service (CLDS). This transition can begin from the age of 16, with quarterly pre-transition meetings taking place with CAMHS and CLDS. Referrals to CLDS can be made six months prior to the child turning 18, with pre-transition meetings taking place up until the child turns 18. Where necessary, CAMHS can continue to provide joint support with CLDS until six months following the child's 18th birthday.

However, in interviews with stakeholders, it was outlined that the transition between children and adult services can be difficult if children do not meet inclusion criteria. For example, if they have an IQ of 70 or above, they would not be able to access support from CLDS, which may mean they have to seek support from the adult social care team to be assessed. This could take some time, thus delaying support for the individual.

8.9 What works

School approach: Teachers should adopt a positive, supportive approach when working with children and young people with SEMH needs. By fostering a comfortable and inclusive environment and building strong relationships with pupils, they can help increase motivation, engagement, and participation in learning¹⁸⁸.

Cognitive Behavioural Therapy (CBT): CBT has been shown to be effective in supporting the mental health of children and young people, particularly those experiencing anxiety disorders and depressive symptoms¹⁸⁹. However, adaptations may be necessary when delivering CBT to individuals with SEND, including those with learning difficulties, Conduct Disorder, or ADHD. Such adaptations can focus on developing self-regulation, problem-solving abilities, and social skills¹⁹⁰. For individuals (both children and adults) with ASD, further adjustments may enhance engagement and outcomes. For example, permitting the use of fidget objects to increase comfort, and modifying communication strategies such as reducing the expectation of eye contact¹⁹¹.

Art therapies: Digital-based art therapy has been shown to help young people with learning disabilities to express their emotions more effectively¹⁹². It has also been found to support those with hearing impairments by enhancing emotional expression and reducing feelings of anxiety, depression and loneliness¹⁹³. For children with ASD, art therapies can aid in developing social skills and improving communication, offering a non-verbal, creative outlet for self-expression and connection¹⁹⁴.

8.10 Support Services

There are a range of services available to support the social, emotional and mental health needs of children and young people in Tower Hamlets, as outlined on the Tower Hamlets Local Offer website:

- **Tower Hamlets Child and Adolescent Mental Health Service:** Support children up to the age of 18 with moderate to severe mental health problems. This service can be accessed through a referral, although secondary school-age children can self-refer, or their parents and/or carers can do it on their behalf.
- **Kooth:** Free digital support for mental health and wellbeing with an online community with a live chat feature to talk to mental health professionals, for young people aged 10-25 years old. Children and young people can register for this service on their website.
- **Tower Hamlets Early Detection Service:** Provide mental health support for young people aged 17-30 from mental health nurses, psychologists and psychiatrists. This can be accessed via referrals from professionals and non-professionals, and over 17s can self-refer.
- **Tower Hamlets Education Wellbeing Service:** Support young people aged 4-19 years old with their emotional and mental wellbeing, including 1:1 sessions and group interventions. Young people in participating schools can be referred to this service by their school's Mental Health lead.
- **Step Forward:** Tailored support for young people aged 11 to 25 years old including 1:1 support and groups support including counselling and cognitive based therapy. Young people can contact Step Forward directly via email and telephone.

- **Tower Project:** Support children and adults aged 0-25 with SEND to build skills and make friends, as well as offering support to gain employment.
- **Docklands Outreach:** Support children and young people aged 2-25 years old with emotional and mental health difficulties, including advocacy support, counselling and CBT. This can be accessed via referrals from professionals and non-professionals, or young people can self-refer.
- **Short Break Services:** Provide opportunities for children and young people with disabilities to take part in fun and inclusive activities, build independence, and make friends, while giving parents and carers a break from their caring responsibilities. Under the *Children Act 1989* and the *Breaks for Carers of Disabled Children Regulations (2010)*, local authorities must offer such support. In Tower Hamlets, short breaks are available for children aged 5 and over with ASD, complex health needs, sensory impairments, or other disabilities.

8.11 Gaps

Given the gaps in literature, understanding of effective and best-practice approaches is limited. However, it is clear that to best support the SEMH needs of children and young people with SEND, staff must prioritise building positive, trusting relationships with pupils and adapt their teaching approaches to meet individual learning needs.

8.12 Recommendations

The following recommendations are based on the evidence outlined above, along with local and national statistics and stakeholder insights. While they do not necessarily indicate a gap in support provision within the borough, they highlight areas where best practice can inform and enhance current strategies.

- **Identification:** Schools and educational settings should remain vigilant in identifying children and young people with SEND and any co-occurring SEMH needs. Particular attention should be paid to early signs of social isolation, emotional distress, and experiences of bullying, which may not always be explicitly reported.
- **School staff approach:** It is essential for teachers and school staff to foster positive, trusting relationships with children and young people with SEND, creating a sense of safety that supports their engagement and learning. This includes being open to making appropriate adaptations to teaching practices for all pupils, regardless of whether a formal diagnosis is in place.
- **Healthcare professionals:** Healthcare professionals working with children with SEND should continue to promote positive health and emotional wellbeing, ensuring that their approach is responsive to the individual needs, experiences, and developmental stage of each child.

8.13 Summary

Social, emotional and mental health needs often overlap with other SEND needs, such as SLCN, ASD, and ADHD. Children with SEND often face challenges such as loneliness and bullying and typically have lower overall wellbeing than children without.

Supporting the social, emotional, and mental health of children with SEND requires teachers and school staff to foster a positive school environment and build strong, trusting relationships with the

children. This chapter offers several recommendations, including improving the identification of social, emotional, and mental health needs in children with SEND, strengthening relationships with them, and ensuring a safe, supportive atmosphere both in the classroom and in healthcare settings.

9. Sensory impairment

A sensory impairment refers to a difficulty with one or more of the senses (sight, hearing, smell, touch and taste). These impairments can affect a child or young person's ability to communicate, learn, and interact with the world around them, and often require early identification and tailored support to promote development and inclusion.

9.1 Causal Factors

9.1.1. Hearing impairment (HI)

Approximately 18 million people in the UK (around 1 in 4) are estimated to experience some degree of hearing loss, including roughly 50,000 children¹⁹⁵. Hearing loss refers to reduced hearing compared to normal thresholds (20 dB or better in both ears) and can range from mild to profound, affecting one or both ears, making it difficult to hear speech or loud sounds¹⁹⁶.

Hearing loss and deafness occur when sound signals fail to reach the brain due to issues within the hearing system. There are two main types of hearing loss: sensorineural and conductive. Sensorineural hearing loss, which is permanent, results from damage to the inner ear's hair cells or the hearing nerve, making quiet sounds harder to hear and reducing sound clarity; it is often treatable with hearing aids¹⁹⁷. Conductive hearing loss, typically caused by ear problems like wax buildup or infections, prevents sound from reaching the cochlea, making sounds quieter and muffled; it can be temporary or permanent. When both types are present, it's called mixed hearing loss¹⁹⁸.

Sudden hearing loss can affect one or both ears, occurring instantly or over several weeks, and may be accompanied by tinnitus or balance issues. Recovery depends on the cause and severity. Possible causes include infections, injury, medication side effects, acoustic neuromas, and Ménière's disease¹⁹⁹.

Noise-induced hearing loss, a type of sensorineural hearing loss, occurs when loud sounds damage the sensitive hair cells in the cochlea, leading to permanent hearing loss and often tinnitus. It is the second most common cause of hearing loss (most common is age-related hearing loss) and may result from a single loud event or long-term exposure to high noise levels. Early signs can include tinnitus, and effects may not appear until years later. Common sources include noisy workplaces, loud music, or sudden bursts of sound²⁰⁰. This type of hearing loss typically affects high-frequency sounds first, making it harder to hear high-pitched noises. Continued exposure can worsen the loss, eventually impacting lower frequencies which can make conversation difficult, even in quiet settings.

Around half of deaf children are born with congenital deafness, mostly caused by genetic factors. This may be syndromic (with other symptoms) or non-syndromic (affecting only hearing), and while it can be inherited, many cases occur without a family history²⁰¹. Infections during pregnancy can also lead to congenital deafness. Common infectious agents that can lead to deafness include cytomegalovirus (CMV), rubella, toxoplasmosis, and herpes. Some babies become deaf shortly after birth, especially if born prematurely, due to infections, ototoxic (having a harmful effect on the organs or nerves

concerned with hearing and balance) medications, severe jaundice, or lack of oxygen during delivery²⁰². In addition, children that are born with the ability to hear but later develop deafness in childhood are described as having acquired deafness. The most common cause of this is glue ear, a condition where fluid builds up in the middle ear, leading to temporary hearing loss. Other causes include infections (e.g. meningitis, measles, mumps, rubella), head injuries, loud noise exposure, and certain medications, such as chemotherapy. Some genetic conditions also cause progressive deafness, where hearing deteriorates over time. Ototoxic drugs, particularly some used in chemotherapy, can damage the inner ear, resulting in hearing loss, tinnitus (ringing in the ear), or balance issues. Children receiving such treatments should have regular hearing checks to detect early changes, allowing for treatment adjustments and timely support, including hearing aids if needed.²⁰³

9.1.2. Visual impairment (VI)

Over 2 million people in the UK live with sight loss, including approximately 340,000 registered as blind or partially sighted⁵. VI can significantly affect individuals throughout their lives, although much of the impact can be mitigated against with timely, quality eye care.

VI refers to sight loss that cannot be corrected with glasses or contact lenses, while "blindness" typically describes complete or near-complete loss of vision. There are various causes of VI. Common causes include glaucoma (damage to the optic nerve from increased eye pressure)²⁰⁴, cataracts (clouding of the eye's lens)²⁰⁵, diabetic retinopathy (retinal damage from diabetes), uncorrected refractive errors (issues with how light is focused on the retina), corneal opacity (scarring or clouding of the cornea), trachoma (a bacterial infection)²⁰⁶, and hemianopia (vision loss in half the visual field, often due to stroke). Common symptoms associated with these conditions include blurred vision, eye pain (with or without discharge), light sensitivity, double vision, flashes of light, vision disturbances, and the appearance of new floaters in the field of vision.

Research has shown that the prevalence of certain VI varies across ethnic groups²⁰⁷. Individuals of African and African Caribbean descent are up to four times more likely to develop glaucoma compared to other populations and are also at increased risk of developing age-related macular degeneration before the age of 60. Similarly, people of Asian backgrounds have a higher likelihood of developing cataracts²⁰⁸.

Many children with VI are affected from birth, though some develop issues later due to illness, injury, or medical conditions. These impairments are often lifelong and may not be immediately visible. Signs in babies can include difficulty focusing, unusual eye movements, sensitivity or lack of response to light, and cloudy or pale pupils. In older children, signs may include eye rubbing, holding objects close, head tilting, clumsiness, tiredness from visual tasks, or difficulty seeing in low light or at a distance²⁰⁹.

9.1.3. Multisensory impairment (MSI)

A child is considered deafblind, or have a multisensory impairment (MSI), when they have both hearing loss and VI. Often, the cause of combined impairments is unknown, and one sense is usually more affected than the other. However, this balance may change over time²¹⁰. It is rare for a child to have both hearing and vision impairments. Recent estimates suggest about 0.031% of children and young people in the UK, around 31 out of every 100,000 under-19s, have both vision and hearing impairments²¹¹.

When a child or young person loses both their hearing and vision after they have already developed language, this is known as an acquired multi-sensory loss. Such a loss may be caused by illness (such as meningitis), injury, or an underlying genetic condition present from birth, such as Usher syndrome. The age at which symptoms appear, as well as the severity and progression of hearing, vision, and balance issues, can vary greatly from one individual to another.

9.1.4. Sensory processing impairment

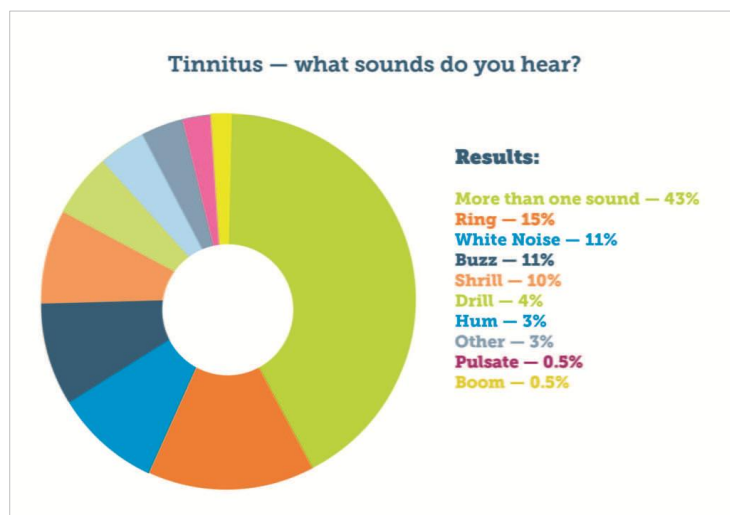
Sensory Processing Disorder (SPD) is a neurological condition that impacts how the brain interprets sensory information such as sight, sound, touch, smell, taste, and movement²¹². People with SPD may have difficulty organising and responding appropriately to sensory input, which can affect daily activities and social interactions. The condition can manifest as:

- Hypersensitivity (over-responsivity), causing discomfort or avoidance of certain stimuli
- Hyposensitivity (under-responsivity), leading to a need for increased stimulation
- Sensory seeking, where individuals actively crave specific sensory experiences
- Sensory discrimination problems, which involve trouble distinguishing between different sensory inputs
- Sensorimotor difficulties affecting coordination, balance, and motor skills.

Sensory processing impairment can occur in many people with ASD and in other populations with neurodevelopmental disorders.

9.1.5. Tinnitus

Figure 10.1: Online poll results of common sounds heard²¹³



Tinnitus is the perception of ringing, buzzing, or other sounds in the ears or head without an external source. It can vary in intensity and may be constant or intermittent, often affecting quality of life. According to the latest research, approximately 1 in 7 adults experience tinnitus. In the UK alone, this translates to over 7 million adults living with the condition, highlighting its widespread impact on the population²¹⁴. Studies show a wide range in how common tinnitus is

among children. In the general paediatric population, including those with normal hearing, estimates range from 4.7% to 46%. Among children with hearing loss, the reported prevalence is higher, ranging from 23.5% to 62.2%²¹⁵

Source: Hearing Link Services.

Tinnitus is influenced by various factors. In children tinnitus can be associated with underlying conditions requiring medical assessment, such as glue ear, hearing loss, or ear infection²¹⁶. Other contributing factors include earwax buildup, ear infections, and injuries to the head or neck that affect

the auditory system. Less common causes involve conditions such as Ménière's disease, jaw joint disorders, and tumours like acoustic neuromas. Circulatory issues, including high blood pressure and vascular malformations near the ear, may also lead to tinnitus. Additionally, chronic illnesses such as diabetes, thyroid problems, migraines, anaemia, and autoimmune diseases like lupus or multiple sclerosis have been linked to the condition²¹⁷.

9.1.6. Physical disabilities with associated sensory impairment

There are a number of physical health conditions that are associated with sensory impairments including cerebral palsy, spina bifida, neuro-muscular dystrophies, and spinal cord injuries²¹⁸. See Chapter 11 for further insight into physical disabilities.

9.2 Local Picture

9.2.1. Hearing impairment (HI)

3.4% of the total EHCPs in Tower Hamlets are for children with a HI, with a near even split of female (52%) and male (48%) children. Progressive hearing loss is seen more particularly in secondary-aged children. The majority of these children are of Asian Bangladeshi heritage (51.6%), although this suggests that this group is still underrepresented as 62.6% of all pupils in schools in Tower Hamlets are of Asian Bangladeshi heritage, according to the latest school census data²¹⁹.

Data from stakeholders and a service evaluation carried out in the borough reported that Tower Hamlets has the second highest rates of deaf children and young people in London²²⁰Error! Bookmark not defined.. In addition, a recent caseload review of deaf children with cochlear implants in Tower Hamlets reported:

- 98% of children and young people are from ethnic diverse backgrounds (mostly Bengali)
- 64% used additional language to English at home
- 45% receive free school meals
- 52% had a communication difference in addition to deafness

For those on the caseload of 'The Deafness Speech and Language Therapy team', only 7% received a cochlear implant before the ideal 12 months of age, an important window for language development²²¹.

According to stakeholder interviews with professionals working in supporting deaf children and young people, free British Sign Language (BSL) classes are offered at stay and play groups for pre-school children. These classes have received a positive attendance rate (53%), but demand outstrips availability and there are currently limitations on numbers which results in people not being able to access classes if they have already done so previously making it difficult to reach suitable levels of fluency.

9.2.2. Visual impairment (VI)

Approximately 1.1% (n=47) of the total EHCPs in Tower Hamlets are for children with a primary need of VI. 51% of whom were female and 49% were male. Although many children with VI have been identified, data on their ethnicity has not been recorded. For those whose ethnicity has been captured,

the majority of children and young people are of Asian Bangladeshi heritage (51.1%), although, as 62.6% of all pupils in schools in Tower Hamlets are of Asian Bangladeshi heritage²²², this group still appears to be underrepresented. However, 25.5% of ethnicity data was 'not yet obtained'.

9.2.3. Multisensory impairment (MSI)

In 2023/24, 0.4% (n=20) of the total EHCPs in Tower Hamlets were for children with MSI's, a particularly rare disability and one of the least prevalent forms of disability in the area. Around two thirds of children who have EHCPs for multisensory impairment were male (70%). For half (50%; n=10) of the children with an EHCP for MSI their ethnicity could not be obtained. For the remaining half, 30% identified as White British and 15% Asian Bangladeshi.

9.3 Diagnosis

9.3.1. Hearing Impairment (HI)

The diagnostic approach for HI for newborn babies and children involves a structured, multi-step assessment.

Newborn hearing screening is offered in hospital before discharge or arranged within the first few weeks by a healthcare professional. The initial test, usually the automated otoacoustic emission (AOAE) test, is quick, safe, and ideally completed within the first 4 to 5 weeks of life. If clear results are not obtained, often due to movement, background noise, or fluid in the ear, a second test may be needed, including a repeat AOAE or the automated auditory brainstem response (AABR) test. Although this is only used for some babies. Babies requiring further assessment are referred to audiology within 4 weeks. These follow-up tests are painless, take 1–2 hours, and parents are encouraged to keep their baby comfortable during the appointment. Results are typically shared at the end of the visit, along with any next steps²²³.

As children grow older, if parents, health visitors or professionals start to suspect a child might have hearing loss, they can request a referral for a hearing test. GPs or SLTs can refer the child to an audiologist, who will carry out age-appropriate assessments such as Visual Reinforcement Audiometry (VRA) for younger children and Play Audiometry for older children²²⁴. These tests help determine the presence, type (conductive, sensorineural, or mixed), and severity (mild to profound) of any hearing loss²²⁵. In addition, hearing and vision screening is offered along with National Child Measurement Programme (NCMP) in reception (at the start of school).

9.3.2. Visual Impairment (VI)

Children's eyes are routinely checked at key stages to identify vision problems early. Initial checks occur within 72 hours of birth and again at 6 to 8 weeks as part of physical examinations. At around 1 year and again between 2 and 2.5 years, parents may be asked about any vision concerns during developmental reviews, with referrals made if needed. At age 4 or 5, most children receive vision screening in school to detect reduced vision. If this is not offered locally, parents should arrange an eye test with an optician. Vision concerns can be raised at any time with a GP or optometrist.

A range of age-appropriate tests are used to assess children's vision. These include red reflex and pupil reflex tests in newborns, visual attention tests for infants, and Snellen or LogMAR charts for children who can recognise letters or symbols. Range of movement tests check eye muscle function, while

refraction tests assess the need for glasses. Colour vision testing, such as the Ishihara test, may be used in older children if colour blindness is suspected. Early detection through these checks supports timely treatment and better long-term outcomes²²⁶.

9.3.3. Multisensory impairment (MSI)

MSI, which affects both hearing and vision, can result from various causes. Some children are born with MSI, while others develop it later due to illness, injury, or progressive conditions that worsen over time²²⁷.

MSI may be identified shortly after birth or during later health assessments. If a baby is born with deafblindness, this is typically detected through the routine newborn screening process. This screening includes a series of checks to identify any significant health concerns present from birth, including those affecting hearing and vision. As children grow, further health checks continue. Children and young people who have both a visual and hearing impairment that significantly affects daily activities, such as communication, access to information, and mobility, may benefit from a Deafblind Guidance Assessment²²⁸.

9.4 Pathway

9.4.1. Hearing impairment (HI)

In the first few weeks of life, all babies are offered a routine hearing screening to help identify any hearing loss. Around 1 to 2 in every 1,000 babies are born with hearing loss in one or both ears, which is often difficult to detect at such a young age. Early identification is important for a child's development and allows parents to access support and information as soon as possible²²⁹.

The screening uses either the Automated Otoacoustic Emission (AOAE) test or the Automated Auditory Brainstem Response (AABR) test. The AOAE involves placing a soft earpiece in the baby's ear to send clicking sounds; the inner ear (cochlea) usually produces an echo in response, which the equipment detects. The AABR test uses small sensors on the baby's head and neck and plays sounds through baby-sized headphones to measure the response. The AOAE takes just a few minutes, while the AABR can take 5–30 minutes. The Automated Auditory Brainstem Response (AABR) test is a core component of the newborn hearing screening programme in Tower Hamlets. Although specific diagnosis rates for the AABR test in this area are not available, the overall programme is designed to identify hearing loss in newborns at an early stage, with the AABR test playing a vital role in this process²³⁰.

9.4.2. Visual impairment (VI)

The visual impairment (VI) pathway for children in Tower Hamlets involves early identification through school-based vision screening, formal diagnosis, and coordinated support following confirmation of need. Vision screening is carried out in schools to detect potential issues such as short-sightedness, long-sightedness, or amblyopia ("lazy eye"). Children who do not pass screening are referred to the Ophthalmology Department at the Royal London Hospital for further assessment and, where appropriate, a formal diagnosis. The ophthalmology team may also issue a Certificate of Vision Impairment (CVI), which can enable access to additional social care and educational support. Following diagnosis, families are referred to the Tower Hamlets Visual Impairment Team.

