



Institute for Fiscal Studies

IFS Green Budget Chapter

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Support for children with disabilities and special educational needs

5. Support for children with disabilities and special educational needs

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Key findings

- 1. Recent years have seen a dramatic increase in the number of children receiving support in schools for special educational needs and through the benefit system for disabilities.** The share of pupils under 16 in England with Education and Health Care Plans (EHCPs) – the highest level of support for children with special educational needs – almost doubled from 2.7% in 2016 to 5.2% in 2025. Over the same period, the share of children receiving child disability living allowance (CDLA) – a cash benefit for children with disabilities – has more than doubled from 3.4% to 7.2%. Forecasts suggest that, absent reform, uptake of both forms of support will continue to grow.
- 2. Spending on educational support for children with high needs has also increased dramatically, putting pressure on local and central government finances.** High-needs spending by councils, which predominantly covers additional support for those with EHCPs, has increased by 66% from £7½ billion in 2016 to at least £12 billion in 2025, after adjusting for inflation. We forecast that spending on high needs will rise by a further £3 billion by 2029 without any reforms, taking it above total day-to-day spending by the Ministry of Justice.
- 3. Councils have little control over this spending as it is determined by the statutory provision set out in EHCPs. Since the cost of provision has exceeded funding provided by central government, local authorities have faced large annual shortfalls.** The resulting debts are forecast to reach £8 billion by 2028. This is not financially sustainable. Local authorities are not normally allowed to borrow for day-to-day spending and a ‘statutory override’ of these rules for school spending is set to expire in 2028. If left unchecked – and without top-ups to school spending plans – these spending pressures will likely imply real-terms cuts to mainstream school

spending per pupil. **Given the scale and growth of spending, and the risks that they pose, the Office for Budget Responsibility should produce and publish annual forecasts for high-needs spending and high-needs deficits.**

4. **Spending on CDLA doubled from £2 billion per year in 2016 to over £4 billion in 2025.** The government spends another £4 billion on means-tested benefit payments – carer’s allowance, universal credit disabled child element and universal credit carer’s element – to the families of children with qualifying disabilities. Official forecasts suggest that spending on CDLA in England will grow by a further £1.8 billion (41%) in real terms over the next five years without reform and we might expect similar growth in related means-tested benefit payments. Together with rising spending on EHCPs, this will put increasing strain on the government’s finances.
5. **There is substantial overlap between children receiving special educational support and children receiving support for a disability through the benefit system.** Of the 141,000 12- to 15-year-olds who received CDLA in England at the start of 2020, 84% had an identified special educational need and 52% had an EHCP. Of the 95,000 12- to 15-year-olds in England with an EHCP, 77% received CDLA. This overlap suggests common factors are driving the large rise in identified need seen for both.
6. **Growth in the number of children receiving support relating to autism and to ADHD (attention deficit hyperactivity disorder) can explain much of the rise in both EHCPs and CDLA claims.** The number of children with EHCPs for autism spectrum disorder has almost tripled from 54,000 in 2015 to 149,000 in 2025, accounting for 40% of the total increase in EHCPs. The number of children with EHCPs for ‘social, emotional and mental health needs’, which includes ADHD, has also more than doubled, from 28,000 to 71,000. Similarly, most of the increase in CDLA claims is due to increased claims in three categories of conditions: learning difficulties (including autism), behavioural disorders and ADHD. A large part of this increase in recognised need is due to increased awareness of these conditions, although there may also be increases in underlying prevalence of the conditions. Past squeezes on school budgets may also have acted as an incentive for parents and schools to seek EHCPs in order to access extra resources.
7. **Those who received support for their special educational needs and disabilities as children are likely to be out of work and to receive additional state support when they reach early adulthood.** At age 22, those who had received both CDLA and an EHCP at age 15 were three times more likely to be not in education, employment or training than their peers (50% relative to 16%), four times more likely to

be on out-of-work benefits (60% relative to 16%) and 23 times more likely to be on adult disability benefits (76% relative to 3%). In part, this will be due to many disabilities enduring into adulthood. But it is also possible that greater numbers of children with identified needs through EHCPs or CDLA will directly lead to greater numbers of young adults out of work and/or on health-related benefits. The evidence base here is worryingly thin, but this is a big risk: it would make it harder for the government to hit its 80% employment rate target and add to the government's spending pressures. The government should review which forms of support aid young people to thrive in adulthood.

8. **Boys, older children and children from poorer families are more likely to receive additional support in the education and benefit systems.** More than two-thirds of children with EHCPs or CDLA are boys, making boys twice as likely to get support. Nearly 6% of 15-year-olds have an EHCP compared with 3.6% of 4-year-olds. An even steeper age gradient exists for CDLA: 9.6% of 15-year-olds receive CDLA compared with 5.7% of 4-year-olds. In 2020, around two in five 12- to 15-year-olds with an EHCP or receiving CDLA were eligible for free school meals, twice the average rate among this age group. Any change to the health-related support system will have big impacts on the distribution of support by gender, age group and income.
9. **There are big differences across ethnic groups in the share of children receiving support relating to a special educational need or disability.** Among those aged 12–15 in 2020, 2.0% of pupils from the Indian ethnic group had an EHCP compared with 4.3% among the White British population and 5.7% amongst the Black Caribbean population. Some of these differences can be explained by different levels of income across groups, but there remain large ethnicity gaps when looking only at children who are eligible for free school meals. These stark differences likely reflect a combination of different levels of needs across different ethnic groups and differences in norms, awareness and access to services.
10. **There is a strong case for the government to review all systems of support for children with special educational needs and disabilities.** It has already committed to reviewing and reforming the special educational needs system; it makes sense to review other forms of support for children with disabilities at the same time. There is a particularly strong case for reviewing CDLA, which has remained broadly unchanged since its introduction over 30 years ago in 1992, despite large changes in the health of young people, to healthcare and to the broader benefit system. The government should also investigate how it can improve support for children with autism and ADHD in mainstream schooling.

5.1 Introduction

The question of how best to support children and young people with special educational needs in schools in England is rising up the government's agenda. More and more children are applying for and receiving targeted support relating to special educational needs or a disability. Spending has risen by two-thirds in real terms since 2016, with this growth accounting for about half of the total increase in school spending in recent years. Council budgets have also come under strain as funding provided by central government has not covered the full cost of additional support that councils are legally obliged to provide. In response, the government has made clear its ambitions to reform the system of support for young people with special educational needs and disabilities (SEND) in England. It plans to publish a White Paper in Autumn 2025.

Spending pressures relating to children with disabilities are not limited to schools. Families of children with disabilities can apply for additional support through the benefits system. Child disability living allowance (CDLA) provides cash support to help with the extra costs of looking after a child who has a disability, and the disabled child element of universal credit provides additional means-tested support to low-income families. Despite receiving less focus from the media or government than rising SEND spending in schools, the number of children claiming CDLA and real-terms spending on CDLA both more than doubled between 2015 and 2025. This growth has outstripped the high growth in disability benefit claims among working-age adults over this period.

Increased demand for assessment for learning and behavioural conditions has put NHS services under strain: the number of under-18s being referred for an NHS assessment of autism has more than tripled from 2,300 a month in April 2019 to 7,900 a month in April 2025, and average waiting times for assessment stand at over a year.¹ Over the last five years, there has been a 10% increase in the number of children receiving support from social services with an identified disability.

The high and rising costs of SEND in schools and of CDLA are putting increasing pressure on the government's finances. Rising costs make it harder to respond to other spending needs. High levels of uncertainty raise questions about whether current spending plans are credible. For example, rapid rises in spending on SEND have led this and recent governments to make almost annual top-ups to the schools budget. It is therefore crucial for policymakers to understand the factors driving rising costs so as to improve forecasts and understanding of how best to reform the systems of support.

¹ <https://digital.nhs.uk/data-and-information/publications/statistical/autism-statistics/july-2024-to-june-2025>.

Looking across different parts of the system can also help the government understand what is driving increased demand for support. If we see similar patterns across different elements of the welfare state, this may point to a common underlying trend – for instance, in children’s health. If instead there are patterns specific to certain elements of support, this might point to other causes such as policy reforms around eligibility criteria or specific support available. We focus our comparison on support for children with special educational needs and disabilities in schools and the benefit system, while drawing on evidence from other areas of the welfare state where possible.

The government also needs to look at the longer-term impacts of support provided to children with special educational needs and disabilities. Whilst most focus is on immediate financial support for families or support to access education, it is also important for children’s long-term well-being that the government provides support that gives them the best chance possible of thriving in adulthood. This may also have benefits for the public finances as the long-run fiscal costs of someone being out of work and on health-related benefits for much of their adult life will outweigh the costs of providing high-quality support to them in childhood. We will provide some evidence in this chapter on the outcomes in early adulthood of children who did receive support for special educational needs and disabilities, although much more evidence is needed on what forms of support actually improve outcomes in adulthood.

Section 5.2 explains what support is on offer. We then document the increasing numbers of people receiving support and the extent to which the same children are receiving different types of support in Section 5.3. Section 5.4 looks at the types of needs that make up the rise in numbers, and Section 5.5 looks at the demographics of those receiving support. We discuss the rise in spending on this support in Section 5.6. We then look at outcomes in school (Section 5.7) and young adulthood (Section 5.8) for those who receive support. Finally, Section 5.9 sets out possible reforms for each system and concludes with potential implications for the Autumn Budget.

At age 16, the benefits available to young people with disabilities in England change. Also, both the benefit system and the education system differ in the constituent parts of the UK. We discuss the consequences of these differences in the chapter but, unless otherwise stated, our analysis focuses on children aged 15 and under in England. Nevertheless, many of the issues raised will be relevant to Scotland, Wales and Northern Ireland.

5.2 What support is available?

Benefits

Child disability living allowance (CDLA) is the main cash benefit available to (the parents of) children aged under 16 in England and Wales who have mobility difficulties and/or who require significantly greater care than average for children of their age. The amount received depends on the severity of the child's mobility and care needs, with each banded into different rates.

Claimants on average receive £5,700 per year, but awards can range from £1,500 per year to £9,700 per year (all in 2025–26 prices). In addition to this, having a child who claims CDLA can also entitle parents to other 'passport benefits' – for instance, those on universal credit can receive the 'disabled child element' for children in their household who are receiving CDLA, and those caring for children on higher rates of CDLA may be eligible for carer's allowance and/or the 'carer's element' in universal credit. Once a child reaches age 16, existing CDLA claimants are asked to apply for personal independence payment (PIP), which is available for adults who have higher living costs as a result of health conditions or disabilities. Those who apply and are awaiting their PIP assessment continue to receive CDLA until they are assessed for PIP, and then they either move onto PIP if they pass the PIP assessment or they lose their award. We discuss this transition in more detail in Section 5.8.

Education

Most pupils who are identified as having special educational needs or disabilities (SEND) receive 'SEN support' within mainstream schools. This support is expected to be provided by schools as part of their general offer and is typically not highly specialist or high cost. When a child has more complex needs that cannot be met by mainstream schools' ordinary SEN support, families can apply for Education, Health and Care Plans (EHCPs), which set out the educational, health and social care support that councils and schools are required to ensure the named person receives. This may include specified weekly hours of one-to-one time with teaching assistants or a placement in a special school. Young people in education up to 25 years of age may have an EHCP, but here we focus on those in schools. Throughout this chapter, we will use 'SEN support' to describe lower-level support within mainstream schools and 'EHCPs' to describe higher-level support in either mainstream schools or specialist schools.²

The most widely used measure of spending on SEND is the level of 'high-needs' spending, which is approximately £12 billion in 2025. While mainstream schools must fund the first £6,000 in support for each pupil with special educational needs, high-needs spending comes from councils and covers costs above this £6,000 threshold in mainstream schools as well as the

² Before 2014, pupils could receive 'statements of SEN', which were roughly equivalent to EHCPs in providing statutory SEND support; for the sake of brevity, we use EHCP to refer to either an EHCP or a statement of SEN.

full cost of places in special schools. In practice, this means that high-needs spending mostly goes on pupils with EHCPs as the costs of SEN support are mostly covered by schools. Mainstream schools receive a ‘notional SEN budget’ as part of their main funding allocation, which is meant to cover their share of the costs. However, there is no clear way to track this spending by schools. We therefore focus on councils’ high-needs funding and spending, which is a key subset of total SEND spending.

Other forms of support

Beyond the two forms of support that we focus on in this chapter, social care and health services provide a range of other support for children with disabilities. Social care services will vary across councils but can include helping families with personal or respite care, paying for home adaptations or providing direct payments to families. Naturally, much healthcare is provided by the NHS – for instance, through referrals to specialist services. NHS professionals will also typically provide diagnoses of specific conditions, which can help to unlock further forms of support.

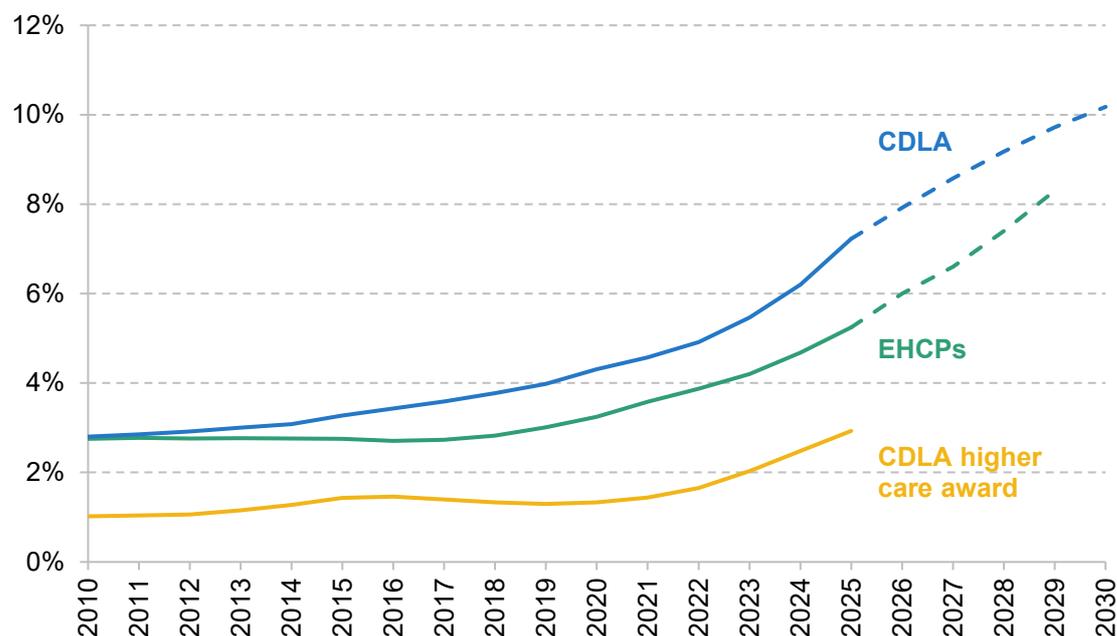
5.3 How many children receive support?

