

Supporting referrals to Forth Valley NHS

Neurodevelopmental Difficulties (NDD) Assessment Pathway

Guidance for Local Authority Education Staff

Across Forth Valley

2023

**Contents**

[Click on headings and subheadings in contents page to navigate the document]

|  |  |
| --- | --- |
| **Headings** | Pages |
| [**1. Introduction 1**](#_heading=h.gjdgxs)* 1. [How to use this guide](#_heading=h.30j0zll)

 [1](#_heading=h.30j0zll) |  |
| [**2. Background Policy and Legislation 2**](#_heading=h.1fob9te)[2.1 National Neurodevelopmental Specification for Children and Young People 2](#_heading=h.3znysh7)[2.2 Education Legislation 2](#_heading=h.2et92p0)[2.3 Getting It Right For Every Child (GIRFEC) 4](#_heading=h.tyjcwt) |  |
| [**3. Gathering initial assessment information 5**](#_heading=h.4d34og8)[3.1 The process of making a request 5](#_heading=h.2s8eyo1)[3.1.1 Categories for recording child development concerns 7](#_heading=h.17dp8vu)[3.2 General principles of initial assessment 9](#_heading=h.3rdcrjn)[3.3 Checklist of information to include 10](#_heading=h.s7c9dk41i6yz) |  |
| [**Appendices 12**](#_heading=h.lnxbz9) |  |
| [**Appendix A:** Forth Valley NDD Test of Change 12](#_heading=h.35nkun2)[A.1 Needs analysis summary 12](#_heading=h.1t3h5sf) |  |
| [**Appendix B:** NDD summaries 16](#_heading=h.mzzu0o2m9gbv)[B.1 ADHD 16](#_heading=h.1ksv4uv)[B.2 ASD 17](#_heading=h.44sinio)[B.3 Developmental Motor Coordination Disorder (previously dyspraxia) 19](#_heading=h.1y810tw)[B.4 Learning Disability/ Disorders of Intellectual development 20](#_heading=h.4i7ojhp)[B.5 Tic disorders 21](#_heading=h.2xcytpi)[B.6 Foetal Alcohol Syndrome/Foetal Alcohol Syndrome Disorder (FAS/FASD) 22](#_heading=h.1ci93xb) |  |
| [**Appendix C:** Example paperwork 23](#_heading=h.3whwml4)[C.1 Form 2A: Wellbeing Observations and Assessment 23](#_heading=h.2bn6wsx)[C.2 Form 6: Record of Child/Young Person’s Meeting 28](#_heading=h.2grqrue)[C.3 ASD home-school observation tool (ICD-11 criteria) 31](#_heading=h.wwx41bufuazq)[C.4 ADHD home-school observation tool (ICD-11 criteria) 35](#_heading=h.92sdkatkz7mc)[C.5 Sensory Checklist 41](#_heading=h.mow9jreaacb9)[C.6 Example covering letter 47](#_heading=h.66zzkxv2oak8) |  |
| [**Appendix D:** Glossary of Terms 48](#_heading=h.46r0co2)[D.1 Education terms 48](#_heading=h.2lwamvv)[D.2 Health Terms 50](#_heading=h.111kx3o)[D.3 Professional titles 51](#_heading=h.3l18frh)[D.4 IAF paperwork section 52](#_heading=h.206ipza) |  |
| [**Appendix E**: 54](#_heading=h.2zbgiuw) [E.1 Pre Education Children Process Map 54](#_heading=h.1egqt2p) |  |

# Introduction

Following a test of change project funded by the Scottish Government (see Appendix A for further details), this guidance has been designed specifically for local authority education staff across Forth Valley who may need to make a request for assistance to Forth Valley NHS (FV NHS) for a Neurodevelopmental Difficulties (NDD) assessment. The aim of the guidance is to support consistency of information being provided at the point of the request for assistance, and to ensure that the information being submitted to colleagues in Health is clear in terms of what the request is for, allowing the request to be processed by Health.