9.4.3. Multisensory impairment (MSI)

Babies with MSI can be identified during newborn screening, if no problems are picked up at this stage they may be picked up at routine hearing or eye tests carried out as children get older²³¹. As each child or young person with MSI presents differently, assessment must go beyond medical tests of vision and hearing alone. It is essential to include a functional assessment that evaluates how combined sensory impairments impact daily life, even where some residual vision or hearing remains²³².

9.5 Healthy Lifestyle

9.5.1. Hearing impairment (HI)

Individuals with HIs may experience several physical and mental health challenges due to communication barriers. In group exercise or sports settings, difficulties in understanding verbal instructions can lead to feelings of exclusion or discomfort. Safety is also a concern when auditory cues, such as alarms, signals or verbal instructions are not accessible.

Hearing aid users often struggle with loud hold music, which makes telephone interactions frustrating. However, many GP surgeries and hospitals insist on telephone only appointment bookings, making it difficult for deaf patients who rely on text or email. This is despite the Accessible Information Standard²³³, a legal requirement for healthcare providers to communicate in patients' preferred formats. As a result, people frequently have to rely on family or friends to book appointments, compromising privacy and independence. Additionally, video or BSL interpreters are often not arranged, leading to appointment cancellations or patients missing vital information, potentially delaying essential treatment²³⁴. Furthermore, many GP practices lack essential assistive technologies such as hearing loops or vibratory pagers²³⁵. Consequently, many individuals with hearing impairments report emotional distress due to feeling ignored or feel unable to communicate effectively within healthcare settings²³⁶.

9.5.2. Visual impairment (VI)

Individuals with VI often encounter significant barriers to maintaining health and well-being due to systemic inaccessibility in their environments. Engaging in physical activity can be particularly challenging. Safety concerns, fear of injury, and limited access to adapted facilities or equipment frequently discourage participation. Without appropriate accommodations, opportunities for exercise are significantly reduced, contributing to sedentary behaviour and related health risks²³⁷.

Vis are also linked to social withdrawal and isolation, which can increase the risk of depression, whilst contributing to cognitive decline over time²³⁸.

Nutrition and food safety are also affected. Difficulty reading food labels and expiry dates may influence dietary choices and increase the risk of unsafe food consumption. These considerations often necessitate external support or the use of assistive technologies which are not always available.

Many children and young people with VIs can also experience difficulties with social participation. Mobility and communication challenges can limit involvement in community activities, leading to reduced interaction and social isolation. Over time, this isolation can lead to increased risk to anxiety and depression²³⁹.

For patients with VIs, health services frequently present accessibility challenges. For example, appointment letters are often sent in printed formats with small fonts that are unsuitable for screen readers or magnification tools. Many digital platforms, including appointment systems used by GP practices, are not compatible with screen readers, and fail to include essential navigation information, leading to confusion or delays in attending appointments. Additionally, individuals with VIs commonly report inadequate guidance within clinical settings. For example, a lack of auditory cues, such as being called by name, makes appointments stressful and impedes independent access²⁴⁰.

9.6 School Life

9.6.1. Hearing impairment (HI)

Research looking into the lived experiences of children with HI found that barriers to inclusion persist, mainly due to a lack of deaf awareness among peers, which can lead to hurtful comments, bullying, and social embarrassment. To cope, some students find they need to withdraw socially or hide their hearing aids²⁴¹.

In addition, research on academic achievement found that children with mild hearing loss often struggle with speech and language development and are more than twice as likely to have problems at school²⁴². As hearing loss becomes more severe, the impact on learning increases. Research suggests that children with mild to severe hearing loss had lower language levels than age and socioeconomically matched hearing peers, and the gap widened with increased hearing loss severity. Among children using hearing aids, greater audibility was linked to faster language growth during the preschool years²⁴³.

9.6.2. Visual impairment (VI)

Children and young people with VIs experience a number of challenges in coping with school life. They are at a higher risk of low self-esteem, difficulties at school, and isolation. Many report struggles with making friends and are more likely to experience teasing or bullying from peers²⁴⁴. In addition children and young people report barriers to participation in Physical Education (PE) both in mainstream schools and specialist schools²⁴⁵²⁴⁶. These issues can have lasting effects, highlighting the need for supportive environments and inclusive practices in schools and communities.

9.6.3. Multisensory impairment (MSI)

Children with MSI face challenges at school regarding their ability to access information, communicate, and move confidently in their environment. Without appropriate support, these children may only engage with what is immediately around them, limiting their learning and understanding of the wider world²⁴⁷. Children and young people with MSI often experience social isolation, with parents being their main source of interaction outside school²⁴⁸. Communication and mobility challenges limit their independence and access to social activities. Environmental barriers such as poor lighting, unclear signage, transport difficulties, and limited participation in subjects like Physical Education further reduce their opportunities for social inclusion²⁴⁹.

9.7 Outcomes

9.7.1. Hearing impairments (HI)

HIs are associated with a broad range of consequences for the child's cognitive, social, and emotional development^{250,251}. Research suggests that children with a HI report significantly lower quality of life compared to children with normal hearing²⁵². In addition, young people with a HI were 21-39% less likely to attend college/university and twice as likely to experience work related stress than people without a HI²⁵³.

Fitting hearing aids or cochlear implants in the first months of life can put many children on a near-typical language path, especially when families use the devices consistently and have good support. Even so, children with hearing loss face higher risks of challenges with memory, attention, and other thinking skills that affect school and later employment^{254,255}.

Early intervention with hearing aids or cochlear implants is associated with significantly better outcomes in speech, language development, and overall functional abilities. Improved speech perception is linked to stronger language skills and higher cognitive function. Furthermore, children with better language and functional performance tend to show more positive psychosocial development²⁵⁶.

Compared to distraction-based hearing screening, newborn hearing screening was linked to better developmental outcomes at ages 3-5 in children with permanent hearing loss²⁵⁷. A study found that children with ongoing hearing problems or ear infections around age 4-5 were more likely to have emotional and social difficulties by age 10-11. These issues were less common in children who had hearing problems as babies, possibly as early issues often improve or are treated. Hearing problems during preschool years, a key time for learning and social development, may have a greater long-term impact. These findings highlight the importance of early detection and support for young children with hearing issues to help protect their emotional and social wellbeing²⁵⁸.

9.7.2. Visual impairment (VI)

Children and young people with VI may face challenges that affect their quality of life²⁵⁹, emotional wellbeing²⁶⁰, and social development²⁶¹. Some research indicates adults with VIs are more likely to experience depression and anxiety.

9.7.3. Multisensory impairment (MSI)

MSI is strongly linked to depression²⁶², cognitive decline²⁶³, and reduced quality of life²⁶⁴. People with MSI face challenges in activities of daily living and social engagement. MSI correlates with higher mortality²⁶⁵, worse general health, and impaired functioning²⁶⁶.

9.8 Transitions

Tower Hamlets has a range of services available to support young people with visual and hearing impairments (including children with MSIs) move from children to adult services.

SEND Information, Advice and Support Service (SEND IASS): SEND IASS provides impartial advice, information, and support to parents and carers of children and young people with SEND, including children with sensory impairment, from birth to age 25. The service covers a range of areas including

education, health, and social care. Support offered includes casework, access to specialist support groups and guidance on matters such as school admissions, exclusions, and bullying.

Tower Hamlets Transition Support Team: This team offers targeted support for children and young people with sensory impairment during the transition from children to adult services. They provide impartial guidance to help families manage changes in care and education pathways. The team can also assist with school-related issues such as admissions, managed moves, exclusions, and bullying.

Tower Hamlets Local Offer: The Local Offer is an online directory that brings together information on services and resources available for children and young people with SEND, including those with hearing and visual impairments. It includes comprehensive guidance on preparing for adulthood and transitioning to adult services.

Tower Hamlets Sensory Support Service for Children and Young People: This specialist service supports children and young people with hearing impairments. While not solely focused on transitions, the team may be able to offer advice and assistance to support children during periods of change, particularly in relation to their sensory needs.

9.9 What works (evidence-based practice)

9.9.1. Hearing impairment (HI)

Speech and language: Early identification of hearing loss in infants, ideally within the first few months of life, enables timely access to intervention services, significantly improving speech, language, and social-emotional development. Research consistently indicates children who receive early intervention demonstrate stronger language skills (spoken and signed) at key stages, compared to those diagnosed later²⁶⁷.

Needs of the parents/caregivers: Research shows that parents of children with hearing loss often find the diagnostic period overwhelming. Two main challenges emerge: uncertainty about what happens after diagnosis and difficulty navigating early intervention services. This underscores the need for clear information, timely guidance, and strong emotional support to help families manage early intervention and support their child's development²⁶⁸.

Clear, unbiased, and timely information is essential for families of children with hearing loss. They need accurate guidance on the condition, communication options, technology, and services, yet many feel underinformed or receive biased advice, pointing to a need for better professional collaboration. A family-centred approach, built on partnership, respect for values, and mentoring, is important. Regionally tailored guides in multiple formats should be widely available and include peer support, deaf role models, and parent networks, which are often overlooked. Home visits by multidisciplinary teams and opportunities to meet other families can ease emotional strain and improve engagement in early intervention.²⁶⁹

Online education provision: Online education can be more accessible for some children and young people with hearing loss, but only when well planned and properly supported. Research during the Covid-19 pandemic suggests that platforms like Zoom are hard to use without tailored help, and visual materials should include captions, high-quality audio, and reliable speech-to-text tools. Because online

learning can also increase social isolation, steps to maintain social connection are essential such as providing access to counselling services ²⁷⁰.

Inclusion in mainstream school: Research with students who have hearing loss, their parents, and teachers identified key factors affecting inclusion in mainstream schools. The biggest facilitator was the teacher's role, supporting speech and language, academic progress, and awareness of hearing loss. Supportive staff, involved parents, understanding peers, and student self-advocacy also helped. Barriers included poor teacher preparation, inconsistent use of assistive technology, and an overemphasis on the hearing loss that sometimes lowered expectations. Inclusion depended on coordinated support from families, educators, and peers. The findings suggest that placing a child in a mainstream school isn't enough, targeted support, awareness, and inclusive attitudes are needed.²⁷¹.

Role of parents in children's development of literacy: At-home sign language training can be effective for parents and carers of children with hearing loss. Early, consistent access to an accessible language, signed or spoken can be important for development, and early exposure to sign language can boost English literacy in deaf children. Parent-led programs show promise for improving children's language skills, but more research is needed to understand best practices and long-term outcomes²⁷².

9.9.2. Visual impairment (VI)

Role of parents and caregivers: Recent studies show that the severity of vision loss can affect children's social, emotional, and cognitive development, but these effects are not fixed. Supportive parenting, effective communication, and early intervention can offset challenges. When parents adapt their behaviour, by offering rich interaction and adjusting communication, children with visual impairment can develop language and social skills similar to sighted peers. The quality of caregiver interactions is especially important in shaping outcomes.²⁷³. Research has also shown that traditionally focused on communication and motor skills in children with visual impairment, but newer perspectives stress the importance of environment, personal interests, confidence, and social participation. Studies show that supportive settings, respect for a child's preferences, and a strong sense of self can improve outcomes²⁷⁴. Although severe VI can delay language and cognitive development, early home-based interventions can lessen these effects and reduce parental stress. While vision loss isn't reversible, supportive parenting, early intervention, and rich social interaction help children thrive. Broadening the focus beyond skill-building to include well-being, environment, and participation offers a more effective, holistic approach.²⁷⁵.

Figure 10.2: Example strategies for parents to help support their child with visual impairment

Objects and toys

Visual understanding can be supported by having lots of very familiar things to look at. It helps if objects and toys can be held or positioned close to your child so they can look at each part and not be confused by a cluttered background. Objects and toys that are simple in design with a clear contrast between colours or features are easier to understand visually. iPads also have lots of useful apps for visual stimulation. In the early stages of children's visual development, large objects with chunky features are more interesting than small things which are visually complex. You may want to set up a small special area for visual stimulation, maybe in your child's bedroom, using objects that interest them.



Source: RNIB Information about vision impairment: Guide for parents²⁷⁶

School support: Research shows that strong support from family and friends can reduce emotional difficulties and improve mental well-being in children with VI. Although Tower Hamlets does not have a specialist school for VI, research suggests that school type (mainstream vs. special education) may influence mental health outcomes, though findings vary across countries, likely due to differences in education systems, support structures and severity of impairments. Parents and teachers play a key role in identifying early signs of emotional distress, particularly in safe and supportive environments. Whilst VI can increase the risk of mental health challenges, early intervention, targeted support and inclusive social experiences can help protect and promote emotional well-being²⁷⁷.

9.9.3. Multisensory impairment (MSI)

Before a child with MSI begins nursery, primary, or secondary school, local authorities should demonstrate proactive planning to ensure inclusive and supportive education. This includes familiarisation visits for the child and family, staff-wide training on MSI and input from specialist teachers and communication support professionals such as sign language interpreters. Schools should also involve therapists and deliver a tailored curriculum that supports sensory development, communication, mobility, and independence. The learning environment should be physically accessible and equipped with appropriate aids and technology. Due to the complexity associated with MSI, it is necessary to involve a range of professionals, such as physiotherapists, occupational therapists, speech and language therapists, and specialist teachers, to advise on suitable tools and strategies. Trying different equipment can help identify what works best. Under equality law, schools must take “reasonable steps” to provide auxiliary aids to reduce barriers for pupils with disabilities. These aids may include communication support (e.g., interpreters or note-takers), assistive technology (e.g., videophones, hearing systems), or human assistance. Which in turn would also be useful for children with isolated VI or HI. These efforts are essential to promoting full participation and learning for students with MSI in mainstream education²⁷⁸.

Tower Hamlets shows an interest in building knowledge in this area. For example, one stakeholder interviewed for this JSNA carried out a small, unpublished study exploring the relationship between

mobility support and the development of symbolic communication in children with MSI. The study suggested that children with MSI who do not learn to walk are less likely to develop symbolic communication.

9.10 Support services

9.10.1. Hearing impairment (HI)

Support for children with hearing HIs in Tower Hamlets is available through the Sensory Support Service, the Deaf Support Base at St Paul's Way Trust School, and the Tower Hamlets Deaf Children's Society. These services provide specialist teaching, audiological support, and family support networks.

Speech and Language Therapy and Occupational Therapy service: the local speech and language therapy team delivers tailored, bilingual interventions, offers family support sessions and BSL classes, and works closely with multi-agency professionals to improve outcomes and reduce language deprivation.

Deaf Support Base (DSB) at St Paul's Way Trust School: A specialist provision for deaf students, offering integrated support within a mainstream secondary school, the only one of its kind in Tower Hamlets. The DSB also offers regular sessions with SLTs, Healthy Minds workshops, and BSL classes. Ongoing collaboration with Hackney Ark audiologists and the Tower Hamlets Peripatetic Team ensures specialist support is consistently available.

Tower Hamlets Deaf Children's Society: Run by a volunteer committee of parents of deaf children, this society provides a free support network for deaf children, young people (ages 0–18) and their families in Tower Hamlets. Activities such as summer trips, seasonal events, coffee mornings, and parent workshops are held throughout the year (term time only) to strengthen the local deaf community. The society also advocates for appropriate services relating to childhood deafness, hearing loss, hearing aids, and cochlear implants. Membership is free.

Ready Steady Go: A support group for parents of preschool-aged deaf and partially hearing children. The sessions use a 'Total Communication Approach', incorporating various communication methods to help children develop effective understanding and communication skills.

Short Break Services: Provide opportunities for children and young people with disabilities to take part in fun and inclusive activities, build independence, and make friends, while giving parents and carers a break from their caring responsibilities. Under the *Children Act 1989* and the *Breaks for Carers of Disabled Children Regulations (2010)*, local authorities must offer such support. In Tower Hamlets, short breaks are available for children aged 5 and over with ASD, complex health needs, sensory impairments, or other disabilities.

9.10.2. Visual impairment (VI)

Sensory Support Service: Includes specialist teachers for VI children, including those with additional needs. The service runs DOVES, a playgroup for VI children aged 0-4 and their families, providing early intervention and social opportunities.

Visual Impairment Team: A team of specialist teachers of the VI, providing support for babies, children, and young people aged 0-25 with diagnosed VIs, including those with additional and complex needs. The team also includes professionals such as bilingual instructors and a Braille instructor. Services include Braille instruction, habilitation (independent living and mobility training), and support for families, schools, and settings. The team is funded via a direct skills grant contributed to only by mainstream schools.

9.10.3. General and combined support

Tower Hamlets Education Wellbeing Service: An NHS service working alongside Step Forward and Docklands Outreach, to support the emotional and mental wellbeing of children and young people aged 4-19. Through evidence-based self-help, parent and carer guidance, and a Whole School Approach, they aim to give young people a voice and ensure their wellbeing is prioritised across the school community.

The Sight and Hearing Service: This service supports adults in Tower Hamlets who are blind, partially sighted, deaf, hard of hearing, or deafblind, aiming to promote independence, equality, and inclusion through personalised, needs-led services. Services include information and advice, assessments related to sensory loss, provision of specialist equipment, vision rehabilitation, mobility and travel training, braille classes, IT advice, and connections to local groups and NHS services. As part of the Reablement Service, they also provide additional support from Reablement Officers when needed. To access the service, individuals must be over 18 and live in Tower Hamlets.

The Educational Psychology Service: The Educational Psychology Service (EPS), part of the Education and Partnerships Directorate, supports the development, learning, and emotional wellbeing of children and young people aged 0-25 in Tower Hamlets. They also offer staff training, parent support, and strategic input to schools and the local authority. Every state-funded school in the borough has a link Educational Psychologist, and a drop-in service is available through SENDIASS for parents and young people aged 16-25.

SEND Information, Advice and Support Service (SEND IASS): SEND IASS provides impartial advice, information, and support to parents and carers of children and young people with SEND, from birth to age 25. People can self-refer to this service. The service covers a range of areas including education, health, and social care. Support offered includes casework, access to specialist support groups, and guidance on matters such as school admissions, exclusions, and bullying.

9.11 Gaps

There are currently several gaps in the provision of services and support for children and young people with sensory impairments as identified through the literature and interviews with stakeholders:

- **Funding misalignment:** There is a mismatch between the funding special schools receive and the expectation they provide specialist support for children with sensory impairments (deafness, VI, or MSI). Many schools struggle to employ staff with mandatory qualifications in these areas. Existing support is overstretched and no longer reflects the rising complexity and volume of need.

- **Funding gap:** Stakeholder interviews highlight that the vision impairment team is solely funded by mainstream schools, creating a significant funding gap for children in special schools. As a result, support in these schools is often limited, underfunded and is provided informally or on a minimal basis. Services such as qualified MSI teachers are rarely available due to limited financial resources.
- **Resource provision:** Insights from stakeholder interviews suggested that children with MSI are underrepresented in the allocation of EHCPs, especially in special schools. There is currently only one qualified MSI teacher in Tower Hamlets, a level of provision which is not seen as sustainable, or representative of the actual need.
- **Language difficulties:** Many families in Tower Hamlets encounter language barriers that can limit access to services and support. Even when interpreters are available, these may not always be fully utilised, sometimes leading to misunderstandings during appointments. Limited awareness of entitlements, particularly regarding specialist services and EHCPs, can further complicate access.
- **Limited BSL offering:** Although there is strong interest in BSL classes, current provision is limited. Demand exceeds supply, and for those who can access classes, there is insufficient capacity to build or maintain fluency. Presently, provision consists of a single free session, which is inadequate for ongoing development.
- **Condition focused approach:** An increased focus on autism in recent years may be overshadowing the identification of other conditions, such as HIs. This raises concerns that hearing loss may go undetected. Given the progressive nature of hearing loss, early detection remains critical.

9.12 Recommendations

The following recommendations have been identified to address key challenges, build on existing strengths, and improve outcomes for children and young people with sensory impairments in Tower Hamlets:

- **British Sign Language (BSL) provision:** Increase the availability and frequency of BSL classes, ensuring sustained access for families, including those from non-English-speaking backgrounds. Provision should move beyond one-off sessions to structured, progressive learning opportunities that support long-term language development and communication within the home.
- **Accessible information at diagnosis:** Provide timely, clear, and emotionally supportive information at the point of diagnosis. This should include multi-format guidance (e.g. written, video, translated) and connect families with peer support networks, deaf role models, and information on interpreting rights. Materials should be culturally sensitive and tailored to varying literacy levels.
- **Cross-sector and multidisciplinary teams:** Strengthen collaboration between education, health, and social care through formal MDT structures. MDTs should include Qualified Teachers of the Deaf and Visually Impaired, Educational Psychologists, Speech and Language

Therapists, Occupational Therapists, Sensory Support Workers, and relevant health professionals such as Paediatric Audiologists and Ophthalmologists. These teams should work jointly with SENCOs and family support practitioners to provide coordinated assessment and intervention planning.

- **Strengthen frontline staff training:** Ensure all frontline staff, including health visitors, school nurses, early years practitioners, and social workers, receive training on hearing, visual, and multisensory impairments. Training should equip staff to identify early signs of sensory needs and to support families in accessing specialist services.
- **Specialist pathways:** Develop clear pathways for children and young people with sensory impairments, including those who are deaf, have visual impairments (VI), or multi-sensory impairments (MSI). Pathways should outline referral routes, assessment processes, and transition support across early years, school, and post-16 education, ensuring equitable access to specialist teaching, rehabilitation, and assistive technology.
- **Equitable funding:** Review the current allocation of high-needs and specialist SEND funding to ensure it reflects the prevalence and complexity of sensory impairments in Tower Hamlets. While core funding structures are statutory, the local area partnership can influence how resources are prioritised within existing budgets and advocate regionally for fairer funding models that recognise sensory needs.
- **Expand support provision: Qualified Teachers of Multi-Sensory Impairments (QTMSI):** Introduce or expand access to QTMSIs, specialist teachers trained to support children and young people with combined hearing and vision loss. This expertise is distinct from Qualified Teachers of the Deaf (QToD) and Qualified Teachers of the Visually Impaired (QTVI), and is particularly important for ensuring appropriate assessment, environmental adaptation, and communication strategies for those with complex sensory needs.
- **School readiness:** Support schools to prepare for the inclusion of children with MSI by offering familiarisation visits, whole staff training on MSI, and development of tailored, accessible curricula. Schools should be equipped with resources and knowledge to meet sensory needs from the outset.
- **Accessible and supportive environments:** Equip classrooms and learning spaces with appropriate assistive technologies, visual and auditory supports, and access to mental health and mobility services. Learning environments should foster both academic progress and social inclusion.
- **Tracking and responding:** Strengthen local data collection and monitoring of children and young people with sensory impairments, including early identification, service access, and educational outcomes. Use this data to inform commissioning, identify unmet need, and ensure responsive planning across education, health, and social care.