In 2025, 1.6 million pupils under 16 (almost 20% of pupils under 16) received support for special educational needs in England. Of these, 1.2 million received the lower-tier of ‘SEN support’ and 420,000 had the higher-tier support of an EHCP. In the same year, 760,000 under-16s in England received CDLA.³

Figure 5.1 shows that the numbers in receipt of CDLA and EHCPs have increased significantly over time. Between 2010 and 2025, the share of pupils under 16 in England with an EHCP rose from 2.8% to 5.2% and the share of children under 16 receiving CDLA has more than doubled from 2.8% to 7.2%. Among 4- to 15-year-olds (a more comparable group to pupils), the share with CDLA is even higher at 8.9% in 2025. The trends for each follow slightly different patterns, with the increase in CDLA claimants starting earlier and increasing more gradually over the entire period since 2010, while the increase in pupils with EHCPs has mostly occurred since 2018; however, both have seen steep increases over the past few years. The number of CDLA claimants with the highest level of care needs has increased particularly sharply since around 2020. Finally, the share of pupils with SEN support but not an EHCP (not shown in Figure 5.1) has fluctuated more dramatically since 2010 but has seen a consistent increase over the last decade from 11.6% of pupils in 2016 to 14.0% in 2025.

³ Throughout, we focus on pupils with EHCPs and children receiving CDLA, with the latter therefore incorporating more children under 5. As such, the populations for each are slightly different which is why relative differences in numbers may not perfectly map to differences in the share of the relevant population.

Figure 5.1. Share of pupils under 16 with EHCPs and share of children under 16 receiving CDLA, out-turns and forecasts



Note and source: CDLA data from Department for Work and Pensions (DWP)'s Stat-Xplore (<https://stat-xplore.dwp.gov.uk/>). Forecasts are based on DWP caseload and expenditure tables forecasts. We adjust the forecasts to cover only England rather than England and Wales by applying estimated growth rates in CDLA caseload from Office for Budget Responsibility forecasts to the English caseload in 2025. Population estimates for 2010–24 from Nomis, population projections for 0- to 15-year-olds after 2024 from Office for National Statistics population projections available on Nomis (<https://www.nomisweb.co.uk/>). EHCP figures refer to January of selected year and CDLA figures refer to February of selected year. EHCP numbers only encompass school pupils and are taken from Department for Education's SEN in England statistics (<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>), while CDLA numbers encompass all children under 16 although relatively few children under 4 receive CDLA. Statements of SEN are included in EHCP numbers.

Comparing the trends in caseloads for the two forms of support can help us understand the potential drivers of the increase in each. There have been changes to SEND policy, most notably the 2014 Children and Families Act, which are often given as an explanation for recent rises in EHCPs (or equivalent statutory SEN support). In contrast, there have been no major policy changes to the child disability benefits system since the introduction of CDLA in 1992. The fact that we still see a consistent rise in CDLA claims suggests that there has been a change in underlying demand for support, and that policy reforms are unlikely to be responsible for the entire increase in EHCPs. The increase in underlying demand for cash support may be due to changing awareness of certain conditions (by families and by the health system), changing prevalence of conditions, changes in economic conditions or some combination of all three. As we explore in Section 5.4, there seem to be global trends in expanded recognition and diagnosis of certain conditions such as autism and ADHD (attention deficit hyperactivity disorder) that are also a key part of the explanation for these increases in EHCPs and CDLA caseloads. The 2014

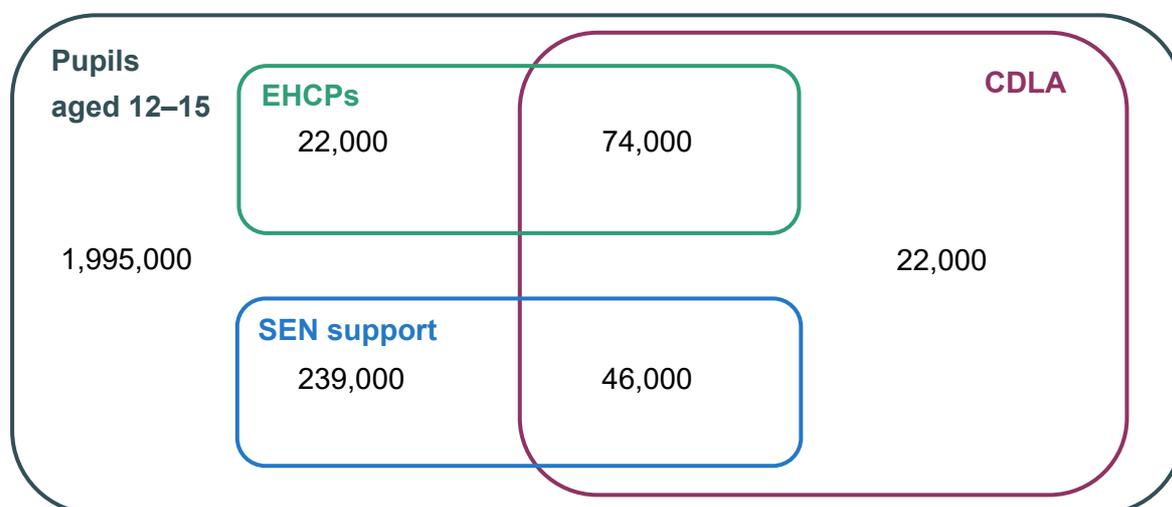
Children and Families Act may also be playing a role in the rise in EHCPs – which may itself have had a knock-on impact on CDLA claims – but is unlikely to be the whole explanation.

Figure 5.1 also shows forecasts for the percentage of under-16s with CDLA or an EHCP until 2030. Official forecasts suggest that without reform 10% of under-16s will receive CDLA in 2030, up from 7.2% in 2025. There are no official forecasts for EHCPs, so we have projected the number of plans forward using historical growth rates (for more detail, see Appendix 5B). Our projections suggest that without reform 8% of pupils under 16 will have an EHCP in 2029, up from 5.2% in 2025. While there is uncertainty around these forecasts, it is clear that without reform we should expect further increases in caseloads. Further increases in claims would have commensurate impacts on costs, which we discuss in Section 5.6.

Overlap between CDLA and EHCPs

Figure 5.2 shows there is a large degree of overlap between the CDLA claimants and EHCP recipients.⁴ We focus on 12- to 15-year-olds as we have access to detailed data for this group. For this age group at the start of 2020, 77% of those with EHCPs also received CDLA, and 52% of those receiving CDLA had EHCPs. Another 32% of CDLA recipients did not have an EHCP but received a lower level of SEN support. The overlap of EHCPs and CDLA is unsurprising

Figure 5.2. Number of pupils aged 12–15 in England in 2020, by CDLA receipt and SEND status



Note and source: Authors' calculations from Longitudinal Education Outcomes data. Data on CDLA receipt only fully available for children aged 12 and over as of January 2020. Excludes pupils in private schools.

⁴ We focus on 12- to 15-year-olds in this analysis and at other points in the chapter as we have access to novel linked administrative data for this age group. As we discuss in Section 5.5, there has been a sharp increase in both CDLA and EHCP recipients across all ages from 4 to 16.

given that both systems provide targeted support for children with additional needs, but it is more evidence that the rises in caseloads in both are likely related.

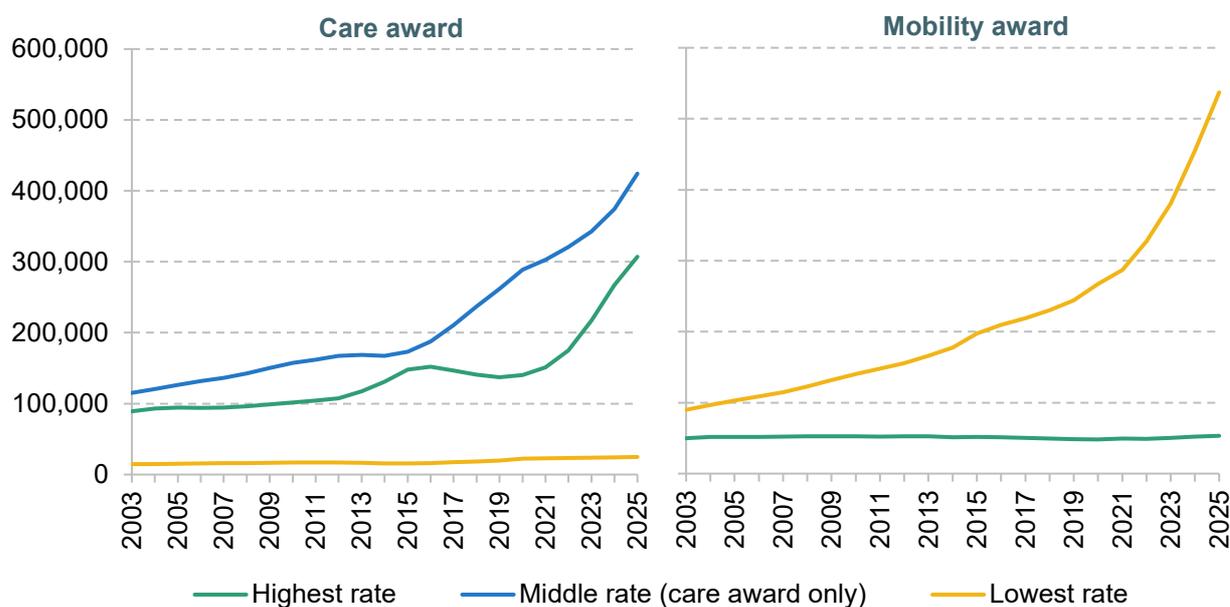
The overlap between two forms of support may partly be due to links between the assessment processes. Although there is no automatic link between CDLA and EHCPs, being in receipt of one can act as evidence when applying for the other. Whether a child has an EHCP is recorded in their application for CDLA, for instance.⁵ These links mean that any policy change that changes access to support for EHCPs – such as the 2014 Children and Families Act – could have knock-on impacts on CDLA claims, and vice versa.

There are also many children who receive one form of support but not the other. This could be because some conditions or disabilities mean that children need additional support to thrive in education but are not associated with higher living costs (or vice versa), and thus some children only pass the assessment criteria for one form of support. However, it also may be due to differences in awareness around what support is on offer. There may also be local factors which shape the SEND support in particular that pupils receive. For instance, local authorities have some discretion over whether applicants are granted EHCP assessments, and there are differences between schools in identifying and seeking specialist support for high-needs pupils. In Section 5.5, we show there are large differences in EHCP rates across local areas. By contrast, CDLA assessment processes are the same across England and Wales. This could lead to two children with similar needs who live in different areas being able to claim the same level of CDLA, but receiving different levels of SEND support.

As well as rising numbers claiming CDLA, there has been a shift in the types of award claimants receive. In particular, far more are being awarded CDLA on the basis of severe care needs rather than severe mobility needs (shown in green in Figure 5.3). This likely reflects the rising share of CDLA claims that are for conditions such as autism, where care needs are likely to be greater than mobility needs, but where children may qualify for the lower rate of mobility award (we discuss types of need in Section 5.4). Furthermore, while most of the rise before 2021 was driven by those receiving the middle rate of care awards (shown in blue), since then we have seen a particularly steep rise in the number of claimants receiving the highest care award. This somewhat reflects the trends in SEND that we have seen: although both the number with SEN support and the number of EHCPs have risen, the proportional rise in EHCPs (which are designed for those with the most complex needs) has been much greater.

⁵ <https://assets.publishing.service.gov.uk/media/67a0f71cc58a6a5aa9217653/dla-for-children-claim-form.pdf>.

Figure 5.3. Numbers in receipt of CDLA by care and mobility award rates, 2003 to 2025



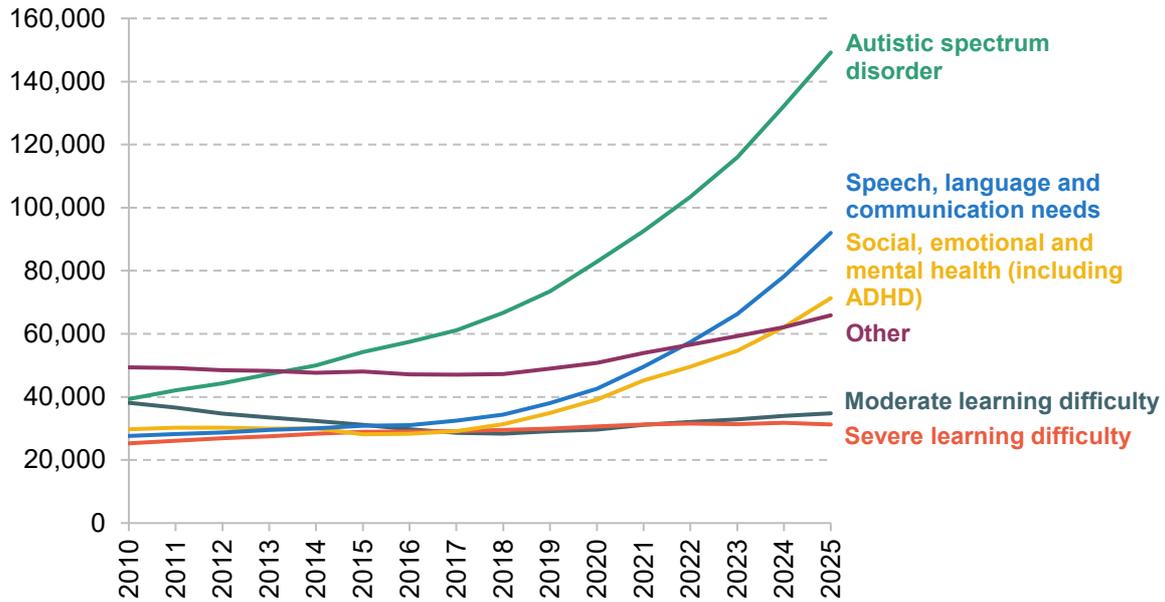
Note and source: DWP Stat-Xplore. Data for February of each year. Numbers may not sum as not all recipients are awarded both care and mobility awards.