## 1.1 How to use this guide

This guide aims to provide all the information needed to make a request for assistance for a child or young person (CYP) where there are concerns about a possible NDD. For ease, links have been embedded in the contents page and throughout the document, to allow users to navigate to different sections of the document.

**Readers are invited to proceed straight to Section 3,** [**Gathering Initial Assessment Information**](#_heading=h.4d34og8) **for the specific outline of making a request**, while information about the context and background to the creation of the document has been included at Section 2.

Documents designed to be referenced while gathering assessment information are included in Appendices:

* Appendix B - [NDD Summaries](#_heading=h.35nkun2)
* Appendix C - [Example paperwork](#_heading=h.3whwml4)

Throughout this document the word assessment has been used to describe the process of gathering initial information to inform these requests. Assessment can be qualitative, observational or include more standardised assessments where they have been used. It is not expected that standardised assessments are required to make a request for NDD assessment.

Neurodevelopmental Disorders (NDs) are a group of lifelong conditions that affect the way an individual’s brain develops. They include, but are not limited to, Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Intellectual Disability (ID) and Foetal Alcohol Spectrum Disorder (FASD).

# Background Policy and Legislation

## 2.1 National Neurodevelopmental Specification for Children and Young People

The process of assessing and identifying NDD is undergoing a process of change in Scotland. The National Autism Implementation Team (NAIT) published the ‘[Children’s Neurodevelopmental Pathway and Guidance](https://www.thirdspace.scot/wp-content/uploads/2021/05/Childrens-Neurodevelopmental-Pathway-and-Guidance-2021.pdf)’ in 2021 for professionals involved in identification of a broad range of NDD and proposes a new model of assessment. This model would see a single pathway of assessment from the age of 0-18 years, with a single point of entry, which would consider all NDD profiles within a multidisciplinary team, meaning that multiple referrals for assessment should no longer be needed.

The recent publication of the Scottish Government [National Neurodevelopmental Specification for Children and Young People: Principles and Standards of Care (2021)](https://www.gov.scot/publications/national-neurodevelopmental-specification-children-young-people-principles-standards-care/) sets out the standards and availability of services that people aged up to 25 years old can expect. The Specification is for children and young people who have neurodevelopmental profiles with support needs and require more support than currently available.

Historically, in Forth Valley, referrals for assessment of NDD were made to Forth Valley Child and Adolescent Mental Health Service (CAMHS), but in many cases mental health was not the primary concern. Work is now underway in Forth Valley

to have a different NDD assessment pathway that sits separately from CAMHS.

## 2.2 Education Legislation

[The Education (Additional Support for Learning) (Scotland) Act](https://www.legislation.gov.uk/asp/2009/7/contents) (2004, amended 2009) outlined the expectations and duties for local authorities to identify and provide support for a broad range of additional support needs ([ASN](#_heading=h.2lwamvv)). While broadening the agreed definition of ASN the Act, and the supporting Codes of Practice outline that support in education is not dependent on having a diagnosis. This means that often significant adaptations are being provided, sometimes universally, in schools without formal identification of difficulties. In Forth Valley, the three local authorities (Stirling, Falkirk, Clackmannanshire) identify, manage and review additional support needs regularly in schools and nurseries, and in Stirling and Clackmannanshire this is managed by their respective [Staged Intervention Processes](#_heading=h.2lwamvv).

The Act also give parents and carers or eligible children, the right to request assessments (see the Enquire website for information made available to parents/carers <https://enquire.org.uk/parents/getting-support/assessment/>). Where those assessments cannot be completed by the Local Authority, and would normally be carried out by an ‘appropriate agency’ (such as Health), then the Local Authority would request the assessment on behalf of the parents or carers, or eligible child. In practice this may mean that parents and carers can ask schools or the education authority to help them access assessment for NDD from Health even where the school has not observed significant indicators for concern, or they may feel they already have a good understanding of the ASNs with appropriate support in place.