9.13 Summary

Hearing and vision impairments can significantly impact children and young people's development and wellbeing. Causes range from genetics and infections to environmental factors such as noise exposure.

Some children experience MSI's, which affect both hearing and vision, often linked to complex conditions. Early screening through hearing and vision tests helps with timely identification. Without the right support, children with sensory impairments can face challenges in education, communication, and social inclusion, leading to poorer outcomes later in life.

Early intervention, inclusive education, and strong support systems are essential to improving outcomes. Family involvement, trained school staff and emotionally supportive environments help children thrive. Tower Hamlets provides various services, including specialist teaching, therapy, and family support, but gaps remain in funding, staffing, British Sign Language (BSL) access, and support in special schools.

Tower Hamlets demonstrates positive approaches in this area, offering a wide range of resources, support, and a clear commitment to improving outcomes. However, there are still opportunities for further development. Key recommendations include expanding BSL provision, enhancing coordination across services, and establishing clear pathways for young people with sensory needs beyond school age.

10. Physical Needs

For the purposes of this JSNA, physical needs refer to limitations or disabilities that affect a person's physical functioning. This includes, but is not limited to, mobility challenges, hearing impairments, and other physical conditions that may require specialist support or equipment. Physical and sensory needs are often interconnected and, as such, are explored across both the physical and sensory needs chapters. Specifically, hearing and visual impairments are addressed within the sensory needs' sections.

A child with a physical difficulty may have a diagnosed medical condition that impacts their physical abilities, or they may present with delayed physical development due to an undiagnosed issue. Children and young people with physical disabilities may experience challenges with mobility, coordination, or stamina, and may need adjustments to their learning environment, specialised equipment, or support with everyday activities.

Physical disabilities encompass a range of conditions that affect a person's movement, coordination, and physical abilities. These can include:

- **Mobility impairments:** Difficulty with walking, standing, or using limbs.
- **Dexterity limitations:** Challenges with fine motor skills, such as writing or using tools.
- **Stamina issues:** Fatigue or limited endurance.
- **Other physical impairments:** Conditions like respiratory disorders, epilepsy, or sensory impairments (like visual or hearing impairments) that impact physical functioning.

10.1 Causal Factors

Physical disabilities can stem from various causes, broadly categorised as congenital (present at birth) or acquired (developed later in life). Congenital disabilities can result from genetic factors, prenatal

conditions, or birth trauma. Acquired disabilities can be caused by accidents, injuries, illnesses, or degenerative conditions.

Congenital causes:

- **Genetic factors:** Inherited conditions can lead to physical disabilities.
- **Prenatal conditions:** Problems during foetal development can result in physical impairments. For example, cerebral palsy due to lack of oxygen in the womb or foetal growth restriction due to maternal malnutrition.
- **Birth trauma:** Injury during delivery, such as oxygen deprivation or prematurity, can cause disabilities.
- **Congenital malformations:** Also known as congenital abnormalities or birth defects which occur at or before birth. Examples include, heart defects, spina bifida, cleft lip / palate.

Acquired causes:

- **Accidents and injuries:** Traumatic injuries can lead to physical disabilities. For example:
 - Spinal Cord injuries: Damage to the spinal cord can result in loss of function and mobility.
 - Brain injuries: Head and brain injuries, whether from falls, accidents, or other causes, can have lifelong physical or mental consequences.
- **Illnesses and degenerative conditions:** These may be contracted or develop after birth, or which can progressively worsen over time after birth, causing gradual loss of physical function. Examples include:
 - **Illnesses:** Stroke causing brain damage affecting movement and coordination or traumatic infections such as severe arthritis (i.e. Juvenile Idiopathic Arthritis) which can reduce mobility.
 - **Degenerative conditions:** Muscular dystrophy causing progressive weakening of muscles or Charcot-Marie-Tooth Disease causing gradual muscle weakness and foot deformities.

It's important to note that the experience of physical disability is unique to each individual, and the causes can be diverse.

10.2 Local Picture

In 2024, there were 95 children and young people with a physical disability in a school setting in receipt of SEN support and a further 134 registered on an EHCP³. Of all children and young people in receipt of an EHCP, 2% had a primary need as a physical disability.

In Tower Hamlets, 42.9% of those in receipt of a EHP plan for a physical disability are from the Bangladeshi community. A further 25.7% have not had their ethnicity recorded, highlighted continued challenges with the recording of data associated with ethnicity. 9.3% are from a white-British background, and a further 6.4% identified as Black-African.

There are more males than females in receipt of an EHCP, 63% and 37% respectively. Most EHCP plans begin at age 4, typically in line with the beginning of primary school. Of children and young people with an EHCP for a physical disability, 91% live in areas experiencing some of the highest levels of deprivation across Tower Hamlets.

10.3 Diagnosis

In some cases, there is no single test of diagnosis and therefore a combination of approaches are undertaken to determine the diagnosis. Consequently, the process can take time, sometimes involving ongoing monitoring of developmental milestones over months or even years.

For some conditions, diagnosis and early identification may begin before birth or shortly after delivery. Antenatal screening, including ultrasound scans and genetic testing, can detect certain congenital abnormalities such as spina bifida, heart defects, or limb differences. Postnatal checks, such as the NHS Newborn and Infant Physical Examination, can also identify early signs of physical or sensory impairments. Early identification at these stages enables timely intervention and family support.

A definitive diagnosis may not always be immediately possible, and a "working" or "interim" diagnosis might be given to allow for support and treatment while further investigations are conducted.

Diagnosis processes vary depending on the nature and severity of the child's presentation. For most children, assessments may involve GPs, paediatricians, physiotherapists, occupational therapists and other specialists, supported by a multidisciplinary approach. Parents play a crucial role in providing developmental information and participating in decisions around care.

The time it takes to reach a diagnosis can vary significantly depending on the complexity of the condition. This may be reflective of how diagnosis increases with age.

Early detection remains a critical component of the diagnosis approach, to allow for timely intervention and support.

Down Syndrome (DS):

Diagnosis of DS is through a combination of physical exams, screening and diagnostic tests. This is facilitated at both pre- and postnatal stage.

Between 10 and 14 weeks of pregnancy:

- Testing for DS is undertaken together with screening for trisomies 18 and 13.
- This screening is known as the 'combined test', combining an ultrasound with a blood test.
- Alongside the age of the mother, the information from these two tests is then used to assess the chance of the baby having DS.
- If the foetus chance is found to be higher than 1 in 150, the mother is offered either non-invasive prenatal testing or an invasive test²⁷⁹.

Between 14 and 20 weeks of pregnancy:

- If presenting too late for the combined test, at this stage, a quadruple screening test can be undertaken. It is not considered as accurate as the combined test.
- When the chance of DS found to be higher than 1 in 150, further testing is offered.

Fewer than 1 in 20 results will be considered higher chance. For those where a higher chance is identified, there are three options for further assessment and testing:

- 1) Not have any further testing
- 2) Have a second screening test called non-invasive prenatal testing (NIPT) – a blood test providing a more accurate screening result
- 3) Have a diagnostic test which will advise for certain whether the baby has DS or not.

Postnatal diagnosis:

During initial newborn examinations, any suspected dysmorphic features / other abnormalities should be identified and appropriately responded to. At this stage, a combination of physical examinations and genetic testing is undertaken. Following on from this testing and depending on the results, a diagnosis may be given.

10.4 Pathway

Once a physical disability has been identified, either prenatally, postnatally, or through early developmental screening, children and families are referred to local health, education and social care services for coordinated assessment and support.

In Tower Hamlets, pathways for children with physical disabilities typically involve a multi-agency approach, including the community paediatrics team, occupational therapy, physiotherapy, and educational support through SEN services. Referrals may also come from GPs, health visitors, or early years settings where concerns arise about motor skills, coordination, or mobility.

The pathway emphasises early identification, integrated planning, and access to support at the right time, in line with the SEND Code of Practice (DfE & DoH, 2015). Families are supported through coordinated care planning and review meetings that ensure health and education professionals work together to meet each child's needs.

10.5 Healthy Lifestyle

Children and young people with physical disabilities may require additional support and equipment to access learning and participate in daily life. Establishing a healthy lifestyle is both achievable and critical for individuals with physical disabilities.

Physical activity: Children and young people with physical disabilities may have a lower perceived ability to engage in physical activity, leading to decreased motivation²⁸⁰. Furthermore, certain physical disabilities can cause pain or fatigue, limiting the duration and intensity of physical activity. Often a lack of accessible facilities and programmes create additional barriers to engagement.

Diet and hydration: Some children and young people may have difficulties with eating and drinking. This may be because they are not necessarily able to make physical movements to bite, chew and swallow food and drink²⁸¹.

Sleep: Physical disabilities can significantly impact sleep patterns and duration in children and young people, leading to difficulties with both falling asleep and staying asleep. These challenges can arise from a variety of factors, including physical discomfort, pain, breathing difficulties, and the use of medical technology that may be in use²⁸².

Mental health: Children and young people with physical disabilities face increased risk of mental health challenges, including anxiety, depression and feelings of isolation. These challenges can be exacerbated by social stigma, limitations on activities and difficulty accessing appropriate support. Conversely, mental health difficulties can also impact physical and health and contribute to the development or worsening of physical disabilities²⁸³.

Down Syndrome

Children and young people with DS can experience a wide variety of challenges in maintaining a healthy lifestyle. They may be particularly susceptible to infections, whilst also living with greater risk of some health conditions which can introduce further challenges. However, each individual with DS is different and not every person will have serious health problems.

That said, some symptoms have historically been viewed as inherent to Down syndrome, leading to missed underlying conditions a phenomenon known as diagnostic overshadowing. A proactive, tailored programme of health surveillance that recognises potential comorbidities can ensure timely treatment and better outcomes²⁸⁴. With appropriate care, individuals with Down syndrome can enjoy good health, independence, and a quality of life extending well into their 60s, 70s, and beyond²⁸⁵.

Barriers to healthy living may include developmental delays, reduced muscle tone, or sleep and swallowing difficulties, all of which can affect daily routines, participation in activity²⁸⁶, and dietary choices. Environmental barriers, such as limited accessibility of public spaces, can also restrict opportunities for physical and social engagement^{Error! Bookmark not defined. 287 288 289}.

Promotion of healthy lifestyles include a focus on individualised, positive approaches to nutrition, physical activity and social support. Engraining positive habits from a young age can support transitions into adulthood.

Cerebral Palsy

Individuals with cerebral palsy often face numerous barriers to physical activity, including physical limitations, lack of accessible facilities, and social factors. These barriers can lead to reduced physical activity levels, increased sedentary behaviour, and potential health consequence²⁹⁰. However, promoting physical activity and healthy eating is crucial for managing cerebral palsy and preventing secondary health issues²⁹¹. Adaptive equipment such as wheelchairs, walking aids and specialised exercise machines can enable individuals to participate in physical activities.

Physical limitations and swallowing difficulties can make accessing and consuming healthy food difficult. This can also influence the ability to self-feed. Additionally, certain medications used to manage cerebral palsy can cause appetite loss and nausea, leading to deficiencies in specific vitamins and minerals. Furthermore, cerebral palsy can increase the risk of constipation and gastroesophageal reflux, which can further impact appetite and eating habits²⁹².

10.6 School Life

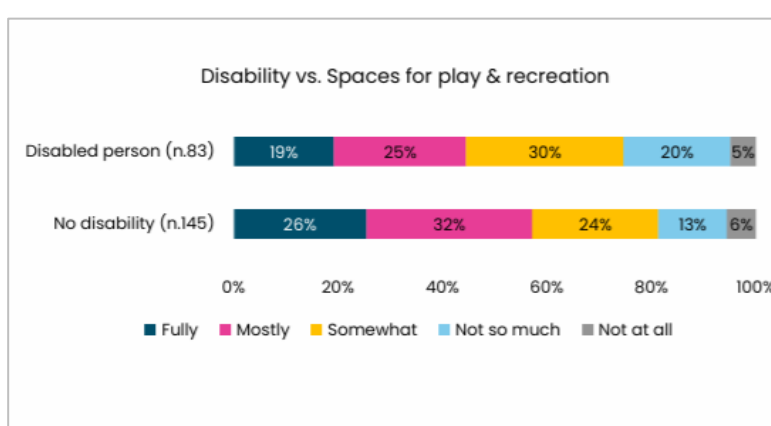
Children with physical disabilities can face both unique challenges and positive experiences in their school lives. These experiences are influenced by factors like the type and severity of the disability, the school environment, and the support systems in place. Whilst some students thrive in inclusive settings, others may encounter barriers related to accessibility, social integration, and the availability

of appropriate support²⁹³. Children and young people with physical needs typically require specific support and adaptations to thrive in school.

Social inclusion: Students with physical disabilities may experience bullying, prejudice and social isolation, leading to anxiety, depression and low self-esteem²⁹⁴.

Accessibility: Physical environments such as playgrounds, toilets and transportation may not be adequately design for students with physical disabilities and therefore create barriers to participation. Identifying needs early and provision appropriate support, such as specialised equipment or tailored learning strategies is crucial to support academic development. This is applicable to not just schools but play and recreation – see figure 11.1.

Figure 11.1: Experience of people with disabilities and the extent they can access a range of spaces with opportunities for play and recreation in Tower Hamlets.



Source: Healthwatch Tower Hamlets²⁹⁵

Mainstream schools: Pupils can thrive in mainstream schools with appropriate support and accommodations. The type and level of support needed will vary based on individual needs, which may include SEN support or an EHCP. Collaboration between parents, teachers and healthcare professionals is crucial for creating an inclusive and supportive environment.

Most children with physical disabilities have typical cognitive abilities and can excel academically in mainstream settings when appropriate support, accessibility, and inclusive teaching practices are in place.

Although education policy and disability legislation emphasise mainstream inclusion, there continues to be a strong demand for special schools to meet the needs of children with more complex or multiple disabilities, highlighting an ongoing challenge for the borough.

10.7 Outcomes

Studies²⁹⁶ have shown that individuals with physical disabilities are more likely than people without disabilities to report: “poorer overall health, less access to adequate health care; or smoking and physical inactivity”.

Additionally, those with disabilities are often at greater risk for additional health problems that can be prevented. There is significant evidence demonstrating that people with disabilities have fewer life opportunities relative to those without disabilities. They are more likely to be unemployed or relatively

under-employed, more likely to be reliant on carers, and to live in poverty than people without disabilities.

Vulnerabilities to conditions: People with disabilities are particularly vulnerable to gaps in health care services. Depending on the group and setting, persons with disabilities may experience greater vulnerability to secondary conditions, co-morbid conditions, age-related conditions, engaging in health risk behaviours and higher rates of premature death²⁹⁷.

10.8 Transitions

Transition periods, such as moving from primary school to secondary school, or beyond can be particularly challenging for students with disabilities. Inclusive education entails preparation for transitions by equipping them with the necessary skills and resources, as well as those who will continue to support them. This therefore requires the development of individualised transition plans that take into account the needs, strengths and goals of each person.

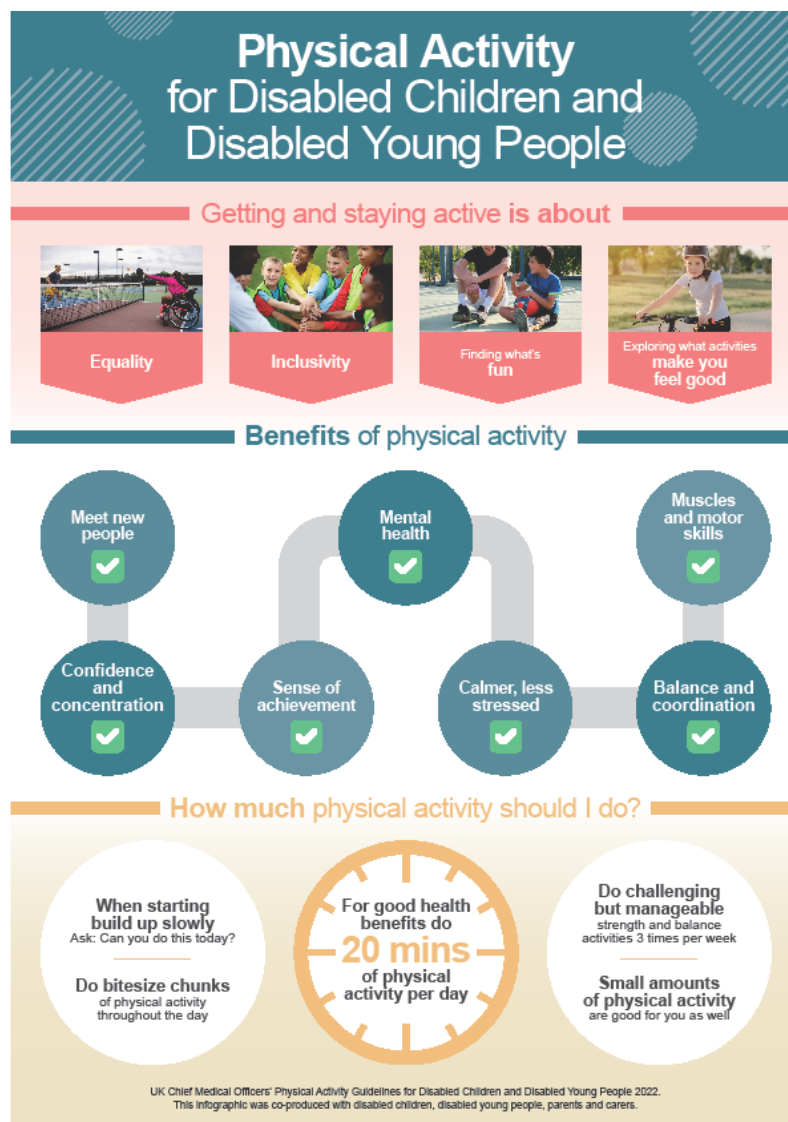
10.9 What works (evidence-based practice)

For children and young people with physical needs, a multi-faceted approach to support continues to remain central within the literature to help them to thrive. This includes²⁹⁸:

- Individualised assessment and planning in order to develop a personalised support plan which includes adjustments to the learning environment, specialist equipment and / or therapeutic interventions
- Targeted interventions for example, occupational therapy to support the development of fine and gross motor skills, whilst physiotherapy can focus on mobility.
- A strong collaborative approach between educators, therapists, parents and the children or young person themselves remains critical to ensure consistent and appropriate support within settings.
- The effectiveness of interventions needs to be regularly reviewed and adjusted based on the child's progress and changing needs. This ensures that the support remains appropriate and continues to promote positive outcomes.
- Recognising and building on a child's strengths and abilities is essential. This approach fosters a positive self-image and promotes confidence in their capacity to learn and participate.

Physical activity: There is evidence showing a likely relationship between engaging in physical activity and positive health outcomes for those with physical needs. This includes a mixture of aerobic and strength-based exercises. Physical activity is safe for children and young people with physical disabilities when adapted to their abilities, health, and developmental stage²⁹⁹.

Figure 11.1: UK Chief Medical Officers' Physical Activity Guidelines for Disabled Children and Disabled Young People.



Source: Department of Health & Social Care (2022) ³⁰⁰

Down Syndrome

There remain significant gaps in DS research, however, research to date indicates the following evidence-based approaches to caring for and supporting children and young people with DS:

Healthcare: Management is best delivered through a holistic, multi-disciplinary approach tailored to the child's needs. This includes parental education, hearing and vision assessments, healthy lifestyle guidance, appropriate cardiac referrals, and input from paediatricians, neurologists, psychologists, physical and occupational therapists, language therapists, and audiologists³⁰¹.

Healthy Lifestyle: Effective weight management and healthy habits require a combination of education, practical strategies, and routine-building, rather than solely exercise-based programmes. Activities like walking or cycling to school and active play at home support long-term healthy behaviours, with modelling by caregivers being key^{302 303}.

Speech and language: Early intervention is critical to optimise communication outcomes. Encouraging shared attention, where child and caregiver focus on the same object or event, supports language development by increasing exposure to language in context³⁰⁴.

Parent-child relationship: Positive, responsive interactions with caregivers significantly enhance developmental gains. Early intervention should include support for family interaction patterns and resources to maximise developmental trajectories³⁰⁵.

Cerebral Palsy

Evidence strongly supports that children and young people with cerebral palsy can thrive with early intervention, specialised healthcare and supportive environments. This includes access to physical, speech and occupational therapy as well as education support and assistance technologies. Parental support and participation in therapy programmes are also crucial for positive outcomes³⁰⁶.

Assistive technologies: Assistive technologies play a vital role in enhancing the independence and quality of life for individuals with cerebral palsy. Tools such as speech-generating devices, orthotics, wheelchairs, and adaptive utensils support communication, mobility, and daily living tasks. These technologies help reduce physical barriers, promote social interaction, and increase self-sufficiency. Integrated into physical, occupational, and speech therapies, they enable more effective treatment and greater participation in everyday activities.

10.10 Support services

In Tower Hamlets, children with physical impairments are supported through the SEND system. This includes access to the SEND Information, Advice and Support Service (SEND IASS), advisory teachers for physically children with disabilities, and specialist support within mainstream schools. The borough also has a SEND strategy that aims to ensure timely, effective, and well-coordinated support for children with SEND and their families

In Tower Hamlets, all children should have access to universal services (such as health visitor, general practitioner etc.) in the same way as those without a physical need. In addition, they have easy access to the following services:

- Therapy: physiotherapy, occupational therapy, speech and language therapy
- Hospital Specialists: respiratory, cardiology, ENT, ophthalmology, immunology and endocrine
- Social Care
- Education: early years support, educational psychology

In Tower Hamlets, the Local Offer provides a directory of services, resources, and information related to health, education, and social care for children and young people with additional needs. Parents and carers can access specialist advice and support via the Parent/Carer Advisory Service, which offers guidance on health, social care, benefits, and education. Through this service, families can also be directed to further sources of information and support tailored to their needs.