5.4 What conditions are children receiving support for?

Another reason to be concerned about the rise in CDLA claims and EHCPs is what it implies about the state of children's needs. There is no consensus on the extent to which this rise in recipients is driven by worsening underlying needs among children, increased recognition of needs for similar conditions or other external factors. Analysing the changing composition of needs being supported can shine some light on this.

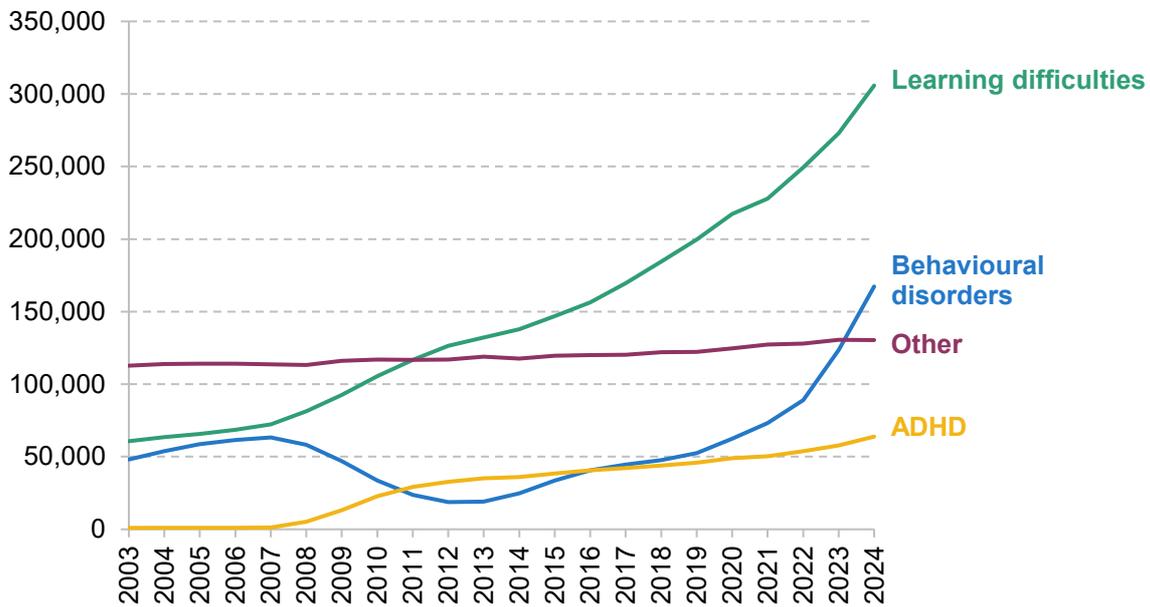
For both CDLA and EHCPs, a large portion of the increase in caseload is made up of increased cases relating to autism and to ADHD (attention deficit hyperactivity disorder). The increase in EHCPs has been almost exclusively driven by increases in autism, social and emotional and mental health needs (which include ADHD), and speech, language and communication needs (Figure 5.4). It is notable that the increase in autism can be seen from at least 2010 onwards, with an accelerating rise over time. The COVID-19 pandemic may have exacerbated this trend, as we have seen the fastest rises since 2019, but there was already fast growth in EHCPs relating to autism before 2019. The increases in social, emotional and mental health needs and in speech, language and communication needs can be seen from around 2018 onwards. There do not appear to be sudden increases linked to a specific policy change (such as the 2014 reforms).

Figure 5.4. Number of pupils with EHCPs by primary need



Note and source: Covers all pupils, not just under-16s. SEN in England statistics (<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>). Data for January of each year.

Figure 5.5. Number of children in receipt of CDLA by main disabling condition



Note and source: DWP Stat-Xplore. Hyperkinetic syndrome has been relabelled as ADHD. 'Other' includes neurological diseases and diabetes; the full list of conditions is on Stat-Xplore. There were changes in how main disabling conditions were coded in 2008 and 2011; this may explain why there were no cases coded as ADHD / hyperkinetic syndrome until 2008.

For CDLA, the increase in caseload is almost entirely driven by an increase in children claiming for learning difficulties, behavioural disorders or ADHD (Figure 5.5). While these categories are relatively broad, we can look in more detail at the main conditions for those transitioning from CDLA to PIP at age 16. This suggests that the bulk of the increase in ‘learning difficulties’ and around half of ‘behavioural disorders’ relate to autism and/or ADHD. In 2024, autism and ADHD were the most common primary conditions for 16-year-olds previously on CDLA applying for PIP, making up 40% and 16% of applications respectively.

We have also seen a rise in the share of registered NHS patients who have diagnoses for autism and ADHD. NHS data suggest that overall around 2.3% of current under-10s and 4.6% of current 10- to 17-year-olds have a diagnosis of autism.⁶ These are up from 1.4% and 2.9% respectively in 2019–20, and look set to increase further over the coming years as over 138,000 children had open referrals for suspected autism as of March 2025.⁷ Waiting times for NHS autism assessments are on average over a year and private options typically range in price between £1,000 and £3,000, putting them out of the reach of many.⁸ Obtaining a diagnosis can be important for accessing certain forms of support (for instance, a diagnosis is required for a child’s SEND need to be recorded as autism (Peterborough City Council, 2023)). As such, this waiting list backlog also raises concerns over the number of children with potential needs who may currently be unable to access support.

The rise in recognised autism and ADHD is not unique to England; a wide range of countries have seen increasing numbers diagnosed with autism and/or ADHD (Zeidan et al., 2022). For example, identified autism prevalence across several US areas has increased from less than 1% of 8-year-olds in 2000 to 3.2% in 2022 (Shaw et al., 2025). To take an example closer to home, Scotland has also seen increasing high-needs demand despite having different systems for child health benefits and SEND support (see Box 5.1 for an overview). Although there is evidence that the nature of the support systems for disabilities affects how many people seek diagnoses (Ranjan and Breunig, 2025), there are clearly also broader-based reasons behind the rise in reported neurodevelopmental conditions and disabilities among English children that apply globally, beyond any changes to systems and incentives that have taken place in England.

⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2023-to-2024>.

⁷ <https://digital.nhs.uk/data-and-information/publications/statistical/autism-statistics/july-2024-to-june-2025>.

⁸ For examples, see <https://adhdandautismclinic.co.uk/how-much-is-a-private-autism-assessment/> or <https://autismnortheast.org.uk/assessment-costs/>.

Box 5.1. Comparing English and Scottish systems

Scotland has a broadly similar system for child disability benefits to England's. Since 2022, the benefit has been named child disability payment (CDP) rather than CDLA and can be paid until a child is 18 instead of 16, but otherwise the award types and rates are identical. Focusing just on those under 16, the rise in the share of under-16s on disability benefits has been even steeper in Scotland than in England over the past decade, rising from 3.4% to 7.2% between 2015 and 2024 compared with 3.3% to 6.2% in England.^a Claims grew at similar rates in Scotland and England before the benefits were devolved, and only started to grow faster in Scotland after CDP was devolved. This steeper rise may be due to a generally lighter-touch process of application and reassessment for health-related benefits in Scotland (Scottish Government, 2020). Trends in the type of need reported have also been similar to those in England. As of June 2025, 41% of CDP recipients in Scotland were claiming for autism and 13% for ADHD. Similarly, among school pupils assessed to have 'additional support needs' (ASN), there has been a large increase in the listed needs of autism and social, emotional and behavioural difficulties (Sibieta and Snape, 2025).

As in England, the Scottish system for supporting children in education with ASN offers two levels of support: general support for pupils with lower-level needs, and statutory support for those with the most complex needs in the form of 'coordinated support plans'. However, the balance between the higher and lower tiers of support in Scotland is significantly different from that in England. The barrier for accessing coordinated support plans generally seems to be much higher than the barrier for EHCPs, with fewer than 0.2% of pupils having one in 2024, down from 0.5% of pupils in 2014.^b By contrast, the number with general ASN has increased dramatically, from 21% of pupils in 2014 to 41% in 2024. This is more in line with English trends of increasing need, but levels are much higher, in part due to the broader spectrum of needs that ASN incorporates (for instance, English as an additional language).^c

By the nature of the system, spending on child disability payments has broadly tracked numbers. However, trends in high-needs spending in schools have looked different in Scotland from in England, with a 29% real-terms increase in identifiable high-needs spending from 2017–18 to 2023–24 compared with 45% in England.^d This is due to the far more limited numbers receiving statutory support in Scotland, which means fewer receive more costly forms of support such as attending special schools. It is unclear exactly whether the drop in coordinated support plans is due to lack of demand or barriers to accessing support, but it does seem that the focus on mainstream inclusion of high-needs pupils has kept a lid on the costs of support.

The comparison between England and Scotland helps to illuminate two main things. First, the underlying trends in need are not unique to England and as such are not fully driven by specifics of the English support system (for instance, the 2014 reforms that introduced EHCPs). Second, policy decisions affect how the system responds to broader health trends. For education, Scotland's approach

means that more pupils with high needs are educated in mainstream schools, with lower spending growth than in England. For benefits, Scotland's approach means more children receive disability benefits than in England. We lack evidence on which approach delivers better outcomes.

- a. Data from DWP Stat-Xplore and table 17 in [Child-Disability-Payment-Statistics-to-30-June-2025-tables.xlsx](#). CDLA and child disability benefit caseloads have been combined where policies overlapped. Population estimates based on mid-year population estimates for ages 0 to 15 of relevant year.
- b. <https://www.gov.scot/collections/school-education-statistics/>.
- c. <https://www.gov.scot/publications/pupil-census-supplementary-statistics/>.
- d. Figures from <https://www.gov.scot/collections/local-government-finance-statistics/>.

There is widespread acknowledgement that public understanding of both autism and ADHD has increased substantially in recent years (Abdelnour, Jansen and Gold, 2022; Hirota and King, 2023), likely leading more children and adults to come forwards for diagnosis. Furthermore, diagnostic criteria have generally become more expansive over time, meaning that more people may qualify for an official diagnosis (Hansen, Schendel and Parner, 2015; Abdelnour et al., 2022). Indeed, some research suggests that the average severity of symptoms among those with an autism diagnosis has declined over time, consistent with lower levels of need being recognised and/or meeting the threshold for diagnosis (Arvidsson et al., 2018). Estimates of underlying prevalence among children vary significantly (see Saito et al. (2020) and Sacco et al. (2024) for contrasting estimates), and as such it is unclear when we might expect the increase in diagnoses to level off and thus ease the pressure on support systems in England.

Other indicators also suggest that many children have additional health and educational needs and that the number of children with additional needs may have increased in recent years. Surveys of child mental health suggest that 21% of 8- to 19-year-olds in England had a probable mental disorder in 2023, up from 12% in 2017.⁹ School readiness surveys suggest that a significant proportion of children lack key skills when starting school, with teachers reporting that a third of children starting Reception in 2024 were not 'school ready' – for example, they were unable to listen to instructions or use books (Kindred², 2025). Similarly, 20% of 2-year-olds are assessed to be not at a 'good level of development', up from 17% in 2019–20.¹⁰ The share of people under 20 self-identifying as having a disability also rose from 4.0% to 7.3% between 2011 and 2021.¹¹ Some of these issues may reflect the long-run effects of the COVID-19 pandemic on young people. While increasing diagnoses of autism and ADHD explain much of the rise in demand for support, these figures highlight other concerning developments in child

⁹ <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up/data-sets>.

¹⁰ <https://www.gov.uk/government/statistics/child-development-outcomes-at-2-to-2-and-a-half-years-april-2023-to-march-2024-annual-2023-to-2024/child-development-outcomes-at-2-to-2-and-a-half-years-2023-to-2024-statistical-commentary>.

¹¹ <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/disabilitybyagesexanddeprivationenglandandwales/census2021/relateddata>.

development and mental health that are likely to be playing a role in the increased uptake of support.

5.5 Who is receiving support?

Understanding the demographic profile of those receiving CDLA or EHCPs complements our understanding of the change in claimants by showing whether the rise is spread across the child population or limited to certain subgroups. For some of this analysis, we focus on 12- to 15-year-olds at the start of 2020, as more detailed data are available for this group.