For example, professionals who work with and/or assess pupils who have an autism spectrum disorder (ASD) are aware that sometimes presentation between home and school may be very different. Some pupils with ASD may engage in the strategies of masking and/or social camouflage and their difficulties may not be apparent in a school setting. Sometimes the general environment of school may be set up to support difficulties (such as for concentration or short term memory issues) which may mean that parents see more difficulty at home than would be evident at school. These discrepancies in presentation should not be a barrier to the Team around the Child (TAC) gathering initial assessment information or making a referral for further assessment

## 2.3 Getting It Right for Every Child (GIRFEC)

GIRFEC provides a framework for assessment through the [National Practice Model](https://www.gov.scot/policies/girfec/national-practice-model/) and the [eight wellbeing indicators](https://www.gov.scot/policies/girfec/wellbeing-indicators-shanarri/) (including an emphasis on the [UN Convention on the Rights of the Child](https://www.unicef.org.au/united-nations-convention-on-the-rights-of-the-child)).

In Forth Valley, GIRFEC is the approach used for the assessment and planning of a child or young person's support needs. There is an agreed [suite of paperwork](#_heading=h.206ipza) (described as the Integrated Assessment Framework or IAF paperwork) designed to be used by all agencies. In practice the IAF paperwork is widely used by education and child care services in all three local authorities as part of their assessment, planning and reviewing processes.

# Gathering initial assessment information

## 3.1 The process of making a request for assistance for NDD



This guidance outlines the process of:

* Gathering initial assessment information.
* Providing a description of the assessment information, and any supports already provided, using the Integrated Assessment Framework (IAF) paperwork such as the completion of the request for assistance.
* Where to send the request for assistance once completed.

The process of triaging requests for assistance and proceeding with assessment, sits with Health and are not described here.

The [Team Around the Child (TAC)](#_heading=h.2lwamvv), supporting a child or young person, are not responsible for ‘proving’ that an NDD is present when they make their request. Their role is to describe, with enough relevant information:

* what has been observed,
* the impact this has for the child or young person and,
* what supports are in place or have been tried.

For the benefit of colleagues in Health it is important to note that membership of a TAC can vary. In some cases there may be representation from a variety of agencies. In other cases the TAC may consist of the school and family. **Educational Psychologists, Speech and Language Therapists and other professionals do not need to be involved for a TAC to make a request for NDD assessment.** Schools are involved in a continuous process of assessment and review and can provide a rich source of assessment information, without seeking additional support from other agencies. Where these agencies have been involved recently, and have relevant information to provide, the school will include this in the paperwork at the point of referral. Colleagues in Health should also note that the local authorities in Forth Valley do not all use the staged intervention approach in the same way. This means that the stage of intervention cannot be used as an indication of the impact of difficulties.

To support schools to gather relevant information to make a request for assistance, a description of the various difficulties that may be referred for assessment has been provided in Appendix B. The TAC can use these descriptions to guide their initial observation gathering. They can be used as a checklist. Additional observation tools for ASD and Attention Deficit Hyperactivity Disorder (ADHD) are provided in Appendix C.

It is important to note that the TAC does not have to consult or involve other professionals to gather assessment information to support the request for assistance. Where other professionals are involved their views can be recorded in minutes of a meeting.

Example IAF paperwork with an outline of what (and what not) to include in each section has been provided as a guide for schools to support the provision of relevant information (see Appendix C). It is not necessary to describe every example of a behaviour that has been observed. A summary of behaviours with some indication of how these might relate to the potential NDD is all that is required. A summary of the categories outlined in the NAIT referral document is also included below and the TAC may want to consider how their observations sit under these headings, where relevant, (e.g. the TAC may not know, or it may not be relevant to comment on issues related to Physical Health). In the table these headings have been mapped on to the GIRFEC Wellbeing Indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included (SHANARRI).