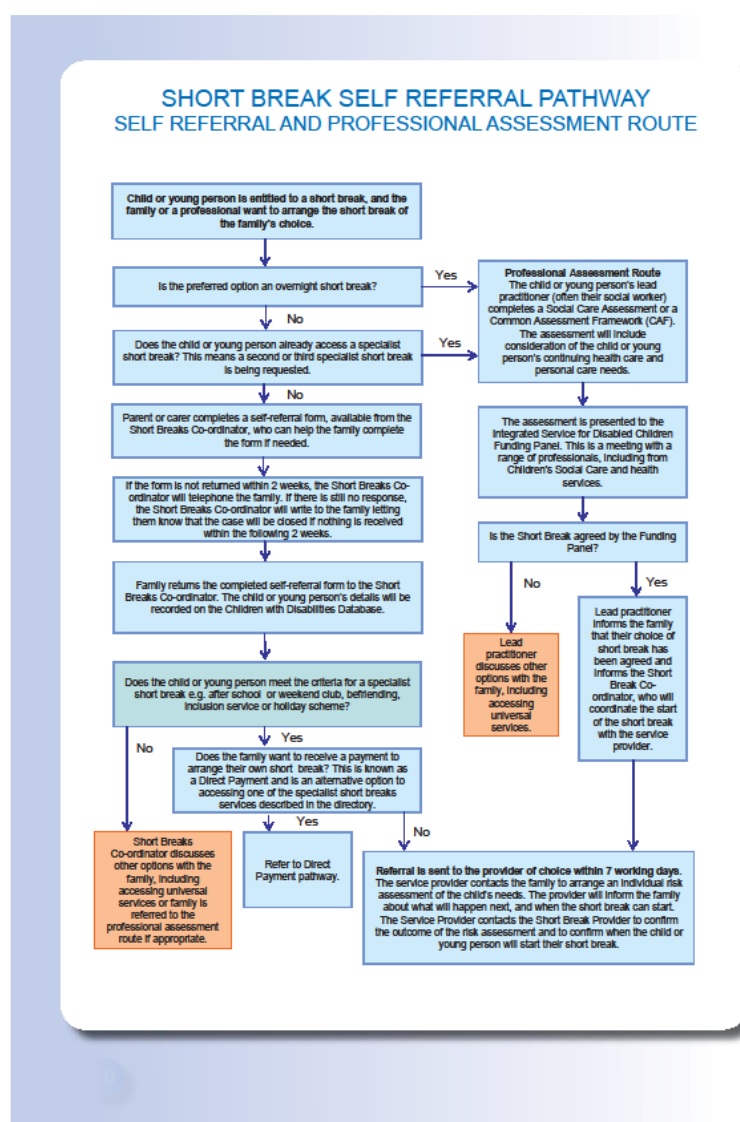
Children with disabilities (CWD) Team: The CWD Team works with families and can arrange practical support, personal care in the home, short breaks, direct payments, counselling and residential services and can also put carers in touch with other specialist organisations. Parents / carers can self-refer to this service.

Further resources for specific conditions are also accessible via the local offer website.

Short break services: Short breaks enable and support children and young people with a disability to live ordinary family lives, to have fun, try new activities, gain independence and make friends. They

provide parents and carers with a short break from their caring responsibilities. Local authorities are required under the Children Act 1989 to provide services designed to give breaks for carers of children with disabilities. The 'Breaks for Carers of Disabled Children Regulations' (2010) sets out what local authorities should do to meet their duties in relation to the provision of short breaks. Short breaks are available for children and young people aged 5 or over who either live with ASD or complex health needs (physical and/or learning disabilities, those who require palliative care and those with sensory impairments).

Figure 11.2: Short break self-referral pathway



Source: Tower Hamlets Local Offer: Short Break Services

Disabled Children's Outreach Service (DCOS): A community based, therapeutic interventions team supporting children and young people with behaviour that is challenging to understand and manage due to diagnosed developmental difficulties, disabilities and/or complex lifelong physical health needs. Eligibility for this includes children and young people with ASD (who also have severe learning disabilities or behaviour which is challenged) or children and young people with complex health needs (physical and / or learning disabilities, who require palliative care and those with sensory impairments).

Tower Project: Support children and adults aged 0-25 with SEND to build skills and make friends, as well as offering support to gain employment.

10.11 Gaps

Stakeholders have shared that there are notable gaps in SEND education for individuals with physical disabilities, including limited funding, poor accessibility, a lack of inclusive practices, and insufficient specialist support. These shortcomings contribute to wider achievement disparities, reduced access to essential resources, and negative educational experiences.

Stakeholders face challenges in the organisation, management, facilitation, and funding of equipment (i.e. hoisting equipment, wheelchairs). Additionally, there is a lack of clarity regarding the regular monitoring and maintenance of this equipment. A further gap exists in the management of equipment once it is no longer needed, for example, when a child leaves school.

10.12 Recommendations

Improved coordination of equipment: Review and streamline the approach to organising and managing equipment to ensure it can be appropriately repurposed and regularly assessed for health and safety compliance.

The following recommendations are based on evidence-based research and reflect best practice approaches. While they do not necessarily indicate a gap in support provision within the borough, they highlight areas where best practice can inform and enhance current strategies.

- **Multi-faceted approach:** Supporting children and young people requires a continuous multi-faceted approach, including access to multi-disciplinary teams, tailored therapies and assistive technologies alongside strategies to promote independence and wellbeing.
- **Funding and Support:** It is essential to recognise and address the diverse needs of individuals with physical disabilities through sustained and targeted funding. Continued investment is crucial to support development, promote inclusion, and reduce health inequalities, ensuring equitable access to services and opportunities.
- **Accessibility:** Providing appropriate and accessible equipment is key to breaking down barriers to physical health and social inclusion. Prioritising accessibility in the design of housing, commercial spaces, and recreational facilities helps create inclusive environments where individuals with physical disabilities can fully participate in everyday life.
- **Physical activity:** Promote regular, inclusive, and adaptive physical activity for children and young people with physical disabilities. Opportunities should be provided in schools, community settings, and at home, using accessible facilities and equipment when needed. Encouraging a range of activities, including aerobic, strength-based, and play-based exercises, can improve physical health, mental wellbeing, social inclusion, and overall quality of life. Education for parents, carers, and staff on safe participation and adaptation is essential to ensure engagement and sustainability.
- **School and education:** It is recommended that an individualised, person-centred approach is adopted. Each child and young person are unique and therefore the schooling environment

must seek to identify individual strengths and barriers to learning, in order to offer differentiated learning and support.

- **Continued learning opportunities:** Students should be offered a broad and balanced curriculum and extra curricula opportunities, on an equal basis with their peers with no physical disabilities. It is important to offer continuing learning opportunities beyond secondary school³⁰⁷.

10.13 Summary

Physical disabilities encompass a range of conditions that affect a person's movement, coordination, and overall physical abilities, and they can arise from a wide variety of causes. Individuals with physical disabilities often face challenges related to physical activity and mental health, which may become more pronounced with age.

Tower Hamlets offers a wide variety of support services, with short breaks being a particular strength within the borough. However, challenges remain, including limited funding, ongoing accessibility issues, and a need for enhanced specialist support. Drawing on evidence-based research, the recommendations aim to strengthen existing strategies across key areas such as funding, accessibility, education and life-long learning opportunities.

11. Community Insights

Capturing the lived experiences of children and young people with SEND, as well as their parents and carers, is essential to designing services that are relevant, inclusive, and effective. These insights offer a vital understanding of how policies, services, and support systems are experienced in everyday life - not just how they are intended to function. Lived experience helps identify strengths, challenges, and gaps that might not be evident through quantitative data alone. Engaging meaningfully with children, young people, and their families ensures services are more responsive, person-centred, and aligned with their real needs and aspirations. It also fosters greater trust, accountability, and partnership between families and professionals, reinforcing the principle that those who are directly affected by services should play a central role in shaping them.

11.1 Children and young people with SEND

There is consistent evidence that the borough actively engages with children and young people with SEND to understand their lived experiences and use these insights to inform ongoing planning and service development. In 2024/2025, participation and engagement activities have contributed to several key developments, including:

- **Designing a Future Youth Offer for Tower Hamlets** – A comprehensive consultation was conducted to understand the needs, preferences, ideas, and ambitions of young people, their parents, and carers.
- **Coproduction Charter** – Finalised and launched, this Charter outlines shared commitments from professionals, parents/carers, and children and young people to co-produce services.
- **Local Offer** – Routinely reviewed and updated based on feedback from parents and young people.

Figure 12.1 Let's Talk SEND – SEND Event initiative developed in partnership with the SEND Independent Parent Forum. See an example newsletter [here](#).



Source: Tower Hamlets Local Offer

Building capacity for participation and co-production remains a core strategic priority. A new workforce development initiative has been introduced to address training needs, ensuring all staff working with children, young people, and their families understand SEND and the principles of participation and co-production.

The borough also promotes youth leadership through the Young People's SEND Ambassador programme ("Our Time"), which empowers young people with SEND to engage in their communities, lead workshops, and foster inclusion and confidence. The programme helps amplify their voices and strengthen community cohesion.

A Young People's SEND ambassador shares:

"Participating is a nice way to meet with others so it's really good to be part of any events which ambassador work allows you to do. Supporting others is a really good way to find out about different needs that young people face, and your support can make a difference.

Representing young people with SEND is a good way to build up your confidence and feel good about having SEND yourself as you are included.

Connecting with others is a great way to build relationships and work on issues around SEND with others which is very important in ambassador work"

Examples of engagement and participation (with parents and carers as well) include:

- SEND Improvement Board
- Coproduction Charter
- SEND Quality Assurance Group
- STAG (Special Transport Advisory Group)

- Local Offer Parents Advisory Group
- Local Offer YP Advisory Group
- Healthwatch
- CAMHS Parents Group
- CAMHS YP Group
- ASD Pathway Working Group
- Integrated Therapies Group
- Continuing Care Group

11.2 Experiences of children and young people with SEND

For the purposes of this JSNA, efforts were made to engage with children and young people; however, within the timelines engagement was limited. Despite this, insights gathered aligned well with wider experiences discovered and were explored in the 2024 Cabinet Office's Disability Unity commissioned report to explore the lives, experiences and needs of children with SEND in England. These experiences highlighted³⁰⁸:

Aspirations and Positives

Children with SEND have the same aspirations as their peers - to live happy lives, secure good jobs, and form meaningful relationships. Many report positive experiences, especially those in inclusive mainstream schools, where their overall well-being can even surpass the national average. These children and young people place great importance on a sense of belonging, genuine friendships, and being treated equally within both school and the wider community.

Safety, loneliness and bullying

Children with SEND are more likely to feel unsafe with 6% report being unhappy with their safety, compared to 4% of their peers. Loneliness was seen as a significant issue, with 36% often or sometimes feeling lonely, compared to 23% of their peers.

Bullying and discrimination was often felt, both verbal and physical and typically linked to disability or neurodivergence. Being singled out, underestimated or excluded was a recurring theme in both school and community settings.

Barriers in Education

It was felt that many schools lacked the resources or training to provide individualised support, with some children being excluded from mainstream education, either informally or through alternative provision when their needs are not met.

Transitions such as moving between school stages or into adulthood were reported to be especially difficult, with little consistent support.

Accessibility and Exclusion

Many found that public spaces, such as toilets and playgrounds, as well as things like toilets were often not designed with SEND children in mind. This results in social exclusion, limited independence, and missed childhood experiences.

11.3 Recommendations

From the children and young people insights, the following recommendations are made:

- **Continued engagement:** Community engagement must be ongoing to ensure a diverse range of voices are consistently heard. Too often, engagement efforts with children and young people with SEND involve the same individuals, limiting the inclusivity and breadth of perspectives. Whilst this input should not be dismissed, strengthening and broadening partnerships is essential to reach those who are typically underrepresented, ensuring services reflect the diverse needs, experiences, and aspirations of all children and young people with SEND.
- **Optimising reach and representation:** Recognise and continue to develop and implement tailored strategies to actively reach a wider group of people, including those with more complex needs, from minority ethnic backgrounds, or those who are not currently engaged with services.
- **Strengthen approaches to discrimination and bullying:** Enhancing strategies and approaches to address bullying and discrimination should be co-developed with both children and young people with and without SEND. This inclusive, participatory approach ensures that anti-bullying frameworks are grounded in lived experience, fostering a culture of empathy, peer support, and mutual respect across educational and community settings. Preventative measures should include targeted awareness campaigns, restorative practices, and staff training on identifying and responding to SEND-related bullying and microaggressions. Furthermore, schools and services must implement robust reporting and accountability mechanisms, ensuring that incidents are not only addressed promptly but are also used to inform continuous improvement. A whole-system approach, spanning policy, curriculum, staff development, and peer education is essential to dismantle entrenched stigma, reduce social isolation, and promote genuine inclusion.

11.4 Parental Insights

The lived experiences and insights of parents and carers are invaluable when reviewing and shaping SEND (Special Educational Needs and Disabilities) services. As the primary advocates and constant figures in children's lives, parents and carers have a unique, first-hand understanding of the challenges within the current system. Their perspectives not only highlight systemic gaps but also provide practical, solution-focused suggestions rooted in day-to-day realities.

Method

This section draws on qualitative insights gathered from over 60 parents and carers of children and young people with Special Educational Needs and Disabilities (SEND) in Tower Hamlets. Participants represented a diverse range of experiences, caring for children with varying diagnoses and needs,

including ASD, speech and language difficulties, social, emotional and mental health challenges, learning disabilities, and complex health conditions.

Data collection was conducted using a combination of qualitative research methods, including semi-structured focus groups, opportunistic contact during relevant community events, and one-to-one interviews. These approaches allowed for a flexible and responsive methodology that encouraged rich, first-hand narratives and context-specific reflections from parents and carers. This design aligns with established qualitative research frameworks that prioritise lived experience, narrative depth, and participant voice¹.

Four core open-ended questions guided the discussions:

- What are your child's special educational and disability needs?
- How do you feel your needs as a parent or carer of a child with SEND are being met?
- What do you perceive as the current gaps in service provision?
- How do you think these gaps could be addressed?

The facilitator used follow-up prompts to explore responses in greater depth, encouraging participants to elaborate on their experiences and provide additional context.

The one-to-one interviews and opportunistic conversations - held during coffee mornings, community group meetings, or other community events, offered an informal approach to gathering insights. These were particularly helpful for reaching parents who might not feel comfortable speaking in a group setting or who had individual stories requiring more time and space to explore.

Focus groups were useful to ensuring that a range of carers and parental voices were heard, and capturing a wide variety of experiences, views and feelings regarding SEND services. The interaction within a group allows insights to be built upon and differences and similarities of opinions to be expressed reflecting a rich and wide varied data².

Insights were grouped into three key themes - education, health, and social support, which were interwoven throughout the narratives shared by parents and carers. The following section presents a summary of the insights aligned with these themes.

11.4.1. Insights - Education

More personalised and inclusive school support

Parents and carers consistently raised concerns about a lack of personalised support for children with SEND in mainstream education. While some schools provide effective one-to-one assistance, others rely heavily on group-based or limited support models. One parent shared frustration that, despite their child being on a higher support band, the child received minimal in-class help because *"he appears to be managing,"* which has discouraged him from attending school. Others highlighted that even when support exists, it's often capped at two hours per day, insufficient for meeting the full scope of need.

A significant perceived challenge lies in schools' reluctance to provide early support before formal diagnosis. One parent described being denied school-based support until a diagnosis was confirmed, despite ongoing difficulties. Additionally, support services such as after-school clubs often lack trained SEND staff for children over six, leaving a service gap.

SEND understanding and teacher training varies

The quality of SEND support often depends on individual staff knowledge and attitudes. While some parents praised SENCOs who championed their children and kept them informed, they noted that some staff misinterpreted behaviour and used inappropriate discipline. This mismatch results in children feeling misunderstood, further disengaging them from education.

Teachers' limited understanding of neurodiversity, especially autism in girls, was frequently mentioned. Parents felt professionals lacked the training to recognise less overt symptoms and adapt their approach, making advocacy a continuous struggle.

"It's you versus the professional"

Transition between educational settings lacks continuity

Transitions - both into the borough and across age groups were described as fragmented. One family moving into Tower Hamlets experienced a two-month delay in accessing SEN support, and only one school accepted their child's EHCP, located 30 minutes from home. Meanwhile, post-16 options are limited, especially for young people who fall outside the most severe needs category. These "in-betweeners," as described by parents, face a lack of structured continued education. Previously available foundation courses have been cut, compounding this challenge.

Recognising individual progress and the power of personalised support

Amid the challenges, some families and carers pointed to specific examples where tailored interventions helped their child flourish. For instance, one parent described how a SENCO noticed their child had independently gone out - an important developmental step - and took the time to call the parent to celebrate the moment. The parent shared how this recognition *"boosted my confidence"* illustrating how emotionally attuned responses from staff can support both the child and the wider family unit. In another example, adaptations within Langdon School were specifically mentioned as effective, with parents noting positive experiences where adjustments had been made to suit the individual child's learning style and pace.

11.4.2. Insights - Health

Long waits and overstretched therapy services

SLT and OT services were identified as critical but chronically overstretched. Whilst progress has been made in this area, parents described long waiting lists, often up to three years, resulting in children missing early intervention opportunities. One mother reported that her child never received one-to-one therapy, only large group sessions, despite a clear need.

However, those who accessed support described significant progress with their child's development. For instance, one parent shared:

'Before SLT, my child barely spoke. Now they are holding conversations.'

Parents advocated for embedding SLTs and OTs within schools or local hubs to offer consistent, accessible support.

Gaps in early support and diagnostic dependency

Access to services often hinges on formal diagnosis, leaving children without support during crucial early periods. Parents and carers often explored that school staff were dismissive of concerns because the child had not yet received a formal diagnosis. Others noted their GP was unaware of their child's SEND status due to poor inter-agency communication.

Some services were reported to stop entirely after children reach a certain age (e.g., 5 years), creating a critical gap during the early primary years. Parents requested greater service continuity and better coordination between professionals to avoid repeating information and fighting for basic support.

Mental health needs are often overlooked

Parents and children alike can experience significant emotional strain. Mental health support, both preventative and ongoing, was identified as a significant gap. Parents described feeling overwhelmed, burnt out, and unsupported.

"[There's] no recognition of the grief that people might be going through as they find out their child is neurodiverse – they are already finding it difficult, combined with issues with getting support, and not knowing who to go to".

Parents often delayed their own health needs to focus on their children, leading to declining personal wellbeing and recognised a need for more holistic care for the child and caregivers, particularly during the diagnostic process and major transitions.

11.4.3. Insights – Social Support

Accessing services is overwhelming and inconsistent

Many parents described the process of finding, accessing, and navigating services as *"exhausting."* Services operate in silos, requiring families to repeat their stories multiple times. One parent discovered their GP had no record of their child's diagnosis, illustrating a wider breakdown in data sharing.

Parents reported needing to *"chase"* services constantly, with waiting list statuses often unclear.

"I didn't even know if we were still on the list," one parent noted.

Others recommended practical strategies such as marking emails as *"urgent"* to prompt responses. The lack of transparency creates additional stress, particularly for families already coping with complex needs.

Inequities in access - particularly for marginalised families

Language barriers, immigration status, and unfamiliarity with UK systems compound challenges for some families. This was reflected in the quote:

"If I had known, it would have made things better for my child,"

Even for native English speakers, the Local Offer website was described as difficult to navigate. Much of the useful information was instead accessed informally, through WhatsApp parent groups or word-of-mouth.

Strengths in community support and peer networks

Despite challenges, several parents noted positive experiences within their community. Peer-run coffee mornings provided emotional support and information sharing. Some parents reported excellent experiences with specific schools or SENCOs. The IASS surgeries were praised, although awareness of them remains low.

“There are lots of really great things happening, but people don’t know about them - they should be shared more widely through GPs or schools”

Making these resources more visible and accessible could help reduce the feeling of isolation and confusion.

11.5 Recommendations

The following recommendations are based on insights gathered from parents and carers of children and young people with SEND:

- **Single solution to source knowledge:** Parents strongly advocated for a single, up-to-date website or hub containing information about all local services, including SEND, therapies, mental health support, and parent networks. Several suggested QR codes linking to centralised resources, and for service details to be shared via school bulletins or GP surgeries. One parent recommended a dedicated Autism portal for Tower Hamlets.
- **Increasing accessibility of OTs and SLTs:** Having OTs and SLTs located within family hubs would improve access and help parents feel more supported. Parents also requested better guidance during key processes, including HCP transitions and when moving boroughs. Additionally, addressing capacity challenges would help to reduce long-waiting times.
- **Increased knowledge and understanding:** Several parents suggested distributing a clear, printed guide or diagnosis pack for newly diagnosed families, outlining available services, contact points, and common next steps. This could be provided at diagnosis, at school entry, or during any transition stage to help families navigate the system with greater confidence. Developing this resource through co-production with families and professionals would ensure that both lived and professional experiences are reflected with appropriate nuance. Additionally, local service mapping could help highlight the diversity of provision and prevent overgeneralisation.
- **Expanding peer-led support networks:** Parents also recommended expanding peer-led support networks - such as local coffee mornings facilitated by experienced carers, whilst ensuring these are consistently publicised through schools, GPs, and community venues. Making these groups more accessible would reduce isolation and allow families to benefit from shared lived experience earlier in their journeys.
- **Post-16 educational support:** Consider what support should be available for young people aged 16 and over who do not fit into apprenticeships and are not classified as having high or complex needs. This could include continued learning opportunities, such as foundation or bridging courses, which allow young people to remain within an educational support structure while developing skills for further education, training, or employment..