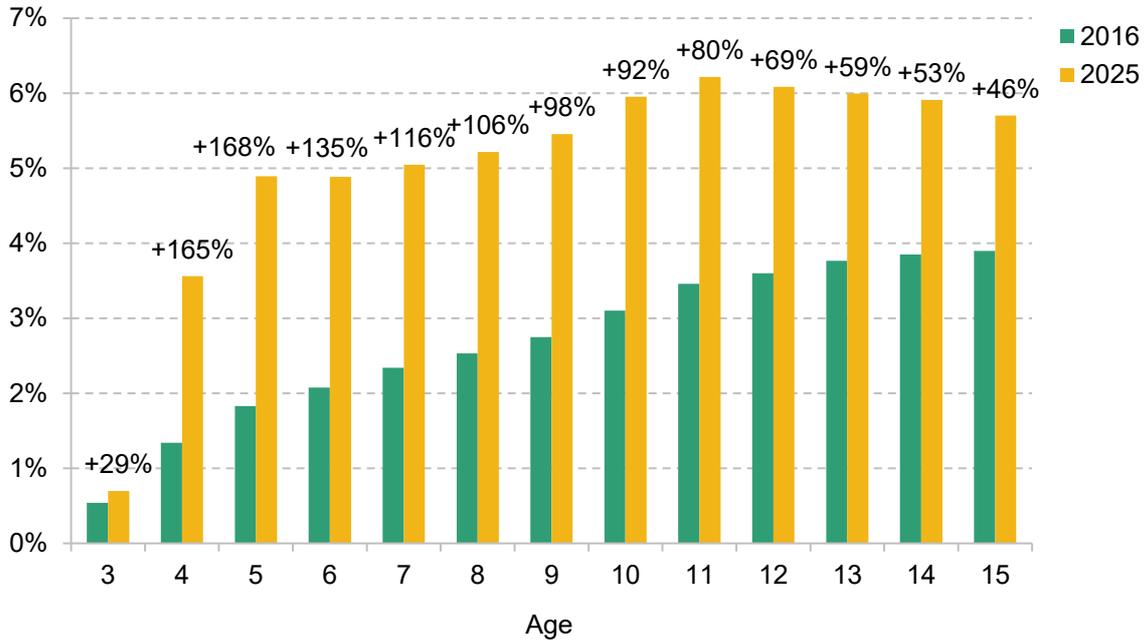
Age

The age profiles of those with EHCPs and those receiving CDLA look relatively similar for the most recent years. Figures 5.6 and 5.7 show that 10-year-olds are much more likely to receive support than 4-year-olds. For both types of support, this age gradient flattens in the teenage years. However, the change in age distributions has been different over time for the two forms of support. EHCPs have seen much larger growth among younger age cohorts. There has been a 168% increase in the share of 5-year-olds with EHCPs, compared with a 46% increase for 15-year-olds. In contrast, while CDLA has also seen higher growth at younger ages, the difference between the growth rates at older ages is far less stark. As incentives for schools to support their pupils' applications for EHCPs have increased, school entry may be becoming an increasingly important trigger of applications for EHCPs.

Sex

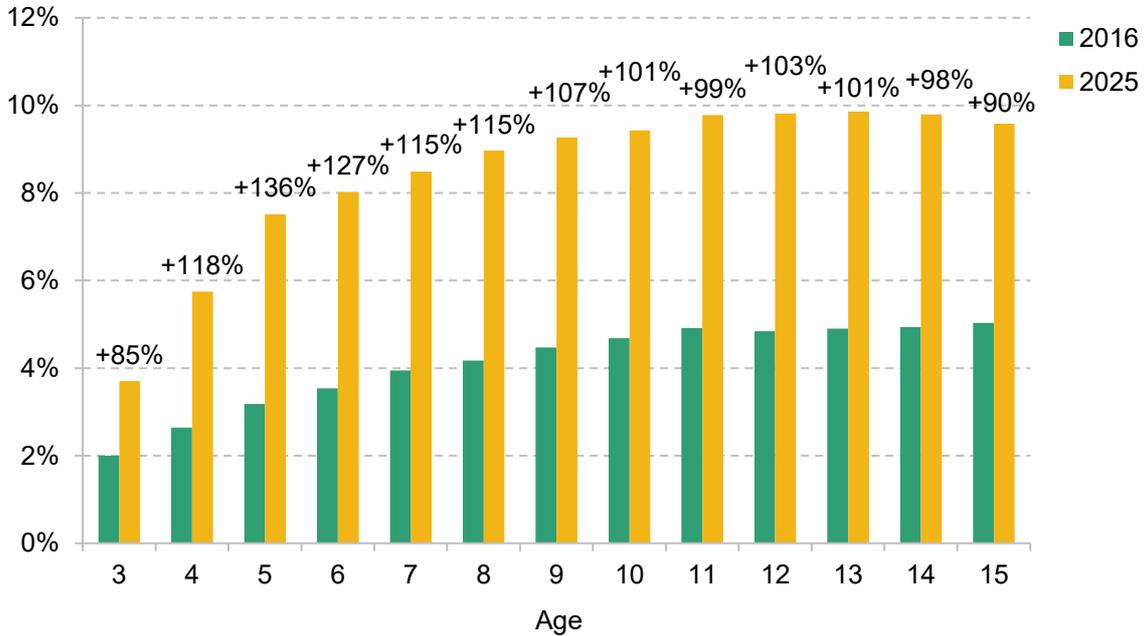
Receipt of CDLA and EHCPs is more prevalent among boys than girls, with the difference remaining persistent over time. Only 29% of pupils with EHCPs are female, little changed from the rate of 27% in 2016. Similarly, 33% of CDLA recipients in 2025 are female, up slightly from 30% in 2016. This gender split is roughly in line with estimates of prevalence differences for autism and ADHD between girls and boys (see Saito et al. (2020) for autism and Salari et al. (2023) for ADHD). The estimates of the gender gap in autism prevalence have been revised down as researchers have become better at detecting autism in girls and women (Napolitano et al., 2022). Some of the remaining gap in estimated prevalence may be due to additional challenges in detecting autism in girls relative to boys. In future, more girls will be identified and get support with the condition. Nevertheless, the current large gender gaps in support for additional educational needs and disabilities mean that any changes to support in schools and the benefit system are likely to disproportionately affect boys.

Figure 5.6. Share of pupils with EHCPs by age, 2016 and 2025



Note and source: SEN in England statistics (<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>). Percentage labels show percentage increase from 2016 to 2025.

Figure 5.7. Share of children receiving CDLA by age, 2016 and 2025



Note and source: DWP Stat-Xplore. Numbers as at February of year. Percentage labels show percentage increase from 2016 to 2025. Population figures from Office for National Statistics, Estimates of the Population for England and Wales (<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/estimatesofthepopulationforenglandandwales>) and Zipped Population Projections Data Files, England (<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/z3zippedpopulationprojectionsdatafilesengland>).

Family income

Table 5.1 shows that children with EHCPs and CDLA tend to be from poorer families. Among children aged 12–15 in 2020 with either EHCPs or CDLA, around two in five were eligible for free school meals – available only to children from low-income families – relative to one in five of all children aged 12–15. Similarly, children in receipt of EHCPs or CDLA are more likely to live in the most deprived tenth of neighbourhoods than their peers. Given this, getting support for disabilities and additional educational needs right matters for reducing inequalities in outcomes and attainment between deprived and less-deprived groups: any improvement or deterioration in support is likely to have unequal impacts by deprivation level.

Table 5.1. Share of pupils with EHCPs or CDLA who are eligible for free school meals or are living in the most deprived tenth of neighbourhoods

Type of support	Share eligible for free school meals	Share living in most deprived tenth of neighbourhoods
EHCPs	37.1%	15.5%
CDLA	40.2%	17.9%
All pupils	17.6%	12.7%

Note and source: Statistics on children eligible for free school meals are from Longitudinal Education Outcomes data and cover pupils aged 12–15 in 2020, excluding those in private schools. Deprived neighbourhood data for EHCPs are also from Longitudinal Education Outcomes data but cover the full age range for pupils in 2021, excluding those in private schools. Deprived neighbourhood data for CDLA are from DWP Stat-Xplore and cover children receiving CDLA as at February 2021. ‘Neighbourhoods’ refers to lower super output areas (LSOAs), and deprivation deciles are based on ranks of average score from the Index of Multiple Deprivation 2019.

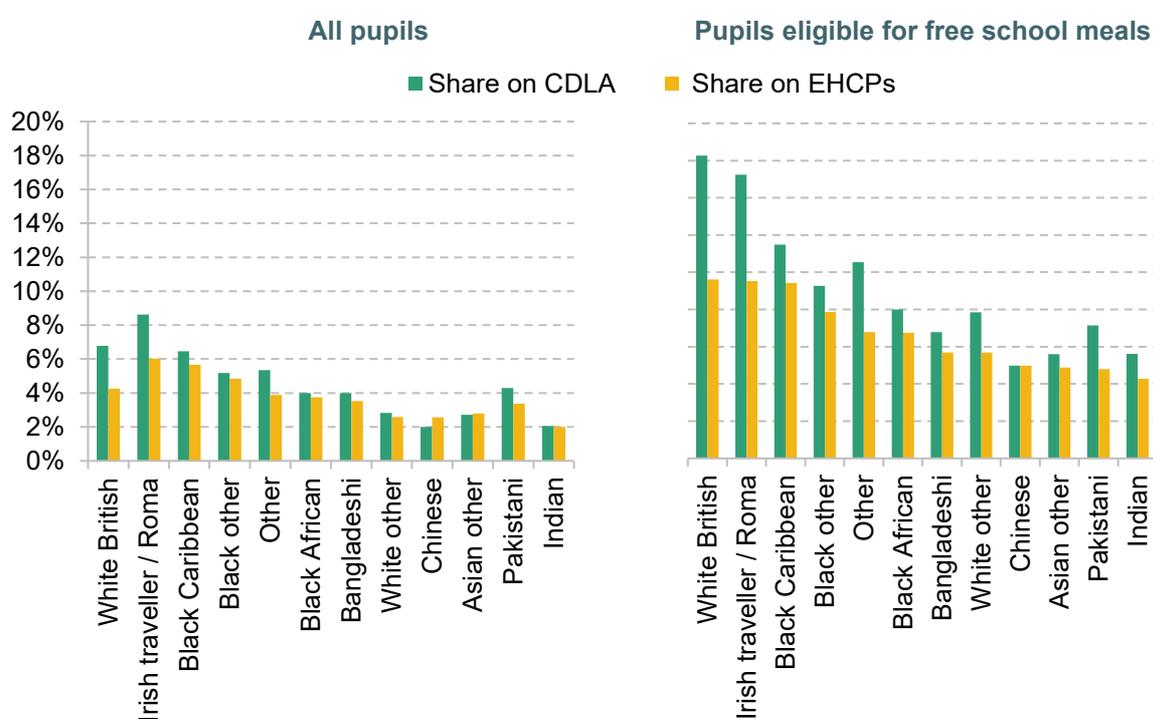
CDLA tends to have a stronger relationship with deprivation than EHCPs. Part of this may reflect the different types and levels of need that CDLA and EHCPs cater to. It may also reflect different incentives for poorer and richer families: the payment that CDLA provides is likely more valuable to those on low incomes, for instance, meaning more deprived groups would be expected to have a stronger incentive to claim CDLA. By contrast, EHCPs do not provide monetary support directly to the family but provide additional educational support. The difference in strength of relationship with deprivation may also be due to differences in application processes and levels of awareness about the support that is available. It is also worth noting that the types of need that children have differ by deprivation too: among pupils with EHCPs, those with social, emotional and mental health needs are more likely to be eligible for free school meals than average, while those with autism are slightly less likely to be.¹²

¹² <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2025>. Data from January 2025.

Ethnicity

There are also significant ethnic gaps in the proportion of pupils who receive support for special educational needs and disabilities (Figure 5.8). Among those aged 12–15 in 2020, 2.0% of Indian pupils and 2.6% of Chinese pupils had one, compared with 4.3% among the White British population), and this gap has been persistent over time. Children from Irish traveller and Roma backgrounds, by contrast, are 1.2–1.4 times more likely to have an EHCP or CDLA than White British children. These relationships still hold, and in some cases are stronger, when looking only at the subsample of pupils eligible for free school meals, suggesting that these patterns are not solely driven by differences in deprivation. The differences in uptake likely reflect a combination of differences in underlying need and differences in awareness and cultural norms across ethnic groups.

Figure 5.8. Share of pupils aged 12–15 in 2020 with CDLA and/or EHCPs, by ethnic group



Note and source: Longitudinal Education Outcomes data. Excludes children in private schools. 'White other' includes ethnic categories 'White Other' and 'White Irish'.

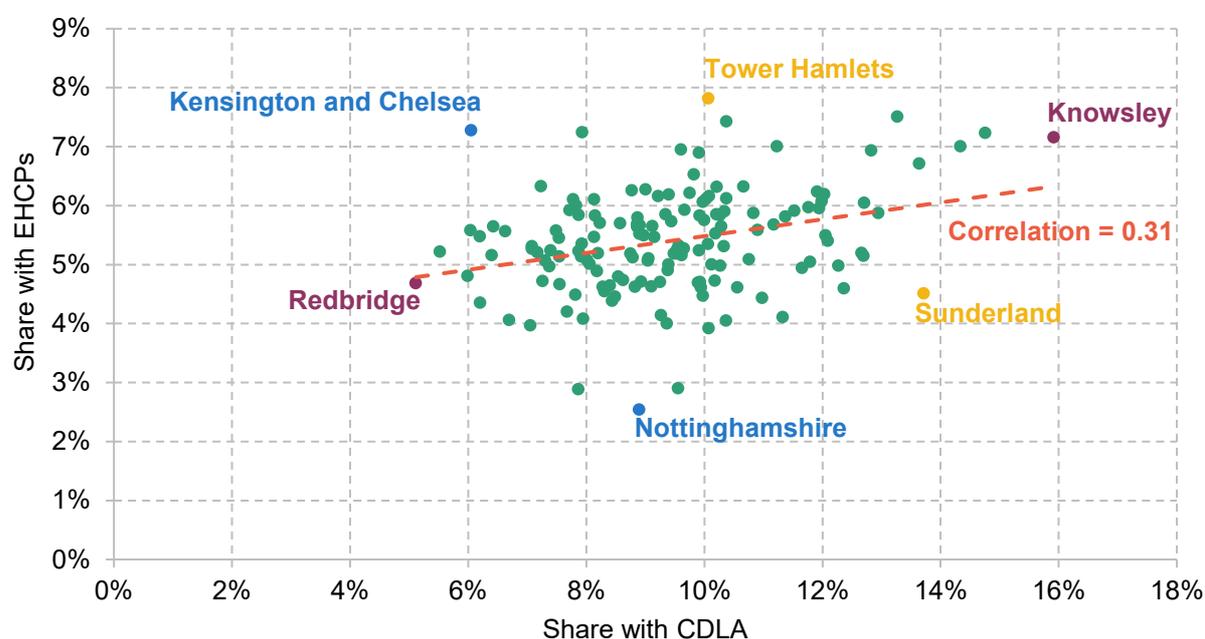
Geographic variation

Beyond demographic characteristics, there is significant local variation in the share of under-16s who receive support in the form of either CDLA or EHCPs.¹³ As we might expect, areas that

¹³ For interactive maps of SEND variation across councils in England, see <https://ifs.org.uk/calculators/how-do-special-educational-needs-vary-across-areas>.

have a relatively high share of pupils with one form of support tend to see higher levels of the other form as well (Figure 5.9) but the relationship is not very strong. There is only a correlation of 0.31, where 0 indicates no relationship and 1 indicates a perfectly predictive relationship. EHCPs tend to be more concentrated in London, for example, whereas CDLA rates are relatively higher in deprived areas often outside of London (see Appendix 5A for maps). These geographic differences may be partly driven by the differences in underlying demographic characteristics that we have explored above. They may also reflect differences in local policies, particularly for EHCPs as provision of these is shaped by school and council policies. In particular, school-level variation seems to account for a significant amount of variation in whether a pupil is identified as having SEND and receives an EHCP (Hutchinson et al., 2025).