### 3.1.1 [Categories for recording child development concerns](https://www.thirdspace.scot/wp-content/uploads/2021/05/Appendix-2-NAIT-Request-for-Neurodevelopmental-Assessment-Template.pdf)

|  |  |  |
| --- | --- | --- |
| NAIT Category | Examples | Matched SHANARRI indicator |
| **Physical Health** | Medical investigations, diagnoses, treatment, sleep, eating/weight - especially where these things are being impacted on by the potential NDD | **Healthy** |
| **Mental Health** | Emotional wellbeing, anxiety, mood, any evidence of self-harming behaviours - especially where the possible NDD appears to be having an impact, or where this might be the principal indicator.  | **Healthy** |
| **Learning** | Curriculum levels, supports required in school, areas of strength/difficulty in learning - describe the impact the potential NDD is having on the child/young person's ability to access the curriculum | **Achieving** |
| **Attention, hyperactivity and impulse control** | Attention and focus for tasks, levels of activity, organisational skills, impulse control, challenging behaviour - comment here on issues that are out with what would be expected for the age or developmental stage of the child (e.g. if a child has a learning Disability their attention skills would be expected to be behind what is typical for their age). | **Achieving** (for attention to tasks and impact on learning)**Active** (to describe levels of activity and how these may be different to what may be expected for same age peers and the impact of this activity on learning)**Safe** & **Responsible** (to describe the impact of impulsive behaviours if present) |
| **Speech and Language** | Speech clarity/fluency, receptive and expressive language skills - particularly difficulties following and using language to communicate | **Achieving** (to describe how this may be different developmentally from peers)**Included** (how these issues may impact on the child/young person's ability to be successfully included) |
| **Adaptive Functioning** | Personal care skills such as washing, toileting, teeth brushing, dressing; sense of safety such as hot, sharp, road safety, car travel; understanding of time, money - this is the place to describe the impact of any difficulties on functions of daily living and development of self-care and life skills | **Healthy**(to describe any impact issues with these skills may be having on a cyp health)**Achieving** (to describe how these skills are different to what might be expected for same age peers) |
| **Social Communication & Interaction** | Communication skills, how successful are they at being able to communicate their thoughts and ideas, conversational skills, ability to build relationships with peers and adults, social awareness and how interested/motivated are they to interact with others | **Achieving** (describe how any difficulties with these skills are impacting on learning)**Respected, Responsible****Included** (how do any difficulties with these skills impact on a cyp ability to be included) |
| **Thinking Skills** | Memory, problem solving, planning skills, ability to cope with changes in routine, adapt behaviour for situations, specific interests | **Achieving**  |

A glossary of terms has been provided to support mutual understanding across the Local Authorities and Health (See Appendix D).

## 3.2 General principles of initial assessment

When making a request for assistance, those requesting assistance will outline the concerns and the behaviours observed.

It is helpful to provide information about appropriate relevant education and developmental history. This might include whether or not there has been a delay in reaching developmental milestones; if there has been any access to other professionals for support or assessment; if there has been adequate access to learning and support opportunities; if the intervention was successful or effective.

Requesters may wish to describe universal supports that are in place which may minimise the presentation of difficulties or support functioning. When making requests it is helpful to describe good practice that is currently being used and how this may be supporting the child/young person to function more effectively. It is also helpful to describe what has already been assessed or excluded. Being clear where other relevant professionals have assessed and what has been identified or ruled out (e.g. Speech and Language Therapy do not have concerns about speech and language development), what a school’s assessment of attainment is - especially where there are no concerns about learning or if specific learning difficulties have already been identified.

In general, Additional Support Needs of a neurological basis:

* are likely to present in childhood (although they can be masked or managed better depending on what they are, how significant they are and the supports in place),
* will have an impact in all settings (although what the impact is will depend on the setting, the demands of that setting and what existing supports are in place there),
* and persist over time (although how they present may change as the child/young person develops and in response to intervention).

Providing an outline that shows evidence of when concerns first emerged, of how concerns have presented over time and how they present across different settings, i.e. of how pervasive and persistent they might be, helps to show that an NDD may be present.

## 3.3 Checklist of information to include

1. Contact information (Usually on a Form 1)
2. Relevant developmental and education history information
3. Information about any strategies, supports or interventions
4. Description of the difficulties and behaviours observed (use the descriptions of NDD in Appendix B to support)
5. Description of the impact the difficulties are having just now AND/OR the potential impact if the difficulties are not assessed (can be included in the SHANARRI assessment and minutes of the TAC meeting
6. Decision of the TAC about referral for assessment including the parent/carers’ views about this (and where appropriate the views of the child/young person).
7. Covering email (see Appendix C)

This information can be provided using the [IAF paperwork](#_heading=h.206ipza), Form 1, Form 2 and Form 6. (see Appendix C for an outline of the various IAF forms and their uses). Form 2 provides the fuller assessment picture and an opportunity to outline factors that are impacting on a child or young person’s wellbeing or development. Form 2 and 6 both provide space to share the decisions of the TAC regarding making a Request for Assistance.