- **Holistic, person-centred service coordination:** Continue to develop stronger cross-agency working between education, health and social care to provide joined-up, person-centred support. Shared planning and data-sharing (with appropriate protocols in place) can help ensure consistent and continuous care, reducing the burden on families to navigate complex systems alone.

11.6 Summary

The insights shared by children, young people, and their families provide a powerful perspective on the strengths and challenges of current SEND services. In Tower Hamlets there is evidence of strong engagement, meaningful coproduction, and committed professionals across education, health, and care. However, systemic challenges remain. These include access barriers, delays in diagnosis and support, variability in staff training, and a lack of coordinated, person-centred approaches. Parents and young people consistently advocate for more inclusive, accessible, and responsive services that are shaped by those who use them. Embedding lived experience at the heart of service planning and delivery remains essential to ensuring that SEND services are effective, equitable, and trusted by the communities they serve.

12. Recommendations

Building on the category-specific chapters that have outlined tailored recommendations for each area of need, the following section presents a cohesive set of overarching recommendations for SEND provision in Tower Hamlets. These recommendations draw together the insights and findings from across the review, including data analysis, stakeholder interviews, evidence-based research, and community input, to provide a strategic framework for system-wide improvement.

12.1 Recommendation: Adopting a need-led approach to support

To ensure equitable and effective support, services should prioritise a needs-led approach rather than relying solely on diagnostic labels. Many children and young people may experience significant challenges that do not fit neatly within one diagnostic category or who are still awaiting assessment. A flexible, needs-focused model enables earlier intervention, reduces delays in support, and avoids the risk of some needs being overlooked simply because a formal diagnosis has not yet been made. Embedding this approach across education, health, and care systems can help ensure all children and young people receive timely, tailored support based on their unique strengths and difficulties. To begin this transition, services can develop multidisciplinary teams that collaboratively assess, and plan support based on individual needs, regardless of diagnosis. Training frontline staff to recognise a broad range of developmental and emotional challenges and to respond with early, tailored interventions can also support this shift.

Assessment and diagnosis ADHD and ASD: The overlapping characteristics of ADHD and ASD can create challenges in diagnosis, particularly given the absence of a clear, integrated pathway for cases where symptoms intersect. As a result, some young people may be referred for an autism assessment only to be redirected towards ADHD support later. A needs-led approach rather than one based solely on diagnostic categories would help address this complexity and may lead to improved outcomes for children and young people.

Adopting a holistic approach to neurodiversity: Neurodiversity encompasses a broad spectrum of characteristics that are not always considered in a holistic and inclusive way. This can result in fragmented pathways, over-reliance on specialised approaches, and increased demand for assessment resources and funding. Adopting a more comprehensive understanding of neurodiversity can lead to more effective, inclusive, and streamlined support for children and young people. Development of borough-wide neurodiversity approaches, such as a training programme for education, health and social care to build and share understanding can reduce reliance on formal diagnosis and promote early, needs-based support.

12.2 Recommendation: Promoting early and preventative support

Families and parents should not feel an EHCP is the only route to access support. Whilst an EHCP is necessary in some cases, ensuring adequate support is available from the earliest stages of a child's life is essential. Whilst the family hubs are considered a significant strength of the borough, there are opportunities to strengthen home-learning or core basics of parent-child relationship and development. A proactive, preventative approach is far more likely to lead to improved long-term health and wellbeing outcomes. This could include increased parent educational training and learning opportunities at the pre-natal stage to equip parents and carers with a proactive approach and increased personal responsibility to child development.

12.3 Recommendation: Shifting from reactive to proactive approaches

Conduct in-depth research to explore the underlying causes and contributing factors driving the rise in ASD and ADHD assessments. This research should include epidemiological studies, environmental and social factors, and service access patterns to inform more proactive, targeted approaches to early identification, support, and prevention.

There continues to be a significant increase in demand for assessments of ASD and ADHD within the borough. However, there is limited understanding of the underlying drivers or contributing factors behind this trend. As a result, the current approach remains largely reactive, focusing on assessment and diagnosis, rather than proactive, where early identification, support, and prevention could be further prioritised.

12.4 Recommendation: Strengthening data-driven decision making and sustainable service design

Ethnicity data capturing: In line with national challenges, there is a growing need to improve the accuracy and consistency in the recording and tracking of ethnicity data. Strengthening this data capturing process will allow us to examine if our services are equitable and identify emerging areas of need.

Decision making: Data offers valuable insights that can inform the design and delivery of services. Metrics such as waiting times and the number of assessments are important, but they can sometimes drive narrowly focused responses, such as increasing capacity, which may offer short-term relief, but lack long-term sustainability. To be most effective, data should be used strategically to support both efficient and impactful service delivery and design. It is also important to consider what data is missing, what impact that has in terms of knowledge and understanding, and how those gaps might be

addressed. Finally, it is necessary to reflect that data alone cannot provide the full picture. Combining data with contextual understanding, such as lived experience and professional insight is essential for developing a more holistic and responsive approach to service planning.

Assessing and measuring the impact of interventions and initiatives (e.g., Family Hub courses, VERBO, engagement events): Assessing and measuring impact is essential for understanding how effective interventions and initiatives launched within the borough are. Applying a formal theory of change approach ensures that these initiatives are grounded in evidence-based decision-making and are evaluated consistently for their impact. This enables the borough to continually refine and adapt its services to better meet the needs of individuals and families.

12.5 Recommendation: Ensuring a balanced approach across all areas of need

The growing number of ASD assessments has rightly led to an increased focus on autism support. However, it is important to ensure that attention to other conditions is not diminished, and that a balanced approach continues to be taken across all areas of need.

12.6 Recommendation: Improve access of information and support services

The Borough has made clear efforts to improve awareness of available support services. However, these services continue to be hard to access for many parents and carers. For example, if you are in a specialist school, awareness of additional support offerings is more likely to be known than those in mainstream schools. More inclusive communication strategies are recommended to ensure that families are fully informed and empowered to access the help they need. This could include improving the clarity and navigation and delivering targeted outreach through schools.

12.7 Recommendation: Empowering young people to understand and manage their needs

There has been a strong and necessary focus on enhancing support for parents and carers, particularly around how they can engage with their child to support optimal development. While this remains critical, there is also a valuable opportunity to broaden the focus to include the child or young person themselves, empowering them to understand their needs, develop self-management strategies, and build the skills necessary to thrive throughout life.

12.8 Recommendation: Transition pathways

Post-16 educational support: Develop and expand tailored post-16 support options for young people who are not suited to apprenticeships, do not meet criteria for high-complex needs, and have not achieved level 2 qualifications. This should include accessible continued learning opportunities, such as foundation courses that enable young people to remain engaged within an educational support structure and build essential skills for future success.

Youth to adult services: There remain opportunities to strengthen the support to young people and families as they transition from young people services and support to adults. For example: for those who move across the Community, Learning and Disability Service (CLDS) tends to see more joint working. However, if they do not meet the CLDS criteria this can increase difficulties in terms of assessments as well as understanding who or what support can be provisioned.

Develop clear, coordinated transition pathways regardless of criteria. This should include multi-agency planning, improved communication with families, and tailored assessment processes to ensure no young person falls through gaps in service provision during this critical period.

12.9 Recommendation: Continuous learning and specialist training for SEND support

Understanding and supporting children and young people with SEND requires continuous learning and development for all those working in and around the SEND system. Ensuring access to relevant specialist training where necessary contributes to better outcomes for those they support. Additionally, as evidence and best practices continue to evolve, embedding a culture of active and continuous learning is crucial to keep approaches up to date and effective. Establishing a comprehensive, ongoing professional development programme incorporating specialist training and regular updates based on emerging evidence and research will support this.

12.10 Recommendation: Provision of education support

Traditional classroom settings, typically characterised by large class sizes, limited staff, and expectations for pupils to sit still and maintain attention for extended periods often do not meet the needs of many children with SEND. By continuing to draw on specialist expertise within the borough such as sharing best practice and learning from successful models in other schools, mainstream settings can be better equipped to support children and young people with SEND to thrive without needing to move into specialist provision.

12.11 Recommendation: Continuing to strengthen integration and multi-agency collaboration

Stakeholders highlighted various strengths in partnerships and collaborative efforts across teams, with several examples of good practice. However, siloed working approaches persist, presenting opportunities to further build and strengthen collaboration. A greater focus on fostering a collaborative culture by bringing together education, health, and social care is essential to address the holistic needs of children and young people. Shared learning and joint working options create more opportunities for creativity and service enhancement. Achieving this requires challenging longstanding structural barriers and systems that segment health, education, and social care. This collaborative approach should include a blend of formal and informal methods, using both in-person and remote options to maximise flexibility and accessibility. Sharing physical spaces can also promote fluid and effective ways of working together.

Importantly, there is a clear sense of commitment within the borough to develop community-based provisions, which provide a strong foundation for delivering effective services and support.

12.12 Recommendation: Clarifying responsibilities for children placed out of Borough and cross border movement

There remains a lack of clarity on the responsibility and accountability when children and young people are placed in schools outside of the borough. Other boroughs may vary in their support offering which can create difficulties in the provisioning of the required support. For example, Tower Hamlets has an

auxiliary aids fund to support eligible children, but neighboring boroughs may lack the budget to offer similar services. As a result, children, whether moving into the borough or attending schools elsewhere may not receive equitable support.

Establish clear protocols and agreements between Tower Hamlets and neighbouring boroughs to define responsibilities and accountability for children and young people placed in out-of-borough schools. This should include transparent communication channels, shared plans, funding approaches and coordinated support arrangements to ensure consistent, high-quality support regardless of placement location.

12.13 Recommendation: Expanding inclusive community opportunities for young people

Work with community youth services to train staff in SEND awareness and support in order to improve understanding and accessibility. Consider how personal care assistance could be provided in these spaces to ensure all young people can engage safely and confidently in community activities.

There are many young people aged 16 to 25 in the borough who do not meet the criteria for specialist services or interventions but would benefit from engaging in activities outside of school, such as attending inclusive youth centres. However, in some cases, these community provisions are often not equipped to support young people with SEND who experience moderate difficulties or require additional support with personal care needs, such as going to the toilet. Enhancing these provisions is essential to promoting equity and ensuring that all young people regardless of their level of need, have meaningful and accessible opportunities to participate fully in community life. Tailored support within inclusive settings can help build confidence, social skills, and independence.

12.14 Recommendation: Strengthening support through evidence-based practices

Regularly review and update support provision frameworks to ensure they are firmly grounded in the latest evidence-based approaches and theoretical models. This includes ongoing training for staff on current best practices, commissioning evaluations of existing programmes, and adapting interventions based on emerging research to continuously improve outcomes for children and young people with SEND.

13. References

- ¹ Department for Education and Department of Health (2015). *Special educational needs and disability code of practice: 0 to 25 years*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf
- ² Tower Hamlets Council (2024). *Tower Hamlets Special Educational Needs, Disabilities and Inclusion Strategy: 2024–29*. Available at: <https://democracy.towerhamlets.gov.uk/documents/s242527/Appendix.%20%20for%20Tower%20Hamlets%20Special%20Educational%20Needs%20Disabilities%20and%20Inclusion%20Strategy%202024%20to.pdf>
- ³ Department for Education (2024). *Special educational needs in England*. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england/2024-25>
- ⁴ Tower Hamlets (2024). Tower Hamlets SEND Analysis Dashboard for Tower Hamlets July 2024_v3.731.
- ⁵ Office for Health Improvement and Disparities (2025). *Public health profiles*. Available at: <https://fingertips.phe.org.uk/>
- ⁶ Braun, V. and Clarke, V. (2006). 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp.77–101. doi: <https://doi.org/10.1191/1478088706qp063oa>
- ⁷ *Equality Act 2010*. Available at: <https://www.legislation.gov.uk/ukpga/2010/15/section/6>
- ⁸ NHS England (2025). *ADHD Taskforce*. Available at: <https://www.england.nhs.uk/mental-health/adhd/>
- ⁹ Disability Unit and Cabinet Office (2021). *Portraying disability*. Available at: <https://www.gov.uk/government/publications/inclusive-communication/portraying-disability>
- ¹⁰ *Education Act 1981*. Available at: <https://www.legislation.gov.uk/ukpga/1981/60/enacted>
- ¹¹ HM Government (2003). *Every Child Matters*. Available at: <https://assets.publishing.service.gov.uk/media/5a7c95a4e5274a0bb7cb806d/5860.pdf>
- ¹² *Children and Families Act 2014*. Available at: <https://www.legislation.gov.uk/ukpga/2014/6/contents>
- ¹³ Department for Education (2022). *SEND Review: Right support, right place, right time*. Available at: <https://www.gov.uk/government/consultations/send-review-right-support-right-place-right-time>
- ¹⁴ National Institute for Health and Care Excellence (2021). *Autism spectrum disorder in under 19s: support and management*. Available at: <https://www.nice.org.uk/guidance/cg170>
- ¹⁵ National Institute for Health and Care Excellence (2019). *Attention deficit hyperactivity disorder: diagnosis and management*. Available at: <https://www.nice.org.uk/guidance/ng87>
- ¹⁶ National Institute for Health and Care Excellence (2018). *Learning disabilities and behaviour that challenges: service design and delivery*. Available at: <https://www.nice.org.uk/guidance/ng93>
- ¹⁷ National Institute for Health and Care Excellence (2022). *Social and emotional wellbeing in primary education*. Available at: <https://www.nice.org.uk/guidance/ng223>
- ¹⁸ National Institute for Health and Care Excellence (2017). *Developmental follow-up of children and young people born preterm*. Available at: <https://www.nice.org.uk/guidance/ng72>
- ¹⁹ National Institute for Health and Care Excellence (2016). *Mental health problems in people with learning disabilities: Prevention, assessment and management*. Available at: <https://www.nice.org.uk/guidance/ng54>
- ²⁰ Tower Hamlets Council (2023). *TH_IS Accelerate: The Tower Hamlets Children and Families Partnership Strategy 2024-2029*. Available at: <https://democracy.towerhamlets.gov.uk/documents/s226619/Appendix.%20%20for%20Children%20and%20Families%20Strategy%202023-2028.pdf>

-
- ²¹ Tower Hamlets Council (2022). *Tower Hamlets Early Help Strategy 2023-2025*. Available at: https://www.towerhamlets.gov.uk/Documents/Children-and-families-services/Early_help/TH-Early-Help-Strategy.pdf
- ²² Tower Hamlets Health and Wellbeing Board (2021). *Tower Hamlets Health and Wellbeing Strategy 2021-2025*. Available at: <https://democracy.towerhamlets.gov.uk/mgConvert2PDF.aspx?ID=191599>
- ²³ Tower Hamlets and City of London Youth Justice Service (2023). *Strategic Plan 2023-2025*. Available at: <https://democracy.towerhamlets.gov.uk/documents/s229070/9.1b%20Appendix%20Youth%20Justice%20Strategic%20Plan%202023-2025.pdf>
- ²⁴ Family Information Service (2025). *Local Offer*. Available at: <https://www.localoffertowerhamlets.co.uk/>
- ²⁵ Daniel, J. and Wang, H. (2023). 'Gender differences in special educational needs identification', *Review of Education*, 11(3), p.e3437. doi: <https://doi.org/10.1002/rev3.3437>
- ²⁶ Strand, S. and Lindorff, A. (2018). *Ethnic disproportionality in the identification of Special Educational Needs (SEN) in England: Extent, causes and consequences*. Available at: <https://ora.ox.ac.uk/objects/uuid:a28b7858-994a-4474-9c4b-6962d1f6da41/files/maea51f1ea29cde0e36c13a9e2a9dd838>
- ²⁷ Trust for London (2025). *London's Poverty Profile*. Available at: <https://trustforlondon.org.uk/data/>
- ²⁸ Trust for London (2025). *The latest data on London borough-level poverty*. Available at: <https://trustforlondon.org.uk/>
- ²⁹ Office for Health Improvement and Disparities (2023). *Healthy child programme: resources to help keep children healthy and well from preconception to adulthood*. Available at: <https://www.gov.uk/government/collections/healthy-child-programme>
- ³⁰ Shaw, B., Bernardes, E., Trethewey, A., & Menzies, L. (2016). 'Special educational needs and their links to poverty', *Joseph Rowntree Foundation*.
- ³¹ *Education Act 2002*. Available at: <https://www.legislation.gov.uk/ukpga/2002/32/section/175>
- ³² Department for Education (2025). *Statutory guidance: Keeping children safe in education*. Available at: <https://www.gov.uk/government/publications/keeping-children-safe-in-education--2>
- ³³ Department of Education (2025). *Suspensions and permanent exclusions in England*. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/suspensions-and-permanent-exclusions-in-england/2023-24>
- ³⁴ Chaste, P. and Leboyer, M. (2012). 'Autism risk factors: genes, environment, and gene-environment interactions', *Dialogues in Clinical Neuroscience*, 14(3), pp.281-292. doi: <https://doi.org/10.31887/DCNS.2012.14.3/pchaste>
- ³⁵ Rylaarsdam, L. and Guemez-Gamboa, A. (2019). 'Genetic causes and modifiers of autism spectrum disorder', *Frontiers in cellular neuroscience*, 13, p.470832. doi: <https://doi.org/10.3389/fncel.2019.00385>
- ³⁶ Love, C., Sominsky, L., O'Hely, M., Berk, M., Vuillermine, P. and Dawson, S.L. (2024). 'Prenatal environmental risk factors for autism spectrum disorder and their potential mechanisms', *BMC Medicine*, 22(1), p.393. doi: <https://doi.org/10.1186/s12916-024-03617-3>
- ³⁷ National Institute for Health and Care Excellence (2025). *Autism in adults: What are the causes and risk factors?* Available at: <https://cks.nice.org.uk/topics/autism-in-adults/background-information/causes-risk-factors/>
- ³⁸ de Leeuw, A.E., Ester, W.A., Bolhuis, K., Hoek, H.W. and Jansen, P.W. (2025). 'Maternal Migration, Prenatal Stress and Child Autistic Traits: Insights From a Population-Based Cohort Study', *Journal of the American Academy of Child & Adolescent Psychiatry*, 64(1), pp.41-52. doi: <https://doi.org/10.1016/j.jaac.2024.04.004>
- ³⁹ Tower Hamlets Local Area SEND Self-Assessment (June 2025). Submitted as part of the joint Ofsted and Care Quality Commission (CQC) Area SEND inspection process.
- ⁴⁰ Loomes, R., Hull, L. and Mandy, W.P.L. (2017). 'What is the male-to-female ratio in autism spectrum disorder? A systematic review and meta-analysis', *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(6), pp.466-474. doi: <https://doi.org/10.1016/j.jaac.2017.03.013>

-
- ⁴¹ National Autistic Society (2025). *Autism assessment waiting times*. Available at: <https://www.autism.org.uk/what-we-do/news/autism-assessment-waiting-times-9>
- ⁴² Lang, K. (2024). 'Autism and ADHD place "unprecedented" demand on NHS', *BMJ*. doi: <https://doi.org/10.1136/bmj.q802>
- ⁴³ British Diabetic Association (2025). *Autism and diet*. Available at: <https://www.bda.uk.com/resource/autism-diet.html> (Accessed: 4 August 2025).
- ⁴⁴ McCoy, S. M. and Morgan, K. (2019). 'Obesity, physical activity, and sedentary behaviors in adolescents with autism spectrum disorder compared with typically developing peers', *Autism*, 24(2), pp.387-399. doi: <https://doi.org/10.1177/1362361319861579>
- ⁴⁵ Rostami Haji Abadi, M., Zheng, Y., Wharton, T., Dell, C., Vatanparast, H., Johnston, J. and Kontulainen, S. (2023). 'Children with autism spectrum disorder spent 30 min less daily time in moderate-to-vigorous physical activity than typically developing peers: A meta-analysis of cross-sectional data', *Review Journal of Autism and Developmental Disorders*, 10(1), pp.144-157. doi: <https://doi.org/10.13140/RG.2.2.33834.34242>
- ⁴⁶ Elrod, M.G. and Hood, B.S. (2015). 'Sleep differences among children with autism spectrum disorders and typically developing peers: a meta-analysis', *Journal of Developmental & Behavioral Paediatrics*, 36(3), pp.166-177. doi: <https://doi.org/10.1097/DBP.0000000000000140>
- ⁴⁷ Estruch-García, V., Gil-Llario, M.D., Ruiz-Palomino, E., Fernández-García, O., Morell-Mengual, V. and Anastácio, Z.F.C., (2025). Systematic Integrative Review: Sex Education for People with Autism Spectrum Disorder. *Sexuality and Disability*, 43(1), p.6.
- ⁴⁸ National Autistic Society (2023). *Education Report 2023*. Available at: https://dy55nndrxke1w.cloudfront.net/file/24/asDKIN9asAvgMtEas6glatOcB5H/NAS_Education%20Report%202023.pdf
- ⁴⁹ Brown-Lavoie, S.M., Viecili, M.A. and Weiss, J.A. (2014). 'Sexual knowledge and victimization in adults with autism spectrum disorders', *Journal of Autism and Developmental Disorders*, 44(9), pp.2185–2196. doi: <https://doi.org/10.1007/s10803-014-2093-y>
- ⁵⁰ Department for Education (2025). *Relationships Education, Relationships and Sex Education (RSE) and Health Education: Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers*. Available at: <https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education>
- ⁵¹ Weir, E., Allison, C., and Baron-Cohen, S. (2021). 'Understanding the substance use of autistic adolescents and adults: a mixed methods approach', *The Lancet Psychiatry*, 8(8), pp.673-685.
- ⁵² National Institute for Health and Care Excellence. (2013). *Autism diagnosis in children and young people: Evidence Update April 2013*. Available at: [Autism diagnosis in children and young people Evidence Update April 2013](https://www.nice.org.uk/guidance/CG178/evidence/autism-diagnosis-in-children-and-young-people-evidence-update-april-2013)
- ⁵³ Simonoff, E., Pickles, A., Charman, T., Chandler, S., Loucas, T. and Baird, G. (2008). 'Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample', *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(8), pp.921-929. doi: <https://doi.org/10.1097/CHI.0b013e318179964f>
- ⁵⁴ DeFilippis, M. (2018). 'Depression in children and adolescents with autism spectrum disorder', *Children*, 5(9), p.112. doi: <https://doi.org/10.3390/children5090112>
- ⁵⁵ Warrier, V., Greenberg, D.M., Weir, E., Buckingham, C., Smith, P., Lai, M.C., Allison, C. and Baron-Cohen, S., (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature communications*, 11(1), p.3959.
- ⁵⁶ National Autistic Society (n.d) *Autism and gender identity*. Available at: <https://www.autism.org.uk/advice-and-guidance/topics/identity/autism-and-gender-identity#:~:text=There%20is%20some%20evidence%20to,dysphoria%20is%20not%20so%20clear.>