Figure 5.9. Share of children under 16 with CDLA and EHCPs by local authority, 2025



Note and source: Authors' calculations from SEN in England statistics (<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>) for EHCPs and DWP Stat-Xplore for CDLA. Local authorities are upper-tier local authorities.

Summary

We have shown in this section that certain groups of children are much more likely to receive CDLA or EHCPs than others. This means that changes to CDLA or EHCPs would have implications for the distribution of support across demographic groups and local areas. Furthermore, while some differences in support received will reflect genuine differences in underlying prevalence between groups, some may also reflect cultural differences and awareness and others may reflect variation in how policies are being delivered at the local level. The differences may thus help to indicate where certain groups have needs that are less likely to be recognised.

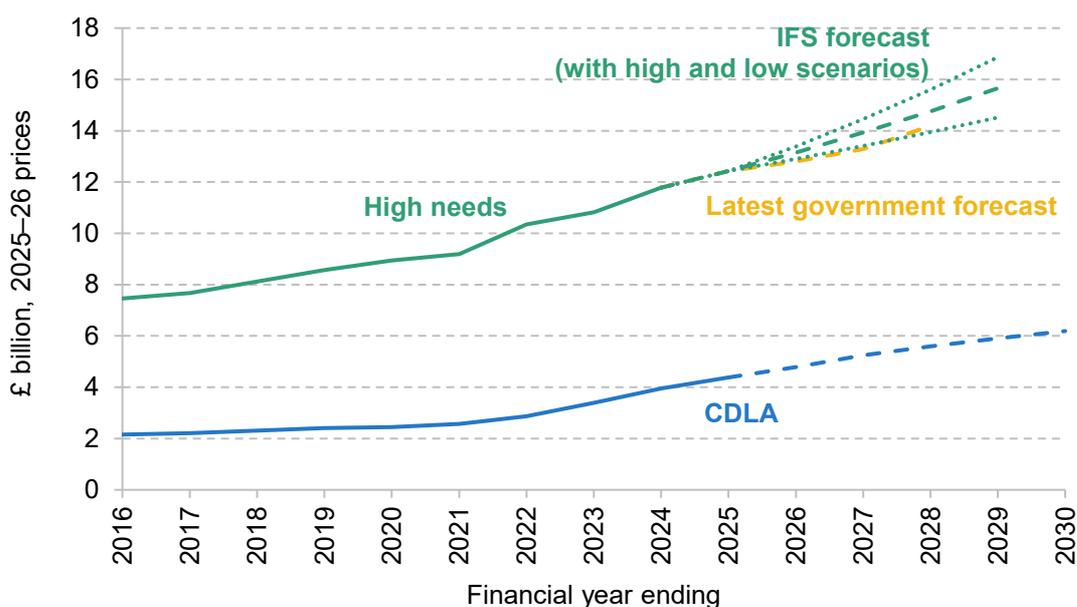
5.6 How much is spent on this support?

The rise in children receiving special educational support and disability benefits is also a growing issue for local and central government finances.

Spending levels

There has been a dramatic rise in spending related to children with high needs in the education system. Figure 5.10 shows historical spending on CDLA and council high-needs spending as well as projections of future spending. High-needs spending does not cover all spending on EHCPs but is the best available measure of spending related to EHCPs (see subsection below on funding systems for more detail). It has grown from £7.5 billion in 2016 to £11.8 billion in 2024 (2025–26 prices), taking up over half of the overall rise in schools funding over that period (Drayton et al., 2025).

Figure 5.10. Estimated spending on CDLA and high-needs support in England (actual and forecast), 2025–26 prices



Note and source: Historical CDLA spending in England is estimated by applying award rates for each band in each financial year to the caseload by award type in England for each quarter. Forecast spending on CDLA is estimated by applying the share of actual England and Wales spending in 2024 estimated to relate to England, to Office for Budget Responsibility forecasts for CDLA spending in England and Wales from Department for Work and Pensions, Benefit Expenditure and Caseload Tables 2025 (<https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2025>). See Sibieta and Snape (2024) for notes and sources for high-needs spending calculations up to 2024. Government forecasts taken from National Audit Office (2024). See Appendix 5B for explanation of IFS forecasts.

Box 5.2. Estimated spending on other benefits for families of children with a disability

As well as providing claimants a cash benefit, CDLA passports access to higher income- and earnings-related benefits. We estimate that spending on these passported benefits for CDLA claimants in England (£3.1 billion in 2024–25) is only slightly smaller than spending on CDLA itself (£4.4 billion in 2024–25). There are three main benefit elements that CDLA passports access to: the disabled child element of universal credit, the carer’s element of universal credit, and carer’s allowance.

Families on universal credit (UC) that include a child who received CDLA can claim the disabled child element of UC.^a If the child receives the highest rate of the care element of CDLA, the household qualifies for the higher disabled child element (£5,950 a year); otherwise, they receive the lower element (£1,905 a year). We estimate that 340,000 families in England receive the UC disabled child element, of which 140,000 receive the higher element.^b In total, the UC disabled child element cost around £1.2 billion in England in 2024–25.

Families can receive further additional income if someone in the household spends at least 35 hours a week caring for a child with CDLA (middle or highest care element). If they claim UC, they can receive the UC carer’s element (£2,420 a year). We estimate that 310,000 households in England claim the UC carer’s element for a disabled child, at a cost of £0.7 billion. If the carer earns less than £196 a week, they can also claim carer’s allowance worth £4,340 a year. We estimate that 290,000 families receive carer’s allowance for a disabled child at a cost of around £1.2 billion in 2024–25.^c If a family receives carer’s allowance as well as UC, their UC award will be reduced by £1 for every £1 of carer’s allowance they receive so some of this £1.2 billion may be compensated for in lower UC awards.

It is difficult to trace how spending on these benefit elements has changed over time, as UC has been gradually rolled out over the last decade, and there are limited data on the disabled child elements of its predecessor benefits.

If the official forecasts for CDLA are correct and spending on CDLA increases by £1.8 billion (41%, from £4.4 billion to £6.2 billion) in the next five years, we should expect spending on the UC disabled child element, the UC carer’s element, and carer’s allowance to increase at a similar rate.

a. Households can also receive the UC disabled child element if they have a child between 16 and 19 claiming personal independence payment or if their child is blind. We assume that 78% of UC disabled child element claims relate to children under 16 claiming CDLA. 78% is the ratio of disability benefit claimants under 16 to disability benefit claimants aged 19 and under.

b. We assume that 41% of recipients receive the higher element, as 41% of CDLA claimants receive the highest care element of CDLA which is the condition for receipt of the higher element of UC disabled child element.

c. We assume that 32% of carer’s allowance recipients and spending is for caring for under-16s. We estimate this based on the share of families who receive the UC carer’s element who also receive disabled child element for an under 16.

Figure 5.10 shows that spending on CDLA has also risen rapidly. We estimate that spending on CDLA in England rose in real terms from £2.2 billion to £4.0 billion over the same period, with most of this rise (60%) occurring in the last two years. This pronounced increase in CDLA spending only after 2022 differs from the more steadily increasing number of CDLA claimants (shown in Figure 5.1) due to the changing mix of awards made. As discussed in Section 5.3, the initial rise in claimants was among those awarded lower and middle rates, while the recent rise has come from those awarded the highest rate for care, at a much higher cost per claimant. CDLA also passports access to higher income- and earnings-related benefits, worth around £3.1 billion (see Box 5.2).

Forecasts suggest that without reform there will be further increases in caseloads and spending on both types of support. Forecast spending growth rates from the Office for Budget Responsibility currently imply that spending on CDLA will rise from £4.4 billion in 2025 to about £6 billion by 2030. For high-needs spending there are no up-to-date official forecasts, so we have produced our own estimates based on historical growth rates in EHCPs by age and the historical relationship between growth in EHCP numbers and high-needs spending (see Appendix 5B for more detail). Our central estimate is that high-needs spending will increase by another £4 billion in the next five years, from £11.8 billion in 2023–24 to well over £15 billion in 2028–29. Given the significant uncertainty in the growth in numbers and spending, we also highlight low- and high-growth scenarios where spending grows by £3 billion and £5 billion, respectively. This high and uncertain growth is a significant problem for the public finances.

Our central forecast for 2028–29 is £600 million higher than the most recent government forecast, published by the National Audit Office in October 2024 (see the yellow line on Figure 5.10). This difference could reflect our use of more-up-to-date data on spending and numbers, as well as differences in the underlying forecasting methodology.

Implications of the forecast growth in spending

Stepping back, a number of key findings emerge from these spending figures. First, if realised, these central forecasts for CDLA and high-needs spending would take spending to a historically high level. On its own, the forecast of over £15 billion for spending on high needs in schools would exceed the entire day-to-day budget for the Ministry of Justice. Combined with the £6 billion forecast for CDLA in 2029, this would be comparable in magnitude to all day-to-day spending by the Home Office. While it is possible that spending at this level would be defensible on the basis of matching needs, it nevertheless would represent a significant outlay and require clear justification.

Second, if realised, the forecasts will have material impacts on fiscal trade-offs, and the fact that spending in this area is highly uncertain adds to the difficulty of managing the public finances.

Third, it becomes increasingly likely that the government will feel obliged to top up the schools budget at fiscal events. At present, the core schools budget is set to be held constant in real terms between 2026 and 2029. Falling pupil numbers mean that the government could freeze spending per pupil in real terms and leave £2 billion headroom to spend on other priorities (Sibieta, 2025). However, if high-needs spending rises by £2–4 billion, as implied by our forecasts, then this would exhaust all of this headroom. Indeed, the government may feel the need to top up plans at future fiscal events just to avoid real-terms cuts to mainstream spending per pupil. This is exactly the experience of this and recent governments over the last five years, with new grants announced almost every year (Drayton et al., 2025).

Spending per recipient

Despite fast growth in overall spending, the average award per CDLA recipient and the amount spent on high needs per EHCP pupil for children under 16 have both declined in real terms since 2015–16, by 2% and 15% respectively.¹⁴ For CDLA, the decline reflects a change in the composition of claimants. Relative to 2015–16, a greater proportion of recent claimants have been assessed with lower levels of need (especially for the mobility element), despite recent growth in the share of claimants qualifying for the highest care element. The drop in per-EHCP spending in schools may similarly reflect a compositional change. New recipients may require less costly support – for instance, due to a lower average level of need. As we will discuss in the next subsection, the growth in high-needs spending has put councils’ budgets under pressure. Given this pressure, local authorities have an incentive to reduce spending per EHCP (as much as statutory requirements allow), and rationing on the part of councils may also partly explain the fall in per-EHCP spending.

Funding systems

The funding systems for EHCPs and for CDLA work in different ways. CDLA is funded by central government, and the total amount of funding is determined purely by the amounts that individual claimants have been awarded. By contrast, EHCPs are mostly funded through the ‘high needs’ element of the ‘Dedicated Schools Grant’ in council budgets. The high-needs block is designed to fund support for pupils with extra needs that cost above a threshold of £6,000 (for mainstream schools, this first £6,000 in expenditure is funded from core school budgets). In practice, this means that funding from the high-needs block primarily goes towards pupils with EHCPs, either by funding placements in special schools or by providing top-up funding to mainstream schools to cover the high-cost specialist support that their pupils with EHCPs are entitled to. Councils have limited freedom to transfer funding from other blocks in the National

¹⁴ The decline in spending per EHCP is far steeper if we factor in young people over the age of 16 with EHCPs, not just those in schools, which reflects the fact that EHCPs for over-16s tend to provide much lower levels of resources (Sibieta and Snape, 2024).

Funding Formula (the schools block and the central services block) to increase the high-needs block.

Councils' 'high needs' budgets are set in advance by central government. This means that budgets do not automatically adjust when costs grow differently from what had been expected. As high-needs spending has consistently overshot the funding allocation, this has led to large council deficits each year (Sibieta and Snape, 2024). These have been artificially taken off councils' main balance sheets until at least March 2028 under an accounting treatment known as the 'statutory override' (see Box 5.3). We have previously projected that the stock of debt would total around £8 billion by 2028 (Sibieta and Snape, 2024) and will continue to rise if the current system is maintained. This hole will presumably be too large for councils to fill themselves and will inevitably eventually require central government to intervene.

Box 5.3. Statutory override

Because spending on high needs has exceeded funding, many councils have seen deficits on their high-needs budgets in recent years. Reducing spending is often infeasible because EHCPs create legal duties on councils. However, running a deficit would mean a council breaching its legal duty to set a balanced budget and potentially require it to issue a section 114 notice (technical insolvency), halting all non-essential expenditure by the council.

To avoid this, the then government created the 'statutory override' in November 2020. This allowed councils to report their high-needs deficits separately from their main budgets, effectively keeping them off their main balance sheets. The override was announced as a temporary measure to allow councils to deal with the deficits by March 2023. However, this end point was then extended to March 2026 and, this summer, was extended again by the new government to March 2028.