-
- ⁵⁷ Warrier, V., Greenberg, D.M., Weir, E., Buckingham, C., Smith, P., Lai, M.C., Allison, C. and Baron-Cohen, S., (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature communications*, 11(1), p.3959.
- ⁵⁸ National Autistic Society (n.d) *Autism and gender identity*. Available at: <https://www.autism.org.uk/advice-and-guidance/topics/identity/autism-and-gender-identity#:~:text=There%20is%20some%20evidence%20to,dysphoria%20is%20not%20so%20clear>.
- ⁵⁹ Madra, M., Ringel, R. and Margolis, K.G. (2020). 'Gastrointestinal Issues and Autism Spectrum Disorder', *Child and Adolescent Psychiatric Clinics of North America*, 29(3), pp.501-513.
- ⁶⁰ Department of Health and Social Care (2020). *Tackling obesity: Empowering adults and children to live healthier lives*. Available at: <https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives>
- ⁶¹ National Autistic Society (n.d.). *Autism and communication*. Available at: <https://www.autism.org.uk/advice-and-guidance/topics/about-autism/autism-and-communication>
- ⁶² National Institute for Health and Care Excellence. (2021). *Autism spectrum disorder in under 19s: recognition, referral and diagnosis (NICE guideline CG128)*. <https://www.nice.org.uk/guidance/cg128>
- ⁶³ National Autistic Society (2020). *Sensory differences - a guide for all audiences*. Available at: <https://www.autism.org.uk/advice-and-guidance/topics/sensory-differences/sensory-differences/all-audiences>
- ⁶⁴ Family Hubs Tower Hamlets (n.d.). *Support for Specific Needs: SEND Support (Special Educational Needs and Disabilities)*. Available at: <https://thfamilyhubs.co.uk/>
- ⁶⁵ NHS (2025). *ADHD in children and young people*. Available at: <https://www.nhs.uk/conditions/adhd-children-teenagers>
- ⁶⁶ Amiri, S., Malek, A., Sadegfard, M. and Abdi, S. (2012). 'Pregnancy-related maternal risk factors of attention-deficit hyperactivity disorder: A case-control study', *International Scholarly Research Notices*, p.458064. doi: <https://doi.org/10.5402/2012/458064>
- ⁶⁷ Thapar, A., Cooper, M., Eyre, O., & Langley, K. (2013). *What have we learnt about the causes of ADHD?* *Journal of Child Psychology and Psychiatry*, 54(1), 3–16. <https://doi.org/10.1111/j.1469-7610.2012.02611.x>
- ⁶⁸ Faraone, S. V., & Larsson, H. (2019). *Genetics of attention deficit hyperactivity disorder*. *Molecular Psychiatry*, 24(4), 562–575. <https://doi.org/10.1038/s41380-018-0070-0>
- ⁶⁹ Kings College London (2016). *Unhealthy diet during pregnancy could be linked to ADHD*. Available at: <https://www.kcl.ac.uk/archive/news/ioppn/records/2016/august/unhealthy-diet-during-pregnancy-could-be-linked-to-adhd>
- ⁷⁰ Asarnow, R. F., et al. (2021). *ADHD following traumatic brain injury in children and adolescents: A meta-analysis*. *Journal of the American Academy of Child & Adolescent Psychiatry*, 60(3), 316–328. <https://doi.org/10.1016/j.jaac.2020.06.011>.
- ⁷¹ Salari, N., Ghasemi, H., Abdoli, N., Rahmani, A., Hossain Shiri, M., Hashemian, A.H., Akbari, H., Mohammadi, M., (2023). The global prevalence of ADHD in children and adolescents: a systematic review and meta-analysis. *Italian Journal of Pediatrics*.49(48). doi: [10.1186/s13052-023-01456-1](https://doi.org/10.1186/s13052-023-01456-1)
- ⁷² Tower Hamlets Together (2024). *Children & Young People's Mental Health and Wellbeing*. Available at: <https://democracy.towerhamlets.gov.uk/documents/s242711/20052024%20TH%20HWBB%20MHWB%20Final%20Draft.pdf>
<https://democracy.towerhamlets.gov.uk/documents/s242711/20052024%20TH%20HWBB%20MHWB%20Final%20Draft.pdf>
- ⁷³ Young Minds (2024). *ADHD and mental health*. Available at: <https://www.youngminds.org.uk/young-person/mental-health-conditions/adhd-and-mental-health/>
- ⁷⁴ Holton, K.F. and Nigg, J.T. (2020). 'The association of lifestyle factors and ADHD in children', *Journal of attention disorders*, 24(11), pp.1511-1520. doi: <https://doi.org/10.1177/10870547166464>

-
- ⁷⁵ Mercurio, L.Y., Amanullah, S., Gill, N. and Gjelsvik, A. (2021). 'Children with ADHD engage in less physical activity'. *Journal of Attention Disorders*, 25(8), pp.1187-1195. doi: <https://doi.org/10.1177/1087054719887789>
- ⁷⁶ Selinus, E.N., Durbeej, N., Zhan, Y., Lichtenstein, P., Lundström, S. and Ekblom, M. (2021). 'Inattention and hyperactivity symptoms in childhood predict physical activity in adolescence', *BMC Psychiatry*, 21(1), p.629. doi: <https://doi.org/10.1186/s12888-021-03603-6>
- ⁷⁷ Family Action (2024). *How to support a child with ADHD with food and eating*. Available at: <https://family-action.org.uk/self-help/support-a-child-with-adhd-with-food-eating/>
- ⁷⁸ Office for Health Improvement Disparities (2024). *The Eatwell Guide*. Available at: <https://www.gov.uk/government/publications/the-eatwell-guide>
- ⁷⁹ Sibley, M.H., Pelham Jr, W.E., Molina, B.S., Coxe, S., Kipp, H., Gnagy, E.M., Meinzer, M., Ross, J.M. and Lahey, B.B. (2014). 'The role of early childhood ADHD and subsequent CD in the initiation and escalation of adolescent cigarette, alcohol, and marijuana use'. *Journal of Abnormal Psychology*, 123(2), p.362. doi: <https://doi.org/10.1037/a0036585>
- ⁸⁰ Mitchell, J.T., Howard, A.L., Belendiuk, K.A., Kennedy, T.M., Stehli, A., Swanson, J.M., Hechtman, L., Arnold, L.E., Hoza, B., Vitiello, B. and Lu, B. (2019). 'Cigarette smoking progression among young adults diagnosed with ADHD in childhood: A 16-year longitudinal study of children with and without ADHD', *Nicotine and Tobacco Research*, 21(5), pp.638-647. doi: <https://doi.org/10.1093/ntr/nty045>
- ⁸¹ NHS (2022). *Southampton researchers launch new study to help children with ADHD sleep better*. Available at: <https://www.uhs.nhs.uk/whats-new/press-releases/southampton-researchers-launch-new-study-to-help-children-with-adhd-sleep-better>
- ⁸² May, F., Ford, T., Janssens, A., Newlove-Delgado, T., Emma Russell, A., Salim, J., Ukoumunne, O.C. and Hayes, R. (2021). 'Attainment, attendance, and school difficulties in UK primary schoolchildren with probable ADHD', *British Journal of Educational Psychology*, 91(1), pp.442-462. doi: <https://doi.org/10.1111/bjep.12375>
- ⁸³ Russell, A.E., Benham-Clarke, S., Ford, T., Eke, H., Price, A., Mitchell, S., Newlove-Delgado, T., Moore, D. and Janssens, A. (2023). 'Educational experiences of young people with ADHD in the UK: Secondary analysis of qualitative data from the CATCH-uS mixed-methods study', *British Journal of Educational Psychology*, 93(4), pp.941-959. doi: <https://doi.org/10.1111/bjep.12613>
- ⁸⁴ Groen, Y., Priegnitz, U., Fuermaier, A. B. M., Tucha, L., Tucha, O., Aschenbrenner, S., Weisbrod, M., and Garcia Pimenta, M. (2020). 'Testing the relation between ADHD and hyperfocus experiences', *Research in Developmental Disabilities*. doi: <https://doi.org/10.1016/j.ridd.2020.103789>
- ⁸⁵ NHS Digital (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24*. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder>
- ⁸⁶ University College London (2025). *Adults diagnosed with ADHD may have reduced life expectancies*. Available at: <https://www.ucl.ac.uk/news/2025/jan/adults-diagnosed-adhd-may-have-reduced-life-expectancies>
- ⁸⁷ Mental Health Foundation (2024). *Attention deficit hyperactivity disorder (ADHD)*. Available at: <https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/attention-deficit-hyperactivity-disorder-adhd>
- ⁸⁸ NHS (2025). *ADHD in children and young people*. Available at: <https://www.nhs.uk/conditions/adhd-children-teenagers>
- ⁸⁹ ADHD UK (2024). *ADHD Education, Health and Care Plan (EHCP)*. Available at: <https://adhduk.co.uk/adhd-educational-health-care-plan-ehcp>
- ⁹⁰ Docklands Outreach Logo (2024). Available at: [Docklands Outreach](#)
- ⁹¹ NHS England (2024). *Attention deficit hyperactivity (ADHD) Programme update*. Available at: <https://www.england.nhs.uk/long-read/attention-deficit-hyperactivity-disorder-adhd-programme-update/>

-
- ⁹² The Royal College of Speech and Language Therapists (2021). *What are speech, language and communication needs?*. Available at: <https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/rcslt-communication-needs-factsheet.pdf>
- ⁹³ Dockrell, J., Ricketts, J. and Lindsay, G. (2010). *Understanding speech, language and communication needs: Profiles of need and provision (2012)*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/557156/DFE-RR247-BCRP4.pdf
- ⁹⁴ Department of Health & Social Care and Department for Education (2020). *Best start in speech, language and communication: Supporting Evidence*. Available at: https://assets.publishing.service.gov.uk/media/5f9be9c48fa8f57f3b4cb075/BSSLC_Supporting-evidence.pdf
- ⁹⁵ Lanz, R. (2009) A pilot project examining the Speech, Language, Communication needs of young people accessing the Milton Keynes Youth Offending Team. Available at: [justice-evidence-base2017-1.pdf](#) (Accessed: 5 August 2025).
- ⁹⁶ MacRae, A., and Clark, A. (2021). 'Police officers' awareness of the speech, language and communication needs of young offenders', *The Police Journal*, 94(4), pp.539-555. doi: <https://doi.org/10.1177/0032258x20968591>
- ⁹⁷ Herefordshire and Worcestershire Health and Care (2025). *Identification of SLCN*. Available at: <https://www.hacw.nhs.uk/identifying-slcni>
- ⁹⁸ The Royal College of Speech and Language Therapists (2020). *Promoting social, emotional and mental health*. Available at: <https://www.rcslt.org/wp-content/uploads/2022/04/RCSLT-promoting-SEMH-factsheet.pdf>
- ⁹⁹ Mind (2024). *The Big Mental Health Report*. Available at: <https://www.mind.org.uk/media/vbbdclpi/the-big-mental-health-report-2024-mind.pdf>
- ¹⁰⁰ Hobson, H., Kalsi, M., Cotton, L., Forster, M., and Toseeb, U. (2022). 'Supporting the mental health of children with speech, language and communication needs: The views and experiences of parents', *Autism & Developmental Language Impairments*, 7. doi: <https://doi.org/10.1177/23969415221101137>
- ¹⁰¹ The Royal College of Speech and Language Therapists (2021). *Supporting children and young people with communication and swallowing needs*. Available at: <https://www.rcslt.org/wp-content/uploads/2021/12/Supporting-children-and-young-people-with-communication-and-swallowing-needs-December-2021.pdf>
- ¹⁰² van der Niet, A. G., Hartman, E., Moolenaar, B. J., Smith, J., and Visscher, C. (2014). 'Relationship between physical activity and physical fitness in school-aged children with developmental language disorders', *Research in Developmental Disabilities*, 35(12), pp.3285-3291. doi: <https://doi.org/10.1016/j.ridd.2014.08.022>
- ¹⁰³ Tower Hamlets Health and Wellbeing Board (2025). *Meeting the needs of children and young people with SEND*. Available at: <https://democracy.towerhamlets.gov.uk/documents/s250000/HWBB+SEND+Report+27+Feb+2025.pdf>
- ¹⁰⁴ Meschi E., M. J., Vignoles, A. and Lindsay, G. (2010). *The transitions between categories of special educational needs of pupils with Speech, Language and Communication Needs (SLCN) and Autism Spectrum Disorder (ASD) as they progress through the education system*. Available at: <https://assets.publishing.service.gov.uk/media/5a7c9f1eed915d6969f462d2/DFE-RR247-BCRP11.pdf>
- ¹⁰⁵ Hobson, H., Kalsi, M., Cotton, L., Forster, M. and Toseeb, U. (2022). 'Supporting the mental health of children with speech, language and communication needs: The views and experiences of parents', *Autism & Developmental Language Impairments*, 7. doi: <https://doi.org/10.1177/23969415221101137>

- ¹⁰⁶ Law, J., Reilly, S., & Snow, P. (2019). Child language, mental health and wellbeing: Interconnections and implications. *International Journal of Language & Communication Disorders*, 54(3), 431–443. <https://doi.org/10.1111/1460-6984.12411>
- ¹⁰⁷ Norbury, C. F., Gooch, D., Wray, C., Baird, G., Charman, T., Simonoff, E., & Pickles, A. (2016). The impact of nonverbal ability on prevalence and clinical presentation of language disorder: Evidence from a population study. *Journal of Child Psychology and Psychiatry*, 57(11), 1247–1257. <https://doi.org/10.1111/jcpp.12573>
- ¹⁰⁸ George, A. and Abi-Aad, G. (2017). *Speech, Language and Communication*. Available at: https://www.kpho.org.uk/data/assets/pdf_file/0010/71695/Speech-Language-and-Communication.pdf
- ¹⁰⁹ Tower Hamlets Council (2025). *Transition into Adult Services*. Available at: <https://www.towerhamlets.gov.uk/Documents/Children-and-families-services/Supporting-disabilities/Transition-into-Adult-Services.pdf> (Accessed: 4 August 2025).
- ¹¹⁰ DeafPlus (2025). *Giving Quality Advice*. Available at: <https://www.deafplus.org/advice>
- ¹¹¹ Gibbard, D., Roulstone, S., Kandala, N. I., Morgan, L., Harding, S., Smith, C. and Markham, C. (2024). ‘A randomised controlled trial of the effectiveness of parent-based models of language intervention for 2- to 3-year-old children with speech, language and communication needs (SLCN) in areas of social disadvantage’, *International Journal of Language & Communication Disorders*, 59(4), pp.1517-1537. doi: <https://doi.org/10.1111/1460-6984.13016>
- ¹¹² Suggate, S. P., Lenhart, J., Vaahtoranta, E. and Lenhard, W. (2021) ‘Interactive elaborative storytelling fosters vocabulary in pre-schoolers compared to repeated-reading and phonemic awareness interventions’, *Cognitive Development*, 57, p.100996. doi: <https://doi.org/10.1016/j.cogdev.2020.100996>
- ¹¹³ Roberts, M. Y., Curtis, P. R., Sone, B. J. and Hampton, L. H. (2019). ‘Association of Parent Training With Child Language Development: A Systematic Review and Meta-analysis’, *JAMA Pediatrics*, 173(7), pp.671-680. doi: <https://doi.org/10.1001/jamapediatrics.2019.1197>
- ¹¹⁴ McGowan, E.C., Caskey, M., Tucker, R. and Vohr, B.R. (2024). ‘A randomized controlled trial of a neonatal intensive care unit language intervention for parents of preterm infants and 2-year language outcomes’, *The Journal of Pediatrics*, 264, p.113740. doi: <https://doi.org/10.1016/j.jpeds.2023.113740>
- ¹¹⁵ Fricke, S., Burgoyne, K., Bowyer-Crane, C., Kyriacou, M., Zosimidou, A., Maxwell, L., Lervåg, A., Snowling, M. J., and Hulme, C. (2017). ‘The efficacy of early language intervention in mainstream school settings: a randomized controlled trial’, *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 58(10), pp.1141–1151. doi: <https://doi.org/10.1111/jcpp.12737>
- ¹¹⁶ O’Brian, S. and Onslow, M. (2011). ‘Clinical management of stuttering in children and adults’, *BMJ*, 342. doi: <https://doi.org/10.1136/bmj.d3742>
- ¹¹⁷ Downs Syndrome Association (2021). *Healthy Lifestyle & Sports*. Available at: <https://www.downs-syndrome.org.uk/about-downs-syndrome/lifes-journey/healthy-lifestyle-physical-activity/>
- ¹¹⁸ Norbury, C. F., Gooch, D., Wray, C., Baird, G., Charman, T., Simonoff, E., & Pickles, A. (2016). The impact of nonverbal ability on prevalence and clinical presentation of language disorder: Evidence from a population study. *Journal of Child Psychology and Psychiatry*, 57(11), 1247–1257.
- ¹¹⁹ Roulstone, S., Law, J., Rush, R., Clegg, J., & Peters, T. (2011). *Investigating the role of language in children’s early educational outcomes*. DfE Research Report 134.
- ¹²⁰ Tower Hamlets Early Education and Childcare Services (n.d.). *Early Language & The Home Learning Environment*. Available at: <https://www.stepneypark.towerhamlets.sch.uk/attachments/download.asp?file=320&type=pdf>
- ¹²¹ Tower Hamlets Local Offer (2025). *Speech and Language Therapy Children’s Service*. Available at: <https://www.localoffertowerhamlets.co.uk/organisations/28008-speech-and-language-therapy-children-s-service>
- ¹²² Homerton Healthcare NHS Foundation (2023). *Verbo: An award-winning Speech & Language Therapy Toolkit*. Available at: <https://verboapp.co.uk/>

-
- ¹²³ Tower Hamlets Local Offer (2024). *Early Language: Speech and Language Therapy (Under 5s)*. Available at: <https://www.localoffertowerhamlets.co.uk/pages/local-offer/send/speech-and-language-therapy-for-under-5s/early-language-speech-and-language-therapy>
- ¹²⁴ Hobson, H., Kalsi, M., Cotton, L., Forster, M. and Toseeb, U. (2022). 'Supporting the mental health of children with speech, language and communication needs: The views and experiences of parents', *Autism & Developmental Language Impairments*, 7. doi: <https://doi.org/10.1177/23969415221101137>
- ¹²⁵ Newman, L. and Chadwick (Moitra), R., 2023. *Recognising diversity: Understanding bilingual deaf children with cochlear implants*. RCSLT Bulletin, Summer, pp.36–38.
- ¹²⁶ British Dyslexia Association (2025). *About dyslexia*. Available at: <https://www.bdadyslexia.org.uk/dyslexia/about-dyslexia/>
- ¹²⁷ Civil Service (2022). *Designing for people with dyscalculia and low numeracy*. Available at: <https://designnotes.blog.gov.uk/2022/11/28/designing-for-people-with-dyscalculia-and-low-numeracy/>
- ¹²⁸ NHS (2020). *Dyspraxia (developmental co-ordination disorder) in adults*. Available at: <https://www.nhs.uk/conditions/developmental-coordination-disorder-dyspraxia-in-adults>
- ¹²⁹ Learning disability allies (n.d). *Dysgraphia*. Available at: <https://www.hft.org.uk/resources-and-guidance/what-is-a-learning-disability/learning-difficulties-and-other-needs/dysgraphia/>
- ¹³⁰ Theodoridou, D., Christodoulides, P., Zakopoulou, V. and Syrrou, M. (2021). 'Developmental dyslexia: Environment matters', *Brain Sciences*, 11(6), p.782. doi: <https://doi.org/10.3390/brainsci11060782>
- ¹³¹ Castellucci, G. and Singla, R. (2024). *Developmental Coordination Disorder (Dyspraxia)*. StatPearls Publishing.
- ¹³² Aquil, M. A. I. and Ariffin, M. M. (2020). 'The causes, prevalence and interventions for dyscalculia in Malaysia', *Journal of Educational and Social Research*, 10(6), p.279. doi: <https://doi.org/10.36941/jesr-2020-0126>
- ¹³³ Pham, A. V. and Riviere, A. (2015). 'Specific learning disorders and ADHD: current issues in diagnosis across clinical and educational settings', *Current Psychiatry Reports*, 17, pp.1-7. doi: <https://doi.org/10.1007/s11920-015-0584-y>
- ¹³⁴ Krafnick, A. J. and Evans, T. M. (2019). 'Neurobiological sex differences in developmental dyslexia', *Frontiers in Psychology*, 9, p.2669. doi: <https://doi.org/10.3389/fpsyg.2018.02669>
- ¹³⁵ Granocchio, E., De Salvatore, M., Bonanomi, E. and Sarti, D. (2023) 'Sex-related differences in reading achievement', *Journal of Neuroscience Research*, 101(5), pp.668-678. doi: <https://doi.org/10.1002/jnr.24913>
- ¹³⁶ Hettiarachchi, D. (2021). 'An overview of dyslexia', *Sri Lanka Journal of Child Health*, 50(3). doi: <http://doi.org/10.4038/slch.v50i3.9741>
- ¹³⁷ Campbell, T. (2023). *Inequalities in provision for primary children with special educational needs and/or disabilities (SEND) by local area deprivation*. Available at: <https://www.lse.ac.uk/News/Latest-news-from-LSE/2023/k-November-2023/Children-in-affluent-areas>
- ¹³⁸ British Dyslexia Association (2025). *About dyscalculia*. Available at: <https://www.bdadyslexia.org.uk/dyscalculia/how-can-i-identify-dyscalculia>
- ¹³⁹ Molise, D. C. and Luneta, K. (2024). 'An overview of the causes of dyscalculia and its impact on learners' arithmetic ability', *The Independent Journal of Teaching and Learning*, 19(1), pp.124-144.
- ¹⁴⁰ Lingam, R., Hunt, L., Golding, J., Jongmans, M. and Emond, A. (2009). 'Prevalence of developmental coordination disorder using the DSM-IV at 7 years of age: A UK population-based study', *Pediatrics*, 123(4), pp.e693-e700. doi: <https://doi.org/10.1542/peds.2008-1770>
- ¹⁴¹ NHS (2023). *Developmental co-ordination disorder (dyspraxia) in children*. Available at: <https://www.nhs.uk/conditions/developmental-coordination-disorder-dyspraxia/>
- ¹⁴² Karlsdottir, R. and Stefansson, T. (2002). 'Problems in developing functional handwriting', *Perceptual and Motor Skills*, 94(2), pp.623-662. doi: <https://doi.org/10.2466/pms.2002.94.2.623>
- ¹⁴³ McCloskey, M. and Rapp, B. (2019). 'Developmental dysgraphia: An overview and framework for research', *Developmental Dysgraphia*, pp.1-18. doi: <https://doi.org/10.1080/02643294.2017.1369016>
- ¹⁴⁴ Government Office for Science (2020). *Current understanding, support systems, and technology-led interventions for specific learning difficulties*. Available at: <https://assets.publishing.service.gov.uk/media/5f849afa8fa8f504594d4b84/specific-learning-difficulties-spld-cst-report.pdf> (Accessed: 30 July 2025).
- ¹⁴⁵ Graziani, C. L., Brunelli, D., Lorini, D., Bonaccorsi, D., Palese, D., Fedeli, D. and Arnoldo, D. (2024). 'Assessment of the level of health literacy in students with specific learning disorders', *European Journal of Public Health*, 34. doi: <https://doi.org/10.1093/eurpub/ckae144.1718>