At the same time, many councils have continued to run annual deficits. The stock of accumulated debt has thus increased over time. It was estimated at over £3 billion by March 2025. Our previous estimates put the likely stock of debt at over £8 billion by March 2028, without reforms. This is when the statutory override is currently due to end and may be an underestimate given our new higher forecasts for spending.

The government has promised 'a plan for supporting local authorities with both historic and accruing deficits' by the end of this year, alongside SEND reforms (Ministry of Housing, Communities and Local Government, 2025). Given the scale of likely debt by 2028, it seems inevitable that central government will need to intervene.

Can wider funding decisions help to explain increased spending?

Our previous analysis has suggested that increased awareness of conditions such as autism and ADHD is one part of the explanation for the growth in the number of children receiving health-related support. For both EHCPs and CDLA, there is a case that broader funding decisions might also help to explain the growth in claims and spending.

With high-needs spending, a squeeze in spending on those with SEN support, but without an EHCP, could also have played a role. The squeeze on overall school spending during the 2010s may have made it more difficult to provide a baseline level of support for those on SEN support (Drayton et al., 2025). This constraint on core school spending may have played a role in incentivising schools and parents to seek the guarantee of additional funding and support that comes with EHCPs. This incentive has likely been intensified by the cost threshold beyond which schools can seek additional high-needs funding from the council being frozen in nominal terms at £6,000 per pupil since 2013 (thus falling by over a quarter in real terms). The freezing of this threshold, which itself was based on evidence of the cost of meeting needs from 2009 (Pricewaterhouse Coopers, 2009), means that even if levels of SEND remain stable, more pupils will qualify for top-up funding from the council. As securing this funding often tacitly requires the pupil to have an EHCP, schools may therefore have faced stronger incentives to help such pupils get EHCPs.

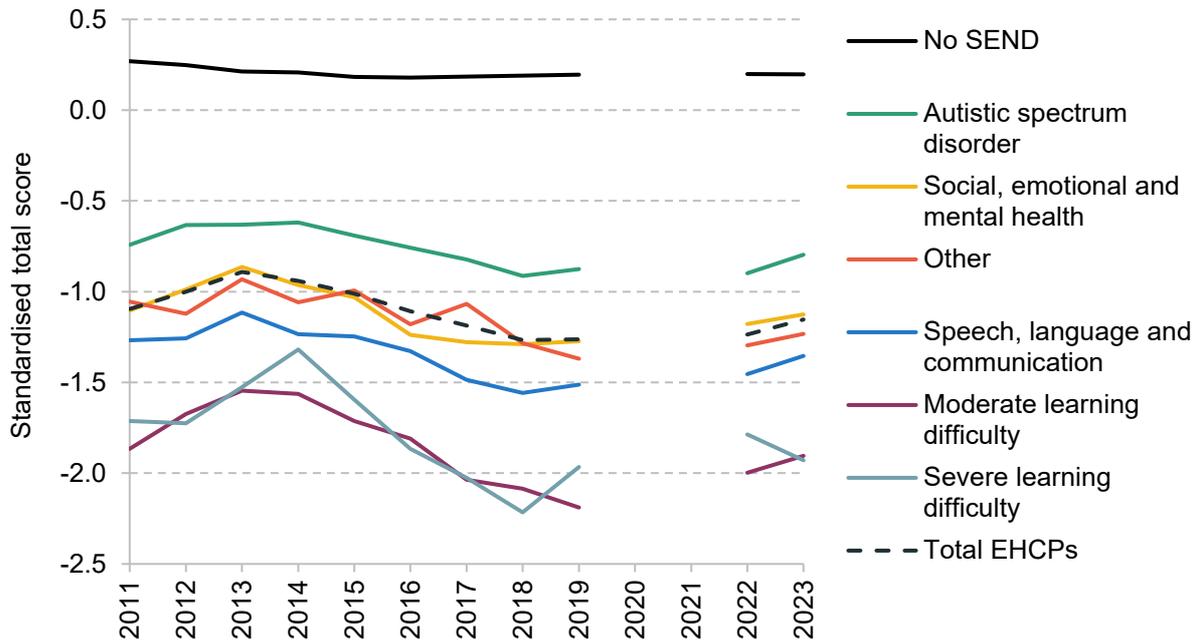
Similarly, for CDLA, reductions in non-health-related support for families in the benefit system may increase the numbers of people claiming health-related benefits. A DWP study found that families that faced a reduction in benefits due to the lowering of the household benefit cap were more likely to start a new claim to both adult and child disability benefits (which in turn gave them an exemption from the benefit cap) than other similar families which were just out of scope of the benefit cap (Department for Work and Pensions, 2023). These potential explanations reinforce the importance of considering the whole package of support that families and children receive when reforming specific elements of the system.

5.7 School outcomes

We now turn to looking at outcomes in school for children who receive additional support in the education or benefit system.

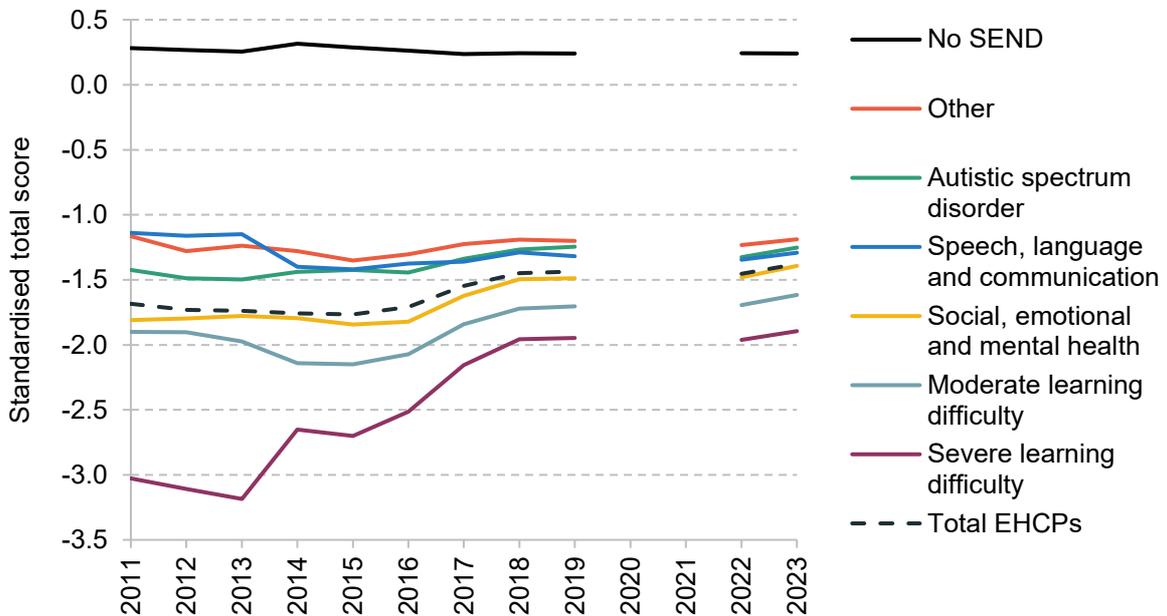
Pupils with SEND and/or CDLA have, on average, lower academic attainment than pupils without either form of support. This is unsurprising: many disabilities and educational needs that children receive support for, such as learning difficulties, directly impact how well a student can perform in exams. What is perhaps more relevant for informing policies on support is how

Figure 5.11. Standardised Key Stage 2 scores of pupils with EHCPs and with no SEND, by primary need



Note and source: Authors' calculations from National Pupil Database data. Results by SEND primary need are only for pupils with EHCPs; 'No SEND' results are for those with no SEND provision and no listed need. Test scores are not available for 2020 and 2021.

Figure 5.12. Standardised Key Stage 4 (GCSE) scores of pupils with EHCPs and with no SEND, by primary need



Note and source: Authors' calculations from National Pupil Database data. Results by SEND primary need are only for pupils with EHCPs; 'No SEND' results are for those with no SEND provision and no listed need. Exam results are not available for 2020 and 2021.

different these attainment gaps look across different types of need. Here, we focus on pupils with identified SEND, as this is more directly relevant to academic outcomes.

In general, pupils with different SEND needs achieve quite differently in terms of academic attainment at age 11 in Key Stage 2 tests (Figure 5.11) and at age 16 in GCSE exams (Figure 5.12). While doing less well than the average school pupil, those with autism tend to achieve more highly than those with other forms of need, particularly at earlier stages, for example. A compositional shift towards types of needs with higher levels of academic achievement, such as autism, may help explain the declining level of spending per EHCP in schools. Figure 5.12 also underscores the variation in the types of need and the forms of support that may best help. Offering high-quality support for pupils with SEND is a challenging task, and good evidence on the efficacy of support across different forms of SEND is needed. However, mainstream schools currently lack capacity in responding to different types of needs and the evidence base on the best forms of intervention for different types of needs is thin (Sibieta and Snape, 2025).

Overall gaps in attainment between pupils with EHCPs and pupils without SEND differ by academic stage (compare the dashed and solid black lines in Figures 5.11 and 5.12). Gaps at GCSE have narrowed since 2015, including for major need types such as autism and social, emotional and mental health needs. This could be suggestive of more moderate needs amongst pupils newly identified as needing EHCPs, although we have not seen this trend continue for more recent years where there has been greater expansion of EHCPs. Furthermore, the gaps in Key Stage 2 scores have actually widened over the same period. It is unclear why the two stages have seen such different trends. They will represent different cohorts, with more of the extra EHCPs being for younger children. The trends will also be affected by how many students take the exams at all, which may too have changed over time.

Looking across types of need, it is notable how stable relative performance has been over time, despite the rapid growth in numbers of pupils identified with SEND of various types (see Section 5.3). Figures 5.11 and 5.12 only display results for pupils with EHCPs and pupils without SEND, but trends for those on SEN support look similarly stable. This may be surprising if we expect the expansion in identification of needs to mean that pupils now being newly identified as having SEND have lower levels of need.

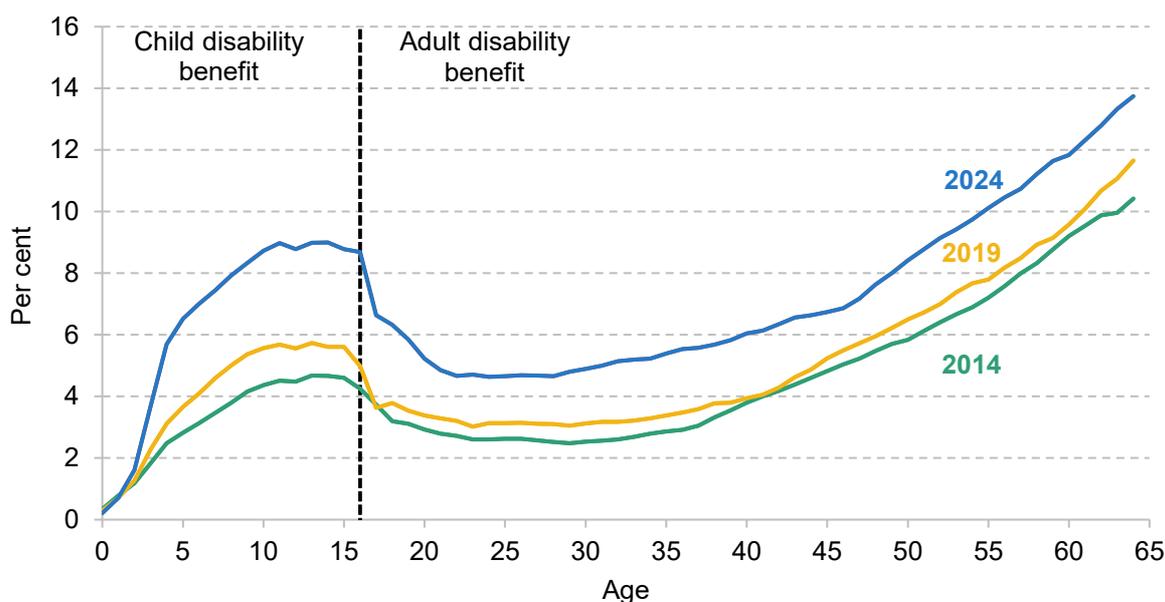
5.8 Later-life outcomes

Children who receive support relating to their disability also tend to have different outcomes in early adulthood compared with their peers.

Adult disability benefits

First, children receiving CDLA often move on to adult disability benefits. When a child who receives CDLA turns 16, they are invited to apply for personal independence payment (PIP), the primary benefit for adults with health conditions or disabilities. Figure 5.13 shows the share of people claiming disability benefits at different ages between 2014 and 2024. We can see that more people are claiming disability benefits at all ages from 0 to 64 now than they were five or ten years ago. The curve after about age 10 continues to be U-shaped, with teenagers and over-40s remaining more likely to claim disability benefits than young adults. In percentage terms, we have seen fastest growth in claims since 2019 for under-16s (+66%) and 16- to 40-year-olds (+70%) and slower growth for over-40s (+36%). Part of the increase in disability benefit claims amongst young adults is due to more children moving from CDLA to PIP at age 16. Currently rising child disability benefit claims imply further rises in disability benefit claims amongst young adults.