-
- ¹⁴⁶ Taanila, A., Ebeling, H., Tiihala, M., Kaakinen, M., Moilanen, I., Hurtig, T. and Yliherva, A. (2014). 'Association between childhood specific learning difficulties and school performance in adolescents with and without ADHD symptoms: a 16-year follow-up', *Journal of Attention Disorders*, 18(1), pp.61-72. doi: <https://doi.org/10.1177/1087054712446813>
- ¹⁴⁷ Lithari, E. (2019). 'Fractured academic identities: Dyslexia, secondary education, self-esteem and school experiences', *International Journal of Inclusive Education*, 23(3), pp.280-296. doi: <https://doi.org/10.1080/13603116.2018.1433242>
- ¹⁴⁸ Alesi, M., Giordano, G., Ingoglia, S. and Inguglia, C. (2024). 'The association among executive functions, academic motivation, anxiety and depression: a comparison between students with specific learning disabilities and undiagnosed peers', *European Journal of Special Needs Education*, 39(5), pp.805-819. doi: <https://doi.org/10.1080/08856257.2023.2300172>
- ¹⁴⁹ Mishra, R. and Mohan, A. (2016). 'Developments in effective teaching strategies for students with dyslexia: A review of literature and research', *International Journal of Applied Research*, 2(6), pp.206-209.
- ¹⁵⁰ Brunswick, N., Wilson, N. J., Kruger, I., Chamberlain, R. and McManus, I. C. (2025). 'The prevalence of Specific Learning Difficulties in Higher Education: A study of UK Universities across 12 academic years', *Journal of Learning Disabilities*, 58(3), pp.179-191. doi: <https://doi.org/10.1177/00222194241281479>
- ¹⁵¹ Matteucci, M. C. and Soncini, A. (2021). 'Self-efficacy and psychological well-being in a sample of Italian university students with and without Specific Learning Disorder', *Research in Developmental Disabilities*, 110, p.103858. doi: <https://doi.org/10.1016/j.ridd.2021.103858>
- ¹⁵² Sewell, A. (2022). 'Understanding and supporting learners with specific learning difficulties from a neurodiversity perspective: A narrative synthesis', *British Journal of Special Education*, 49(4), pp.539-560. doi: <https://doi.org/10.1111/1467-8578.12422>
- ¹⁵³ Rolka, E. J. and Silverman, M. J. (2015). 'A systematic review of music and dyslexia', *The Arts in Psychotherapy*, 46, pp.24-32. doi: <https://doi.org/10.1016/j.aip.2015.09.002>
- ¹⁵⁴ Benavides-Varela, S., Callegher, C. Z., Fagiolini, B., Leo, I., Altoè, G. and Lucangeli, D. (2020). 'Effectiveness of digital-based interventions for children with mathematical learning difficulties: A meta-analysis', *Computers & Education*, 157, p.103953. doi: <https://doi.org/10.1016/j.compedu.2020.103953>
- ¹⁵⁵ Yaacob, H., Zakariya, N. Z. and Rashid, S. M. (2024). 'Technology-based Interventions for Dyslexic Children: A Systematic Literature Review (SLR)', *International Journal of Academic Research in Business and Social Sciences*, 14(2). doi: <http://doi.org/10.6007/IJARBS/v14-i2/20826>
- ¹⁵⁶ Bonifacci, P., Colombini, E., Marzocchi, M., Tobia, V., and Desideri, L. (2022). 'Text-to-speech applications to reduce mind wandering in students with dyslexia', *Journal of Computer Assisted Learning*, 38(2), pp.440-454. doi: <https://doi.org/10.1111/jcal.12624>
- ¹⁵⁷ Bray, L., Skubik-Peplaski, C. and Ackerman, K. B. (2021). 'A systematic review of the effectiveness of interventions to improve handwriting and spelling in children with specific learning disabilities', *Journal of Occupational Therapy, Schools, & Early Intervention*, 14(4), pp.437-465. doi: <https://doi.org/10.1080/19411243.2021.1934227>
- ¹⁵⁸ Grigorenko, E. L., Compton, D. L., Fuchs, L. S., Wagner, R. K., Willcutt, E. G. and Fletcher, J. M. (2020). 'Understanding, educating, and supporting children with specific learning disabilities: 50 years of science and practice', *American Psychologist*, 75(1), p.37. doi: <https://doi.org/10.1037/amp0000452>
- ¹⁵⁹ Family Hubs Tower Hamlets (n.d.). *Mental Health Service*. Available at: <https://thfamilyhubs.co.uk/> (Accessed 5 August 2025).
- ¹⁶⁰ Martin-Denham, S. (2021). 'Defining, identifying, and recognising underlying causes of social, emotional and mental health difficulties: thematic analysis of interviews with headteachers in England'. *Emotional and Behavioural Difficulties*, 26(2), pp.187-205. doi: <https://doi.org/10.1080/13632752.2021.1930909>
- ¹⁶¹ Children's Commissioner (2022). *Experiences of children with SEND: findings from a nationally representative survey*. Available at: <https://assets.childrenscommissioner.gov.uk/wpuploads/2022/11/Annex-4-March-2021-survey-findings.pdf> (Accessed 5 August 2025).

-
- ¹⁶² Morgül, E., Kallitsoglou, A. and Essau, C. (2024). 'Experiences of mothers of children with and without Special Educational Needs (SEN) in England during the COVID-19 lockdowns: a qualitative study', *Current Psychology*, 44, pp.7470-7485. doi: <https://doi.org/10.1007/s12144-024-06954-x>
- ¹⁶³ Lai, M.C., Kasse, C., Besney, R., Bonato, S., Hull, L., Mandy, W., Szatmari, P. and Ameis, S.H. (2019). 'Prevalence of co-occurring mental health diagnoses in the autism population: a systematic review and meta-analysis', *The Lancet Psychiatry*, 6(10), pp.819-829.
- ¹⁶⁴ Sedgewick, F., Leppanen, J. and Tchanturia, K. (2020). 'Gender differences in mental health prevalence in autism', *Advances in Autism*, 7(3), pp.208-224. doi: <https://doi.org/10.1108/AIA-01-2020-0007>
- ¹⁶⁵ NHS Digital (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24*. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder> (Accessed: 5 August 2025).
- ¹⁶⁶ Song, J., Fogarty, K., Suk, R. and Gillen, M. (2021). 'Behavioral and mental health problems in adolescents with ADHD: Exploring the role of family resilience', *Journal of Affective Disorders*, 294, pp.450-458. doi: <https://doi.org/10.1016/j.jad.2021.07.073>
- ¹⁶⁷ Hancock, A., Northcott, S., Hobson, H. and Clarke, M. (2023). 'Speech, language and communication needs and mental health: the experiences of speech and language therapists and mental health professionals', *International Journal of Language & Communication Disorders*, 58(1), pp.52-66. doi: <https://doi.org/10.1111/1460-6984.12767>
- ¹⁶⁸ Lyons, R. and Roulstone, S. (2018). 'Well-being and resilience in children with speech and language disorders', *Journal of Speech, Language, and Hearing Research*, 61(2), pp.324-344. doi: https://doi.org/10.1044/2017_JSLHR-L-16-0391
- ¹⁶⁹ Matteucci, M. C. and Soncini, A. (2021). 'Self-efficacy and psychological well-being in a sample of Italian university students with and without Specific Learning Disorder', *Research in Developmental Disabilities*, 110, p.103858. doi: <https://doi.org/10.1016/j.ridd.2021.103858>
- ¹⁷⁰ Shoham, N., Lewis, G., McManus, S. and Cooper, C. (2019). 'Common mental illness in people with sensory impairment: results from the 2014 adult psychiatric morbidity survey', *BJPsych Open*, 5(6), p.e94. doi: <https://doi.org/10.1192/bjo.2019.81>
- ¹⁷¹ Mallardo, M., Cuskelly, M., White, P. and Jobling, A. (2014). 'Mental health problems in adults with Down syndrome and their association with life circumstances', *Journal of Mental Health Research in Intellectual Disabilities*, 7(3), pp.229-245. doi: <https://doi.org/10.1080/19315864.2013.842622>
- ¹⁷² Walton, C. and Kerr, M. (2015). 'Down syndrome: systematic review of the prevalence and nature of presentation of unipolar depression', *Advances in Mental Health and Intellectual Disabilities*, 9(4), pp.151-162. doi: <https://doi.org/10.1108/AMHID-11-2014-0037>
- ¹⁷³ Hoare, E., Werneck, A. O., Stubbs, B., Firth, J., Collins, S., Corder, K. and van Sluijs, E. M. (2020). 'Association of child and adolescent mental health with adolescent health behaviors in the UK millennium cohort', *JAMA Network Open*, 3(8), p.e2011381.
- ¹⁷⁴ Daniel, J. (2025). 'The academic achievement gap between students with and without special educational needs and disabilities', *European Journal of Special Needs Education*, 40(3), pp.539-556. doi: <https://doi.org/10.1080/08856257.2024.2400771>
- ¹⁷⁵ Dimitrellou, E. and Male, D. (2020). 'Understanding what makes a positive school experience for pupils with SEND: can their voices inform inclusive practice?', *Journal of Research in Special Educational Needs*, 20(2), pp. 87-96. doi: <https://doi.org/10.1111/1471-3802.12457>
- ¹⁷⁶ Arseneault, L. (2017). 'The long-term impact of bullying victimization on mental health', *World Psychiatry*, 16(1), p.27. doi: <https://doi.org/10.1002/wps.20393>
- ¹⁷⁷ Hickinbotham, L. and Soni, A. (2021). 'A systematic literature review exploring the views and experiences of children and young people of the label Social, Emotional and Mental Health (SEMH)', *Emotional and Behavioural Difficulties*, 26(2), pp.135-150. doi: <https://doi.org/10.1080/13632752.2021.1894743>

-
- ¹⁷⁸ Kirkby, J., Ashworth, E., Bray, L. and Alghrani, A. (2021). *A Rapid Scoping Review-The Impact of the COVID-19 Pandemic on the Education, Health and Social Care Provision for Children with Special Educational Needs and Disabilities (SEND)*. Available at: <https://researchonline.ljmu.ac.uk/id/eprint/15715/1/A%20Rapid%20Scoping%20Review.pdf>
- ¹⁷⁹ Winstone, J. (2016). 'Crime, exclusion and mental health: Current realities and future responses', in *Mental Health, Crime and Criminal Justice: Responses and Reforms*. London: Palgrave Macmillan UK, pp.1-20.
- ¹⁸⁰ Mohr-Jensen, C. and Steinhausen, H. C. (2016). 'A meta-analysis and systematic review of the risks associated with childhood attention-deficit hyperactivity disorder on long-term outcome of arrests, convictions, and incarcerations', *Clinical Psychology Review*, 48, pp.32-42. doi: <https://doi.org/10.1016/j.cpr.2016.05.002>
- ¹⁸¹ Chester, V., Bunning, K., Tromans, S., Alexander, R. and Langdon, P. (2022). 'The prevalence of autism in the criminal justice system: A systematic review', *BJPsych Open*, 8(S1), pp.S45-S46. doi: <https://doi.org/10.1192/bjo.2022.179>
- ¹⁸² Bryan, K., Garvani, G., Gregory, J. and Kilner, K. (2015). 'Language difficulties and criminal justice: the need for earlier identification', *International Journal of Language & Communication Disorders*, 50(6), pp.763-775. doi: <https://doi.org/10.1111/1460-6984.12183>
- ¹⁸³ Barry, R., Anderson, J., Tran, L., Bahji, A., Dimitropoulos, G., Ghosh, S.M., Kirkham, J., Messier, G., Patten, S.B., Rittenbach, K. and Seitz, D. (2024). 'Prevalence of mental health disorders among individuals experiencing homelessness: a systematic review and meta-analysis'. *JAMA Psychiatry*, 81(7), pp.691-699. doi: <https://doi.org/10.1001/jamapsychiatry.2024.0426>
- ¹⁸⁴ Gallagher, A. (2023). *Homelessness amongst autistic people and people with ADHD: a systematic review of the prevalence rates and risk factors and a qualitative exploration of individual experiences*. D Clin Psy thesis. University of Glasgow. Available at: <https://theses.gla.ac.uk/83816/5/2023GallagherDClinPsy.pdf>
- ¹⁸⁵ Brown, M. and McCann, E. (2021). 'Homelessness and people with intellectual disabilities: A systematic review of the international research evidence', *Journal of Applied Research in Intellectual Disabilities*, 34(2), pp. 390-401. doi: <https://doi.org/10.1111/jar.12815>
- ¹⁸⁶ Money and Mental Health (2021). *Closing the gap*. Available at: <https://www.moneyandmentalhealth.org/publications/closing-the-gap/>
- ¹⁸⁷ Parsons, S. and Platt, L. (2022). *Special educational needs and disability: a lifetime of disadvantage in the labour market?*. Available at: <https://cls.ucl.ac.uk/wp-content/uploads/2017/02/CLS-Working-Paper-2022-4-Special-educational-needs-and-disability-a-lifetime-of-disadvantage-in-the-labour-market.pdf>
- ¹⁸⁸ Carroll, C. and Hurry, J. (2018). 'Supporting pupils in school with social, emotional and mental health needs: a scoping review of the literature', *Emotional and Behavioural Difficulties*, 23(3), pp.310-325. doi: <https://doi.org/10.1080/13632752.2018.1452590>
- ¹⁸⁹ Arnberg, A. and Öst, L. G. (2014). 'CBT for children with depressive symptoms: a meta-analysis', *Cognitive Behaviour Therapy*, 43(4), pp.275-288. doi: <https://doi.org/10.1080/16506073.2014.947316>
- ¹⁹⁰ Choo, C. (2014). 'Adapting cognitive behavioral therapy for children and adolescents with complex symptoms of neurodevelopmental disorders and conduct disorders', *Journal of Psychological Abnormalities in Children*, 3, pp.1-3. doi: <http://doi.org/10.4172/2329-9525.1000124>
- ¹⁹¹ Spain, D. and Happé, F. (2020). 'How to optimise cognitive behaviour therapy (CBT) for people with autism spectrum disorders (ASD): A Delphi study', *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 38(2), pp.184-208. doi: <https://doi.org/10.1007/s10942-019-00335-1>
- ¹⁹² Kim, J. and Chung, Y. J. (2023). 'A case study of group art therapy using digital media for adolescents with intellectual disabilities', *Frontiers in Psychiatry*, 14, p.1172079. doi: <https://doi.org/10.3389/fpsy.2023.1172079>
- ¹⁹³ Kovačević, T. R. and Đoković, S. T. (2023). 'Development of artistic expression in deaf and hard of hearing preschool children', *Baština*, 33(60). doi: <https://doi.org/10.5937/bastina33-43061>

-
- ¹⁹⁴ Vogel, S. W., Mullins, K. L. and Kumar, S. (2025). 'Art therapy for children and adolescents with autism: a systematic review', *International Journal of Art Therapy*, 30(2), pp.113-122. doi: <https://doi.org/10.1080/17454832.2024.2343373>
- ¹⁹⁵ Royal National Institute for Deaf People (2024). *Prevalence of deafness and hearing loss*. Available at: <https://rnid.org.uk/get-involved/research-and-policy/facts-and-figures/prevalence-of-deafness-and-hearing-loss/>
- ¹⁹⁶ Akeroyd, M.A. and Munro, K.J. (2024). 'Population estimates of the number of adults in the UK with a hearing loss updated using 2021 and 2022 census data', *International Journal of Audiology*, 63(9), pp.659-660. doi: <https://doi.org/10.1080/14992027.2024.2341956>
- ¹⁹⁷ Ohgami, N., Iida, M., Yajima, I., Tamura, H., Ohgami, K. and Kato, M. (2013). 'Hearing impairments caused by genetic and environmental factors', *Environmental Health and Preventive Medicine*, 18, pp.10-15. doi: <https://doi.org/10.1007/s12199-012-0300-z>
- ¹⁹⁸ Royal National Institute for Deaf People (n.d.). *Types and causes of hearing loss and deafness*. Available at: <https://rnid.org.uk/information-and-support/hearing-loss/types-of-hearing-loss-and-deafness/>
- ¹⁹⁹ U.S. Department of Health and Human Services (n.d). *Sudden deafness*. Available at: <https://www.nidcd.nih.gov/health/sudden-deafness>
- ²⁰⁰ U.S. Department of Health and Human Services. (n.d). *Noise-induced hearing loss*. Available at: <https://www.nidcd.nih.gov/health/noise-induced-hearing-loss>
- ²⁰¹ Sutton, A. E., & Goldman, J. (2025). Syndromic sensorineural hearing loss. In *StatPearls* . StatPearls Publishing. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK526088/#:~:text=Approximately%20half%20of%20congenital%20deafness,ideal%20candidates%20for%20cochlear%20implantation.>
- ²⁰² Wroblewska-Seniuk, K., Greczka, G., Dabrowski, P., Szyfter-Harris, J., & Mazela, J. (2017). Hearing impairment in premature newborns—Analysis based on the national hearing screening database in Poland. *PloS one*, 12(9), e0184359.
- ²⁰³ National Deaf Children's Society (n.d.). *Causes of deafness and hearing loss*. Available at: <https://www.ndcs.org.uk/advice-and-support/all-advice-and-support-topics/causes-types-and-signs-deafness/causes-deafness-and-hearing-loss>
- ²⁰⁴ Vieira-Potter, V. J., Karamichos, D. and Lee, D. J. (2016). 'Ocular complications of diabetes and therapeutic approaches', *BioMed Research International*, 2016(1). doi: <https://doi.org/10.1155/2016/3801570>
- ²⁰⁵ Liu, Y. C., Wilkins, M., Kim, T., Malyugin, B. and Mehta, J. S. (2017). 'Cataracts', *The Lancet*, 390(10094), pp.600-612.
- ²⁰⁶ BMJ Best Practice US., (2024) *Trachoma - Symptoms, diagnosis and treatment*. Available at: <https://bestpractice.bmj.com/topics/en-gb/958#:~:text=Summary.%20Trachoma%20is%20a%20keratoconjunctivitis%20caused%20by,the%20reservoir%20of%20infection%20within%20a%20population.>
- ²⁰⁷ Scase, M. O., & Johnson, M. R. (2005, September). Visual impairment in ethnic minorities in the UK. In *International Congress Series* (Vol. 1282, pp. 438-442). Elsevier.
- ²⁰⁸ Siegfried, C. J., & Shui, Y. B. (2022). Racial disparities in glaucoma: from epidemiology to pathophysiology. *Missouri medicine*, 119(1), 49.
- ²⁰⁹ NHS. (n.d). *Eye tests for children*. Available at: <https://www.nhs.uk/tests-and-treatments/eye-tests-in-children/#:~:text=Causes%20of%20eye%20problems%20in,common%20in%20boys%20than%20girls>
- ²¹⁰ Early Support (2012) *Information about multi-sensory impairment*. PDF. Available at <https://councilfordisabledchildren.org.uk/sites/default/files/uploads/files/earlysupportmulti-sensoryimpairmentsfinal2.pdf>
- ²¹¹ Robertson, J., & Emerson, E. (2010). Estimating the number of people with co-occurring vision and hearing impairments in the UK. *Centre for Disability Research*.

-
- ²¹² Passarello, N., Tarantino, V., Chirico, A., Menghini, D., Costanzo, F., Sorrentino, P., Fucà, E., Gigliotta, O., Alivernini, F., Oliveri, M. and Lucidi, F., (2022). Sensory processing disorders in children and adolescents: Taking stock of assessment and novel therapeutic tools. *Brain sciences*, 12(11), p.1478.
- ²¹³ Hearing Link Services (2024). *What is tinnitus?* Available at: [What is tinnitus? - Hearing Link Services](#)
- ²¹⁴ Jarach, C.M., Lugo, A., Scala, M., van den Brandt, P.A., Cederroth, C.R., Odone, A., Garavello, W., Schlee, W., Langguth, B. and Gallus, S., (2022). Global prevalence and incidence of tinnitus: a systematic review and meta-analysis. *JAMA neurology*, 79(9), pp.888-900.
- ²¹⁵ Rosing, S. N., Schmidt, J. H., Wedderkopp, N., & Baguley, D. M. (2016). Prevalence of tinnitus and hyperacusis in children and adolescents: a systematic review. *BMJ open*, 6(6), e010596.
- ²¹⁶ Tinnitus UK (n.d) *My child has tinnitus*. Available at: <https://tinnitus.org.uk/understanding-tinnitus/support-people/my-child-has-tinnitus/>
- ²¹⁷ National institute on Deafness and Other Communication Disorders (NIDCD) (2023). *What is tinnitus? — Causes and treatment*. Available at: <https://www.nidcd.nih.gov/health/tinnitus>
- ²¹⁸ Ismail, F.Y., Accardo, P.J. and Shapiro, B.K. eds., (2024). *Capute and Accardo's neurodevelopmental disabilities in infancy and childhood*. Elsevier.
- ²¹⁹ Tower Hamlets. (2021). *2021 Census — findings*. Available at: <https://explore-education-statistics.service.gov.uk/data-tables/school-pupils-and-their-characteristics>
- ²²⁰ Newman, L., & Chadwick, R. (2022). Supporting language development in deaf children with cochlear implants from low-income families. *BATOD (British Association of Teachers of the Deaf) Magazine*, 17-19.
- ²²¹ Newman, L., & Chadwick, R., (2023). Diversity and Communication Needs of Deaf Children with Cochlear Implants in Tower Hamlets. In *Royal College of Speech and Language Therapists, RCSLT*, pp. 36–37
- ²²² Tower Hamlets. (2021). *2021 Census — findings*. Available at: <https://explore-education-statistics.service.gov.uk/data-tables/school-pupils-and-their-characteristics>
- ²²³ NHS (2024). *Newborn Hearing Screening*. Available at: <https://www.nhs.uk/baby/newborn-screening/hearing-test/#:~:text=The%20AABR%20test%20involves%20placing,your%20baby%20in%20any%20way>
- ²²⁴ Walker, A. (2025). Hearing loss in children: spotting the signs and how it's treated. Spire Healthcare. Available at: <https://www.spirehealthcare.com/health-hub/specialties/childrens-health/hearing-loss-in-children-spotting-the-signs-and-how-it-s-treated/#:~:text=If%20you%20have%20noticed%20any,Temporary%20hearing%20loss>
- ²²⁵ NHS (n.d.). *Hearing loss and deafness*. Available at: <https://cambsporochildrenshealth.nhs.uk/services/cambridgeshire-childrens-speech-and-language-therapy-service/common-speech-language-and-communication-concerns/hearing-loss-and-deafness/#:~:text=Have%20concerns%20about%20your%20child's,Last%20reviewed:%20>
- ²²⁶ NHS (n.d.). *Eye tests for children*. Available at: <https://www.nhs.uk/tests-and-treatments/eye-tests-in-children/#:~:text=The%20red%20reflex%20test%20is,sign%20of%20an%20eye%20problem>
- ²²⁷ Sense for Early Support. (n.d.). *Information About Multi-sensory Impairments*. Available at: <https://councilfordisabledchildren.org.uk/sites/default/files/uploads/files/earllysupportmulti-sensoryimpairmentsfinal2.pdf>
- ²²⁸ Sense (n.d.) *Requesting a care needs assessment in relation to deafblind children and adults*. Available at: <https://www.sense.org.uk/information-and-advice/life-with-complex-disabilities/deafblind-guidance/requesting-a-care-needs-assessment-in-relation-to-deafblind-children-and-adults/>
- ²²⁹ NHS England. (2024). *Newborn hearing screening pathway requirements*. Available at: <https://www.gov.uk/government/publications/newborn-hearing-screening-pathway-requirements-specification/newborn-hearing-screening-pathway-requirements-specification#:~:text=The%20NHS%20offers%20newborn%20hearing,screening%20in%20the%20programme%20overview>

-
- ²³⁰ National Deaf Children's Society. (2025). *Newborn hearing screening*. Available at: <https://www.ndcs.org.uk/advice-and-support/all-advice-and-support-topics/causes-types-and-signs-deafness/newborn-hearing-screening>
- ²³¹ NHS (n.d.) Diagnosis: Deafblindness. Available at: <https://www.nhs.uk/conditions/deafblindness/diagnosis/>
- ²³² Sense. (n.d.) *Route map to meeting the needs of Deafblind Children and young people in the new send system*. Available at: <https://www.sense.org.uk/information-and-advice/for-professionals/resources-for-education-and-early-years-professionals/route-map-to-meeting-the-needs-of-deafblind-children/>
- ²³³ NHS England (2025). *Accessible information standard*. Available at: [NHS England » About the standard](#)
- ²³⁴ Deaf and hard of hearing people's healthcare experiences (2024) *Healthwatch*. <https://www.healthwatch.co.uk/blog/2024-04-10/deaf-and-hard-hearing-peoples-healthcare-experiences>
- ²³⁵ RNID (2025) *Still ignored: The fight for accessible Healthcare*. <https://rnid.org.uk/wp-content/uploads/2020/05/AIS-policy-report-England-UPDATED.pdf>
- ²³⁶ Bailey, T., & Lavery, C., (2018). *Good practice? Why people who are deaf or have hearing loss are still not getting accessible information from their GP*. Available at: <https://rnid.org.uk/wp-content/uploads/2020/07/Good-practice-full-report.pdf>
- ²³⁷ Barasche-Berdah, D., Paltiel, O. and Raz, R., (2023). Active lifestyle and mobility of adults with vision impairment: A multiphase mixed-methods study. *International Journal of Environmental Research and Public Health*, 20(19), p.6839.
- ²³⁸ Beverley, C.A., Bath, P.A. and Booth, A., (2004). Health information needs of visually impaired people: a systematic review of the literature. *Health & Social Care in the Community*, 12(1), pp.1-24.
- ²³⁹ Remillard, E.T., Koon, L.M., Mitzner, T.L. and Rogers, W.A., (2024). Everyday challenges for individuals aging with vision impairment: Technology implications. *The Gerontologist*, 64(6), p.gnad169.
- ²⁴⁰ Healthwatch Royal Borough of Kensington and Chelsea. (2025). *How accessible is your healthcare?* Healthwatch RBKC. Available at: <https://www.healthwatchrbkc.org.uk/blog/2025-06-12/how-accessible-your-healthcare>
- ²⁴¹ Edmondson, S. and Howe, J., (2019). Exploring the social inclusion of deaf young people in mainstream schools, using their lived experience. *Educational Psychology in Practice*, 35(2), pp.216-228.
- ²⁴² Winiger, A.M., Alexander, J.M. and Diefendorf, A.O., (2016). Minimal hearing loss: From a failure-based approach to evidence-based practice. *American journal of audiology*, 25(3), pp.232-245.
- ²⁴³ Tomblin, J. B., Harrison, M., Ambrose, S. E., Walker, E. A., Oleson, J. J., & Moeller, M. P. (2015). Language outcomes in young children with mild to severe hearing loss. *Ear and hearing*, 36, 765-915.
- ²⁴⁴ Tadić, V., Pring, L. and Dale, N., (2010). Are language and social communication intact in children with congenital visual impairment at school age?. *Journal of Child Psychology and Psychiatry*, 51(6), pp.696-705.
- ²⁴⁵ Meier, S., Höger, B., & Giese, M. (2023). "If only balls could talk...": barriers and opportunities to participation for students with blindness and visual impairment in specialized PE. *Frontiers in Sports and Active Living*, 5, 1286909.
- ²⁴⁶ Linsenbigler, K., Petersen, S., & Lieberman, L. (2018). Barriers to physical activity for children with visual impairments: How far have we come and where do we still need to go?. *Palaestra*, 32(1).
- ²⁴⁷ Early Support (2012). *Information about multi-sensory impairment*, 4th edition
- ²⁴⁸ Sense (2002) *Breaking Out: opening the community for deafblind children and young people: a Sense Campaign Report*. London: Sense.
- ²⁴⁹ Möller, K. and Danermark, B., (2007) Social recognition, participation, and the dynamic between the environment and personal factors of students with deafblindness. *American annals of the deaf*, 152(1), pp.42-55.
- ²⁵⁰ Schlumberger, E., Narbona, J. and Manrique, M., (2004). Non-verbal development of children with deafness with and without cochlear implants. *Developmental medicine and child neurology*, 46(9), pp.599-606.

-
- ²⁵¹ Hindley, P., (1997). Psychiatric aspects of hearing impairments. *Journal of child psychology and psychiatry*, 38(1), pp.101-117.
- ²⁵² Roland, L., Fischer, C., Tran, K., Rachakonda, T., Kallogjeri, D. and Lieu, J.E., (2016). Quality of life in children with hearing impairment: systematic review and meta-analysis. *Otolaryngology–Head and Neck Surgery*, 155(2), pp.208-219.
- ²⁵³ Woodcock, K. and Pole, J.D., (2008). Educational attainment, labour force status and injury: a comparison of Canadians with and without deafness and hearing loss. *International Journal of Rehabilitation Research*, 31(4), pp.297-304.
- ²⁵⁴ Idstad, M. and Engdahl, B., (2019). Childhood sensorineural hearing loss and educational attainment in adulthood: results from the HUNT study. *Ear and Hearing*, 40(6), pp.1359-1367.
- ²⁵⁵ Haukedal, C.L., Lyxell, B. and Wie, O.B., (2020). Health-related quality of life with cochlear implants: the children’s perspective. *Ear and hearing*, 41(2), pp.330-343.
- ²⁵⁶ Ching, T.Y., Dillon, H., Leigh, G. and Cupples, L., (2018). Learning from the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study: Summary of 5-year findings and implications. *International journal of audiology*, 57(sup2), pp.S105-S111.
- ²⁵⁷ Korver, A.M., Konings, S., Dekker, F.W., Beers, M., Wever, C.C., Frijns, J.H., Oudesluys-Murphy, A.M. and DECIBEL Collaborative Study Group, (2010). Newborn hearing screening vs later hearing screening and developmental outcomes in children with permanent childhood hearing impairment. *Jama*, 304(15), pp.1701-1708.
- ²⁵⁸ Hogan, A., Phillips, R.L., Howard, D. and Yiengprugsawan, V., (2014). Psychosocial outcomes of children with ear infections and hearing problems: a longitudinal study. *BMC pediatrics*, 14(1), p.65.
- ²⁵⁹ Hamblion, E.L., Moore, A.T. and Rahi, J.S., (2011). The health-related quality of life of children with hereditary retinal disorders and the psychosocial impact on their families. *Investigative ophthalmology & visual science*, 52(11), pp.7981-7986.
- ²⁶⁰ Huurre, T.M. and Aro, H.M., (1998). Psychosocial development among adolescents with visual impairment. *European child & adolescent psychiatry*, 7(2), pp.73-78.
- ²⁶¹ DeCarlo, D.K., McGwin Jr, G., Bixler, M.L., Wallander, J. and Owsley, C., (2012). Impact of pediatric vision impairment on daily life: results of focus groups. *Optometry and Vision Science*, 89(9), pp.1409-1416.
- ²⁶² Kiely, K.M., Anstey, K.J. and Luszcz, M.A., (2013). Dual sensory loss and depressive symptoms: the importance of hearing, daily functioning, and activity engagement. *Frontiers in human neuroscience*, 7, p.837.
- ²⁶³ Brennan, M., Horowitz, A. and Su, Y.P., (2005). Dual sensory loss and its impact on everyday competence. *The Gerontologist*, 45(3), pp.337-346.
- ²⁶⁴ Harada, S., Nishiwaki, Y., Michikawa, T., Kikuchi, Y., Iwasawa, S., Nakano, M., Ishigami, A., Saito, H. and Takebayashi, T., (2008). Gender difference in the relationships between vision and hearing impairments and negative well-being. *Preventive medicine*, 47(4), pp.433-437.
- ²⁶⁵ Ehrlich, J.R., Ramke, J., Macleod, D., Burn, H., Lee, C.N., Zhang, J.H., Waldock, W., Swenor, B.K., Gordon, I., Congdon, N. and Burton, M., (2021). Association between vision impairment and mortality: a systematic review and meta-analysis. *The Lancet Global Health*, 9(4), pp.e418-e430.
- ²⁶⁶ Rune, J., (2018). At risk of exclusion from CRPD and SDGs implementation: inequality and persons with deafblindness. *World Federation of the Deafblind: Oslo, Norway*.
- ²⁶⁷ Yoshinaga-Itano, C., (2003). From screening to early identification and intervention: Discovering predictors to successful outcomes for children with significant hearing loss. *Journal of deaf studies and deaf education*, 8(1), pp.11-30.
- ²⁶⁸ Scarinci, N., Erbas, E., Moore, E., Ching, T.Y. and Marnane, V., (2018). The parents’ perspective of the early diagnostic period of their child with hearing loss: Information and support. *International journal of audiology*, 57(sup2), pp.S3-S14.

-
- ²⁶⁹ Eleweke, C.J., Gilbert, S., Bays, D. and Austin, E., (2008). Information about support services for families of young children with hearing loss: A review of some useful outcomes and challenges. *Deafness & Education International*, 10(4), pp.190-212.
- ²⁷⁰ Aljedaani, W., Krasniqi, R., Aljedaani, S., Mkaouer, M.W., Ludi, S. and Al-Raddah, K., (2023). If online learning works for you, what about deaf students? Emerging challenges of online learning for deaf and hearing-impaired students during COVID-19: a literature review. *Universal access in the information society*, 22(3), pp.1027-1046.
- ²⁷¹ Eriks-Brophy, A., Durieux-Smith, A., Olds, J., Fitzpatrick, E., Duquette, C. and Whittingham, J., (2006). Facilitators and barriers to the inclusion of orally educated children and youth with hearing loss in schools: promoting partnerships to support inclusion. *Volta Review*, 106(1).
- ²⁷² Humphries, T., Mathur, G., Napoli, D. J., Padden, C., & Rathmann, C. (2022). Deaf children need rich language input from the start: Support in advising parents. *Children*, 9(11), 1609.
- ²⁷³ Tören, Z. and Gökçeşlan, E., (2024). Family Life of Parents With Visual Disabilities and Their Sighted Children: How their Families Could Be Empowered From the Social Work Point of View. *SAGE Open*, 14(3), p.21582440241268699.
- ²⁷⁴ Lanza, M., Incagli, F., Ceccato, C., Reffo, M. E., Mercuriali, E., Parmeggiani, F., ... & Guastafierro, E. (2024). Quality of life, functioning and participation of children and adolescents with visual impairment: A scoping review. *Research in Developmental Disabilities*, 151, 104772.
- ²⁷⁵ Veldhorst, C., Vervloed, M., Kef, S. and Steenbergen, B., (2023). A scoping review of longitudinal studies of children with vision impairment. *British Journal of Visual Impairment*, 41(3), pp.587-609.
- ²⁷⁶ RNIB (2016). *Information about vision impairment: Guide for parents*. Available at: [Information about vision impairment Guide for parents](#)
- ²⁷⁷ Aanondsen, C.M., Jozefiak, T., Lydersen, S., Heiling, K. and Rimehaug, T., (2023). Deaf and hard-of-hearing children and adolescents' mental health, quality of life and communication. *BMC psychiatry*, 23(1), p.297.
- ²⁷⁸ Sense for Early Support (2012). *Information About Multi-sensory Impairments* <https://councilfordisabledchildren.org.uk/sites/default/files/uploads/files/earllysupportmulti-sensoryimpairmentsfinal2.pdf>
- ²⁷⁹ NHS England (2023) *Down Syndrome (trisomy 21)*. National Genomics Education Programme. Available at: [Down syndrome \(trisomy 21\) — Knowledge Hub](#)
- ²⁸⁰ Ma, Y., Liu, M., Liu, Y., Liu, D. and Hou, M., (2024) Exploring physical activity in children and adolescents with disabilities: A bibliometric review of current status, guidelines, perceived barriers, and facilitators and future directions. In *Healthcare* (Vol. 12, No. 9, p. 934). MDPI.
- ²⁸¹ SCOPE (2024). *Eating difficulties*. Available at: [Eating difficulties | Disability charity Scope UK](#)
- ²⁸² NHS. (2024). *How to care for a disabled child*. Available at: [How to care for a disabled child - Social care and support guide - NHS](#)
- ²⁸³ RSPCH (2024). *The role of paediatricians in children and young people's mental health – position statement 2024*. Available at: [The role of paediatricians in children and young people's mental health - position statement 2024 | RCPCH](#)
- ²⁸⁴ Michael, A. and Marder, E., (2021). Keeping children and young people with Down syndrome healthy. *Paediatrics and Child Health*, 31(9), pp.340-346.
- ²⁸⁵ NHS Inform (2025). *Down Syndrome*. Illness and conditions. Available at: [Down's syndrome | NHS inform](#)
- ²⁸⁶ Caldwell, A.R., Kim, Y., Alshahwan, N., Vellody, K., Bendixen, R.M., Renz, K., Duong, T., Dodd, J., Terhorst, L. and Must, A., (2023). Parental perception of facilitators and barriers to health among young children with down syndrome: a qualitative study. *Frontiers in Pediatrics*, 11, p.1155850.
- ²⁸⁷ Bull, M. J. (2020). *Down syndrome*. *New England Journal of Medicine*, 382(24), 2344–2352. <https://doi.org/10.1056/NEJMr1706537>

-
- ²⁸⁸ Bertapelli, F., Pitetti, K., Agiovlasitis, S., & Guerra-Junior, G. (2016). *Overweight and obesity in children and adolescents with Down syndrome—Prevalence, determinants, consequences, and interventions: A literature review. Research in Developmental Disabilities, 57*, 181–192. <https://doi.org/10.1016/j.ridd.2016.07.003>
- ²⁸⁹ Foley, K. R., & Lloyd, M. (2018). *Barriers and facilitators of physical activity participation for children and adolescents with Down syndrome: A review. Journal of Intellectual Disability Research, 62*(3), 312–322. <https://doi.org/10.1111/jir.12467>
- ²⁹⁰ Hilderley, E. and Rhind, D.J., (2012). Including children with cerebral palsy in mainstream physical education lessons: a case study of student and teacher experiences. *Graduate Journal of Sport, Exercise & Physical Education Research, 1*, pp.1-15
- ²⁹¹ Verschuren, O., Peterson, M.D., Balemans, A.C. and Hurvitz, E.A., (2016). Exercise and physical activity recommendations for people with cerebral palsy. *Developmental Medicine & Child Neurology, 58*(8), pp.798-808.
- ²⁹² Ferluga, E.D., Archer, K.R., Sathe, N.A., Krishnaswami, S., Klint, A., Lindegren, M.L. and McPheeters, M.L., (2013). Interventions for feeding and nutrition in cerebral palsy.
- ²⁹³ Curtin, M. and Clarke, G., (2005). Listening to young people with physical disabilities' experiences of education. *International Journal of Disability, Development and Education, 52*(3), pp.195-214.
- ²⁹⁴ Children's Commissioner (2024). *The Big Ambition*. Available at: [The Big Ambition | Children's Commissioner for England](#)
- ²⁹⁵ Healthwatch Tower Hamlets (2023). *Healthy Neighbourhoods in Tower Hamlets*. Available at: https://www.healthwatchtowerhamlets.co.uk/sites/healthwatchtowerhamlets.co.uk/files/Healthy%20Neighbourhoods%20Report%20-%20Final%20Version_1.pdf
- ²⁹⁶ NHS Practitioner Health (n.d). *Disability, Health and Wellbeing*. Available at: [Disabilities: Health and Wellbeing](#)
- ²⁹⁷ NHS Practitioner Health (n.d). *Disability, Health and Wellbeing*. Available at: [Disabilities: Health and Wellbeing](#)
- ²⁹⁸ National Institute for Health and Care Excellence. (2022). *Disabled children and young people up to 25 with severe complex needs (NICE guideline NG213)*. <https://www.nice.org.uk/guidance/ng213>
- ²⁹⁹ Office for Health Improvement & Disparities (2022). *Physical activity for general health benefits in disabled children and disabled young people: rapid evidence review*. Available at: [Physical activity for general health benefits in disabled children and disabled young people: rapid evidence review - GOV.UK](#)
- ³⁰⁰ UK Chief Medical Officer (2022). *Physical Activity for Disabled Children and Disabled Young People*. Available at: [UK Chief Medical Officers' physical activity guidelines for disabled children and disabled young people: infographic](#)
- ³⁰¹ Akhtar, F. and Bokhari, R, A., (2023). *Down Syndrome*. National Library of Medicine. Available at: [Down Syndrome - StatPearls - NCB Bookshelf](#)
- ³⁰² Bertapelli, F., Pitetti, K., Agiovlasitis, S. and Guerra-Junior, G., (2016). Overweight and obesity in children and adolescents with Down syndrome—prevalence, determinants, consequences, and interventions: A literature review. *Research in developmental disabilities, 57*, pp.181-192.
- ³⁰³ Down Syndrome (n.d). *Healthy Lifestyle and Sports*. Down's Syndrome Association. Available at: [Healthy Lifestyle & Physical Activity - Downs Syndrome Association](#)
- ³⁰⁴ Buschmann, A., Jooss, B., Rupp, A., Feldhusen, F., Pietz, J. and Philippi, H., (2009). Parent based language intervention for 2-year-old children with specific expressive language delay: a randomised controlled trial. *Archives of disease in childhood, 94*(2), pp.110-116.
- ³⁰⁵ Daunhauer, L.A., Schworer, E. and Howshar, M., (2017). Parenting matters: Parent–child interactions in down syndrome and recommendations for future research. *International review of research in developmental disabilities, 53*, pp.1-43.

³⁰⁶ NHS England (2025). *Commissioning framework for children and young people with cerebral palsy*. Available at: [NHS England » Commissioning framework for children and young people with cerebral palsy](#)

³⁰⁷ Down Syndrome International (2020). *International Guidelines for the Education of Learners with Down Syndrome*. Available at: [International Guidelines for the Education of Learners with Down Syndrome - DSi - July 2020-1.pdf](#)

³⁰⁸ Children's Commissioner (2024). *The Big Ambition: Ambitions, findings and solutions*. Available at: [The Big Ambition | Children's Commissioner for England](#)