Figure 5.13. Share of population claiming a disability benefit by age, in 2014, 2019 and 2024

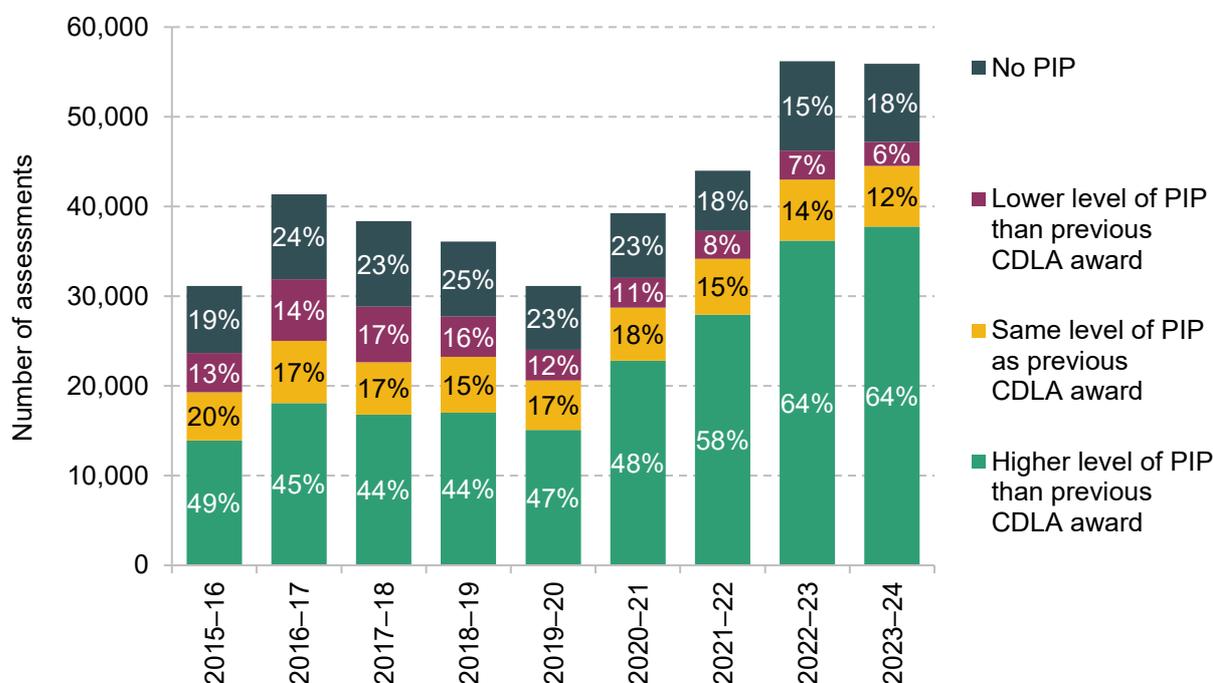


Note and source: DWP Stat-Xplore. Includes both disability living allowance (child and adult) and PIP claimants. During this period, PIP replaced disability living allowance as the main adult disability benefit. Changing state pension age explains part of the increase for claimants over 60.

The extent of the pass-through from CDLA to PIP depends on how many of those receiving CDLA apply for, and are successfully awarded, PIP. Figure 5.14 shows that amongst those who were receiving CDLA at age 15 who do apply for PIP, claims tend to be successful and indeed result in a higher award than CDLA provided. In 2023–24, 82% of CDLA claimants who applied for PIP were successful (and thus 18% got no PIP) and 64% received a higher PIP award than their CDLA award, 12% got the same award, 6% got less. On average, CDLA claimants who applied to be reassessed for PIP received £5,420 in CDLA before reassessment and £6,850

in PIP after reassessment, a 26% increase. This average includes people who were unsuccessful in their PIP claims and so get £0 in PIP. For those who were successful, the average award was £5,590 in CDLA before reassessment and £8,120 in PIP after reassessment, a 45% increase.

Figure 5.14. CDLA to PIP reassessments by outcome, 2015–23



Note and source: Authors' calculations using DWP Stat-Xplore. Bars are labelled with the percentage of reassessments with that outcome.

The share of CDLA claimants who are successful on reassessment has risen slightly since the COVID-19 pandemic, which may reflect either changes in PIP assessment from in-person to mostly online or increased needs amongst CDLA claimants. The fact that so many children receive a higher award when reassessed for PIP suggests a marked difference in how PIP and CDLA assess need. The government is reviewing the assessment process for PIP; there is a strong case for reviewing CDLA at the same time to coordinate the two benefits better.

CDLA claimants who move on to PIP at age 16 following reassessment tend to stay on PIP into their 20s. 61% of CDLA claimants aged 15 in 2014 were claiming PIP aged 22 (in 2021). Table 5.2 shows this relationship is particularly strong for those who also had EHCPs. For 15-year-olds in 2014 who were claiming CDLA and had an EHCP, 76% were on PIP at age 22, compared with 7.0% of those who had SEN support but no CDLA aged 15 and only 1.4% of those with no CDLA or SEND provision aged 15. If this pass-through rate of 61% from CDLA at age 15 to PIP claims at age 22 continues, the share of 22-year-olds claiming disability benefits

will rise from 4.7% now to 6.9% in 2031 due to more young adults being reassessed from CDLA to PIP.¹⁵

Table 5.2. Outcomes for pupils aged 15 in 2014, by SEND and CDLA status

SEND provision	CDLA	NEET rate, age 22	Employed, age 22	Out-of-work benefits receipt, age 22	PIP receipt, age 22	Share of pupils
None	None	13.9%	76.5%	12.4%	1.4%	80.9%
None	CDLA	21.9%	67.9%	28.1%	26.6%	1.0%
SEN support	None	25.5%	66.8%	27.5%	7.0%	11.1%
SEN support	CDLA	35.9%	52.4%	44.5%	47.6%	2.0%
EHCPs	None	35.0%	53.8%	37.9%	25.1%	0.8%
EHCPs	CDLA	50.1%	26.9%	59.9%	76.0%	4.0%
All	All	17.3%	73.0%	16.8%	6.4%	100%

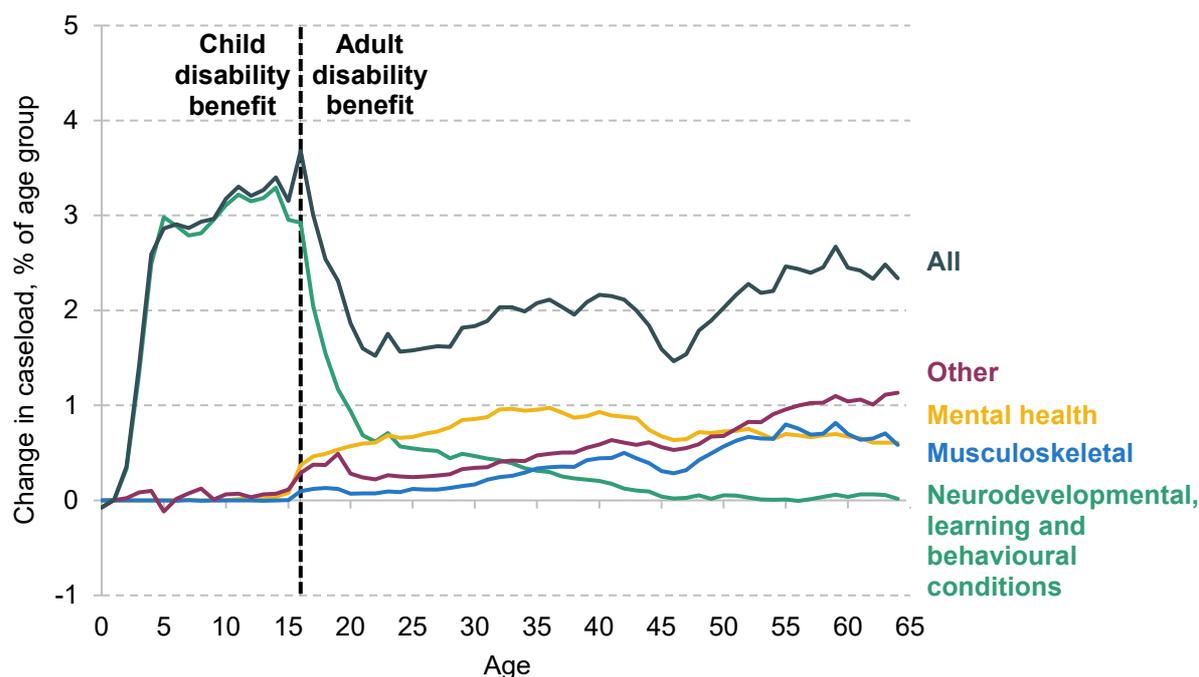
Note and source: Figures are calculated based on Longitudinal Education Outcomes data and as such may not line up with official statistics on NEET (not in education, employment or training) and employment rates or benefit receipt calculated from other sources. 'Share of pupils' percentages may not sum due to rounding. Outcomes for NEET and employment rates are for the cohort aged 15 in 2013, not 2014. Excludes pupils in private schools. 'Out-of-work benefits' includes anyone claiming income support, employment and support allowance, jobseeker's allowance, carer's allowance or UC in out-of-work or no work requirements groups. Some of these benefits allow claimants to do some work with a limit on earnings.

Figure 5.15 shows that there has been a big rise in disability benefit claims relating to neurodevelopmental, learning and behavioural conditions for adults aged under 24 as well as for children. For older adults, there has been a bigger increase in claims relating to mental health or musculoskeletal conditions.¹⁶ The rise in disability benefit claims relating to neurodevelopmental, learning and behavioural conditions in young adults comes from both a big increase in reassessments from CDLA to PIP and a big increase in new PIP claimants (Latimer, Pflanz and Waters, 2024). Currently, there is a steep age gradient in diagnoses and awareness for autism (O'Nions et al., 2023). As current children and young adults with diagnoses age, they will keep their diagnoses, and we may see the demand for support relating to these conditions spread further up the age distribution.

¹⁵ This assumes no change in the share of 22-year-olds who claim disability benefits having not claimed them as a 15-year-old.

¹⁶ Some of the difference in recorded condition between adults and children may reflect differences in recording practices for adult and child disability benefit claimants. We also only have information on the main disabling condition and it is common for claimants to report multiple conditions.

Figure 5.15. Change in disability benefit caseload as a percentage of age group population between 2019 and 2024, by age and type of main condition



Note and source: DWP Stat-Xplore. Conditions listed for disability living allowance and PIP claimants have been combined (see Appendix 5C for details on which conditions are included in each category).

Employment, education and out-of-work benefits

Beyond the receipt of disability benefits as adults, there are a variety of other later-life outcomes we may be interested in. In general, we would expect that employment outcomes would tend to be worse for those who had disabilities as a child as they tend to have worse education outcomes (see Section 5.7) and their condition may persist into adulthood and limit their ability to work. Table 5.2 shows this: 50% of those who received both an EHCP and CDLA aged 15 were not in education, employment or training (NEET) aged 22, making them three times more likely to be NEET than their peers; and 60% of children who received both an EHCP and CDLA aged 15 were on out-of-work benefits at the age of 22, making them four times more likely to be on out-of-work benefits than their peers.

Large gaps can also be seen when looking just at the population of children eligible for free school meals (FSM) at age 15, which serves as a proxy for deprivation. Among this group, those with both an EHCP and CDLA at age 15 were twice as likely to be NEET than the whole FSM population, for example (relative to nearly three times as likely among the non-FSM population). This suggests that the differences in later-life outcomes are far from fully explained by differences in parental income. There are a variety of reasons why disabilities may make it difficult or in some cases impossible for young people to transition into paid work. Nevertheless,

the scale of differences in outcomes between those with and without identified additional needs as children is stark.

Gaps in early-career employment and training outcomes are likely to lead to persistent differences in earnings in later adult life. We are only able to look at outcomes at age 22, but many of those who are not in education, employment or training aged 22 will move into paid work in later life as employment rates tend to rise for young people as they move through their 20s and into their 30s. We therefore might expect some of the gaps in outcomes explained above to shrink over time. However, there is good evidence that both employment experience in early adulthood and educational attainment have persistent positive effects on earnings and employment in later life (Oreopoulos, von Wachter and Heisz, 2012; Machin, McNally and Ruiz-Valenzuela, 2020; De Fraja, Lemos and Rockey, 2021; Britton et al., 2022). Since we know children who receive special educational support or cash support for a disability tend to have both worse academic outcomes and lower employment rates in early adulthood, it is likely that they will continue to have below-average employment and earnings outcomes throughout their adult life.

Given these stark differences, it is important the government consider the impacts of any reforms it makes on outcomes in adulthood. Currently, many children with disabilities will grow up, struggle to find work and receive a significant amount of support through the benefit system. Reforms that helped these children to find work and thrive in adulthood could improve both their income and well-being as adults.

These reforms would also reduce the cost of supporting these children in adulthood and support the government's aims for employment. A third of 22-year-olds who were not in education, employment or training received some form of SEN support or CDLA aged 15, so a key part of the government's strategy to meet its aim of reducing the NEET rate should be to improve outcomes for this group. Similarly, low employment rates amongst young people with disabilities are a barrier to the government's ambitious aim to increase the employment rate to 80%.

We have little evidence on the causal impacts of support for children with special educational needs and disabilities on later-life outcomes. The impact of early-life support on later-life fiscal costs is unclear. It could be that certain types of targeted support for children with additional needs support them to thrive in education, increases their employment in later life and reduces the net subsidy (in taxes and benefits) they receive. An argument could also be made that more support in earlier life increases the likelihood of those children going on to rely too much on

state support in later life through reducing stigma around claiming benefits¹⁷ or through the current model of focused support failing to build children's skills to thrive as adults. Improving evidence on the long-term effects of support for children with additional needs should be a priority for future research.

5.9 Conclusion: options for reform

Before discussing the options for reform, it is important to be clear on the objectives for the systems of support for children with extra needs and disabilities. In general terms, they are to provide the best support at the lowest possible long-run cost.

This further requires a consideration of the outcomes one is seeking to achieve. For benefits targeted at children with disabilities, this is likely to include covering the extra costs associated with children's disabilities, boosting the living standards for families where parents' caring responsibilities limit their ability to work, and unlocking additional opportunities for young people that the costs of a disability might otherwise block. For SEND, the aims usually focus on the ability of children to attend and properly engage with, and benefit from, education. However, it is also crucial to consider longer-run outcomes, such as subsequent educational and labour market outcomes. Given the long-run costs associated with poor educational and labour market outcomes – not least for the individuals concerned, but also for the state – these longer-run outcomes are arguably far more important than immediate outcomes. Unfortunately, they are rarely specified or considered in current policy debates.

With these objectives in mind, one policy option is to maintain the current system. This is likely to involve continued rapid rises in numbers of children with CDLA and EHCPs. Most evidence suggests past increases have been driven by lower diagnostic thresholds and greater awareness, with no obvious stop to this process in sight. Without any reforms, this will also continue to push up spending. Total real-terms spending on high needs in schools and CDLA has already risen from £10 billion in 2016 to £16 billion in 2024, with projections implying spending could rise to over £20 billion by 2028 (all in 2025–26 prices). One could argue that such spending is needed to meet the needs we are increasingly aware of. However, if the quality of support is poor, such spending would be wasteful – and could also be driving poor long-term outcomes, which may be even more costly. It also needs to be traded off against many other areas of spending where the government might want to spend more.

¹⁷ There is some evidence for a similar dynamic in families where parents claim disability benefits. Dahl, Kostøl and Mogstad (2014) use variation in appeal judge leniency to show that a parent claiming disability insurance in Norway has a positive causal impact on the chances of the child claiming disability insurance. Reduced stigma around benefit claiming may be overall a positive outcome, as it increases access to support, but it does come at a fiscal cost.

With or without any policy changes, the Office for Budget Responsibility should produce and publish annual forecasts of high-needs spending by councils. The rapid and uncertain growth in spending is having a material impact on the public finances and the government's ability to manage them. With spending effectively set bottom-up by EHCPs, it is now behaving more like Annually Managed Expenditure (AME, spending that is difficult to precisely control year-to-year) rather than spending with a firm budget. The accumulated level of high-needs debt is also a clear fiscal risk that needs to be tracked transparently.

In our view, there is a strong case for a holistic review of the support that the government provides to young people with special educational needs and disabilities, with a particular focus on growing needs such as autism and ADHD. The government has already set out its ambition to reform the SEND support system in schools and we think this is an opportunity to join this up with a broader review of other support provided for children with disabilities, including support through the NHS, social care and the benefit system. This would require the government setting out its objectives for targeted disability-related support and gathering more evidence on who receives the different types of support that young people receive relating to special educational needs and disabilities, the costs of that support, and how effective different interventions are in improving outcomes for these children and their families.

The government should also review the assessment process, benefit rates and eligibility criteria for CDLA. CDLA was introduced in 1992 and remarkably it has not been subject to a formal review since then. We live in a very different world now from in 1992. There is now much greater awareness around conditions such as autism and ADHD, and there have been numerous large reforms to the benefit system during that time. A review is well overdue. So it makes sense to review CDLA now, especially given that the government is already carrying out the Timms review into PIP.

If the government is looking to reduce projected spending on support for children with special educational needs and disabilities, the obvious – but not easy – options are to restrict eligibility or to reduce the rates of support per child. For CDLA, this could encompass lower rates or stricter eligibility criteria. For education, it could encompass focusing EHCPs on specific groups, such as those attending special schools, or imposing tight caps on support for different types of needs. If applied immediately, such reforms are likely to generate short-run savings. They would also result in lower levels of support for some current recipients. This is an unavoidably difficult trade-off for government. If it wants to reduce costs in the short run significantly, it will need to withdraw and reduce focused support for some children and their families.

A more attractive but challenging option is to try to provide the same – or perhaps even better – quality of support at a lower cost. One way to do this may be to increase the number of state-

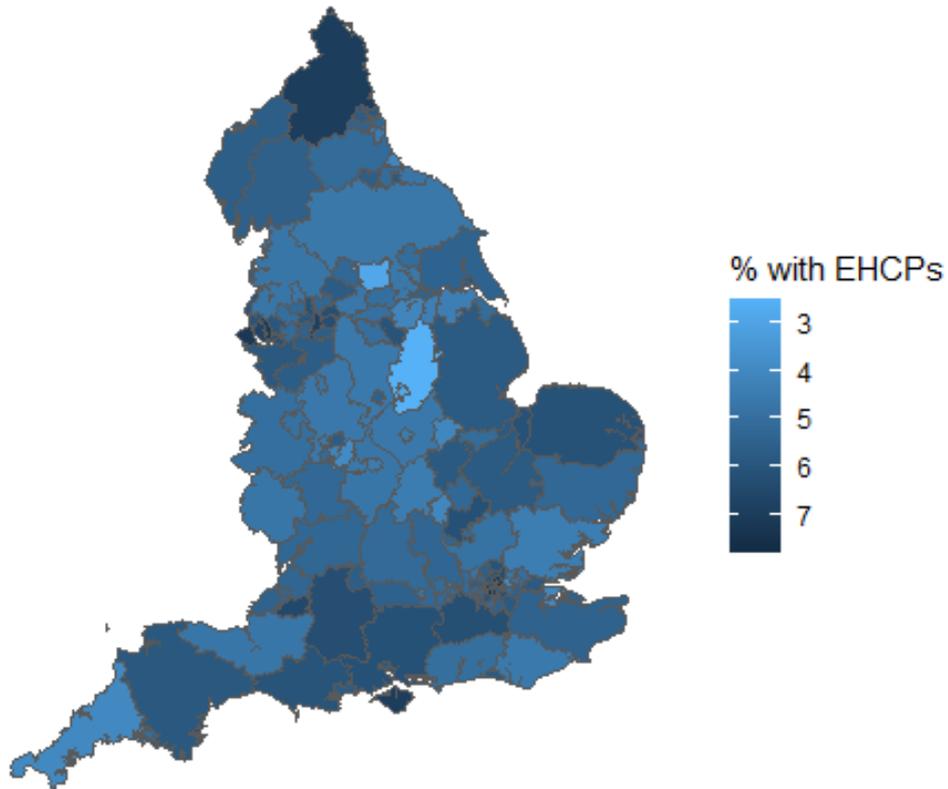
funded special school places and reduce the use of independent special schools, which are particularly costly per student (Sibieta and Snape, 2024). Improving core provision in mainstream schools, with a particular focus on conditions such as ADHD and autism, might be another way of doing this. This could benefit both those who currently have an identified condition and those who have similar symptoms but no identified condition. The government has set aside some money for SEND reform (about £550 million in 2026–27 and £200 million in 2027–28) which may be able to contribute towards funding improved core provision. This could also be enabled by moving funding from the high-needs funding block to the core schools block. However, this would only be possible if demand for spending through EHCPs can be reduced.

The government may also want to consider changing the way support is funded, particularly the way EHCPs are funded. Currently, CDLA is funded in the same way as other social security benefit spending. The overall level of spending is determined automatically by benefit rates and the number of people meeting the criteria. Spending on EHCPs is actually determined in a similar way, with spending set by the statutory provision set out in EHCPs. However, funding is fixed each year, like much of the rest of public service spending. This is a major reason for the present financial crisis in SEND spending and why councils have built up large deficits. One alternative would be to make EHCP funding increase automatically with the number of people awarded EHCPs and to set specific cost rates for different categories of EHCP based on the type and level of need. By automatically linking spending and funding, this would reduce pressure on local authority budgets, would improve transparency around costs, and could help to improve fairness across local areas. Those benefits would need to be weighed against the significant risks of (even) faster growth in the numbers seeking EHCPs, as schools and local authorities may, in the absence of a fixed budget constraint, be more inclined to encourage students (or less inclined to discourage them). That risks adding to the spending pressures facing the government as a whole.

There is unlikely to be an easy solution to the rising demand for support for children with special educational needs and disabilities. Rising costs are making the Chancellor's decisions – not least at the coming Budget – more difficult, and any short-term savings would require reducing support for children with assessed high levels of needs. Nevertheless, as costs continue to rise, there is an urgent case for reviewing the whole current system of support.

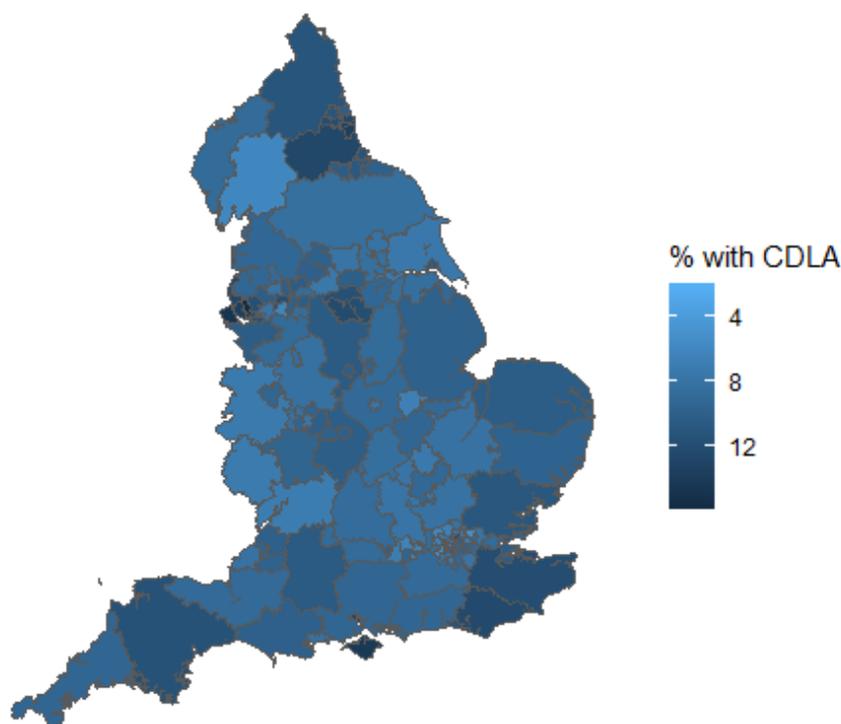
Appendix 5A. Geographical distribution of support

Figure 5A.1. Share of pupils under 16 with an EHCP by local authority, January 2025



Note and source: Authors' calculations from SEN in England statistics (<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>). Local authorities are upper-tier local authorities.

Figure 5A.2. Share of children under 16 with CDLA by local authority, February 2025



Note and source: Authors' calculations from DWP Stat-Xplore. Local authorities are upper-tier local authorities.

Appendix 5B. Forecasting EHCP numbers and spending

This appendix sets out our approach to projecting the future number of children receiving EHCPs and future high-needs education spending. We first describe the existing forecasts that are available, then we explain how we project EHCPs and high-needs spending. High-needs spending predominantly covers the costs of EHCPs, so our projections for high-needs spending are based off our EHCP projections.

Existing forecasts

In its report last year, the National Audit Office published a range of Department for Education forecasts for high-needs spending up to 2028, assuming no reforms. These imply 5% real-terms growth in spending in 2025, taking annual spending on high needs up to about £12 billion. The forecasts then imply further growth in spending up to about £14 billion in 2028, or total real-terms growth of about 4½% per year between 2025 and 2028. These forecasts are now out of date and we have thus created our own projections, again assuming no reforms.

Projecting the number of pupils with EHCPs

We take the share of pupils with EHCPs in 2025 by single year of age as given (from ages 4 to 16). We then estimate the share of pupils with an EHCP in 2026 based on the historical growth rates across ages from one year to the next (e.g. for age 5, it is the average annual growth from age 4 to age 5 over 2016 to 2025). For age 4, we base it purely on the average change in EHCPs amongst 4-year-olds as it is the start of our projection cohort. This process is continued until 2029 (the end of the current Spending Review period). We estimate numbers of EHCPs based on these rates and official projections of pupil numbers by single year of age.

Our projection implies growth in the share of EHCPs amongst school children aged 4 to 16 from 5.4% in 2025 to 8.3% in 2029. This would be even higher if we based our projection only on the more recent rates by age from 2020 to 2025 (8.7% per year). Such forecasts could be biased upwards if growth rates in EHCPs across ages within the same cohort slow down because of increased identification at younger ages (i.e. fewer EHCPs are awarded at later ages because EHCP needs are now identified at younger ages). However, there is no sign of that happening yet. The historical average growth rates across ages remain close to the actual growth rates by age in 2025.

Projecting high-needs spending

We then use the growth in EHCP numbers to project growth in high-needs spending. We assume that, in real terms, high-needs spending grows at 60% of the growth rate in EHCP numbers (the average ratio between spending and numbers growth between 2016 and 2025). This assumes further real-terms falls in spending per EHCP (see Section 5.6). This is likely to happen if increased identification reflects lower-cost and more-moderate needs over time (see Section 5.7). Under this scenario, high-needs spending would grow by over £3 billion in total or 6% per year in real terms between 2025 and 2029, reaching £15.7 billion in 2029. This would match the 6% average annual real-terms rate of growth in spending between 2016 and 2025. Under this scenario, spending in 2028 would be £600 million higher than government central forecasts quoted by the National Audit Office in 2024.

Given uncertainty, we produce two alternative scenarios for the ratio of spending growth to projected growth in EHCP numbers. In the low spending growth scenario, the ratio between spending and EHCP numbers growth is set at 40%, which would be lower than any year since 2016 (excluding the 2020 pandemic year). In this case, annual high-needs spending would rise by about £2 billion in total or 4% per year in real terms between 2025 and 2029. In the high growth spending scenario, we set the ratio at 80%, about the same as in 2024 and the average between 2020 and 2022. In this case, annual spending would rise by over £4 billion in total or 8% per year in real terms.

Appendix 5C. Mapping of PIP and DLA conditions

Figures 5.13 and 5.15 contain data on both claims to personal independence payments (PIP) and claims to disability living allowance (DLA). The information on conditions available for both benefits are broken down into different categories, which do not map exactly to each other. We group these conditions into four categories based on PIP conditions and then allocate DLA conditions to those categories based on data on reassessments from DLA to PIP. The mapping of conditions to grouped categories is summarised in Table 5C.1.

Table 5C.1. Mapping of PIP and DLA conditions

Grouped conditions	PIP main disabling condition	DLA main condition
Neuro-developmental, learning and behavioural	Specific learning disorder	Behavioural disorder
	Learning disability global	Learning difficulties
	Autistic spectrum disorders	Severely mentally impaired
	Hyperkinetic disorder	Hyperkinetic syndrome
Mental health	All other psychiatric disorders excluding those included in learning and behavioural conditions and cognitive disorders	Alcohol and drug abuse Personality disorder Psychoneurosis Psychosis
Musculoskeletal	Musculoskeletal disease (general) Musculoskeletal disease (regional)	Arthritis Back pain – other / precise diagnosis not specified Chronic pain syndromes Disease of the muscles, bones or joints Double amputee Spondylosis Trauma to limbs
Other	Everything not included in above categories	Everything not included in above categories

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