Example forms giving an outline of how the information described above can be included in these forms. Once completed the following paperwork should be submitted to: fv.camhs@nhs.scot

# Appendices

## Appendix A: Forth Valley NDD Test of Change

Following publication of the National Neurodevelopmental Specification for Children and Young People: Principles and Standards of Care (2021), NHS Forth Valley was identified as one of five local NHS boards (with associated local authority areas), to take forward a test of change (ToC) related to the implementation of the national specification. The specification aims to ensure that children and families receive support at the earliest opportunity, in line with the GIRFEC approach and for support to be more community based and easily accessible.

The aim of the Forth Valley ToC originally was to conduct a full initial multi-disciplinary community-based assessment, based on the information within the request for assistance form, (and on the child’s plan where completed) in order to streamline the assessment process and to avoid duplication of work. Forth Valley NHS would support the 3 local authority areas i.e. Falkirk, Stirling and Clackmannanshire on a test of change focused on the provision of early assessment formulation for a child or young person presenting with neurodevelopmental needs, at an earlier stage of the staged intervention process.

To support the ToC a Project Team was established. The Project Team created an evaluation framework with a needs analysis phase, implementation phase and evaluation phase. The results of the needs analysis phase are outlined below and were used to modify the aims of the project.

### A.1 Needs analysis summary

As part of the ToC needs analysis phase a Forth Valley-wide study of the current processes used by those who make Requests for Assistance (RfA) for NDD assessment was completed in October 2022. One element of the needs analysis was a survey of school staff (responsible for making requests), which showed that while most respondents reported feeling confident about how to describe different aspects of various NDDs, less than half (43.7%) felt confident about making the request.



The survey revealed that most felt unsure about exactly what information was expected from them, with respondents describing a variety of information, screeners and assessments that they might include. There was also some frustration that even when seeming to provide a lot of supporting evidence, requests were not always accepted and that responses to requests were not consistent. Survey responses reflected that a considerable amount of additional time and paperwork was required to make these requests, in addition to the processes of planning and review within schools. Overall analysis of responses indicate that the reason respondents did not feel confident about making requests was because they were unsure about the process and what was expected from them by the service receiving the requests.

While the survey reflected that schools were often doing a lot of work, the actual information being provided was very varied and not consistent. This was supported by an audit of the actual requests received by Health, which showed that:

* 46% of requests had an active Team Around the Child (TAC) and supporting evidence
* 24% had no supporting evidence or additional information.

The inconsistency of information at the point of making a request could make it harder for Health to triage referrals, and might lead to requests for further information being made to schools. The experience within Health when reviewing the RfAs was that:

* often there was not clear information about what the issues were,
* what was being asked to be assessed,
* if the issues were having any notable impact on the child or young person’s daily experiences and
* what support (if any) was already in place.

From this research it was identified that a set of guidance to support those who are asked to make requests for NDD assessment would be helpful. This guidance is intended to outline what the process is for making requests and what information should be provided to support the request. It is hoped that this guidance will ensure that all three local authorities will be providing the same information, on the same paperwork at the point of making requests. This should therefore mean a more streamlined process for referrers while providing consistent information for the receivers of requests.

This document (Supporting referrals to the Forth Valley Neurodevelopmental Difficulties (NDD) Assessment Pathway: Guidance for Education staff) outlines the steps schools need to undertake in gathering initial assessment information, pre-referral, and the process of making a request for assessment to the NDD Pathway.

Not all difficulties which might come under the broad heading of neurodevelopmental difficulties would be assessed through the NDD pathway. For example Specific Learning Difficulties, (such as dyslexia and dyscalculia) would be assessed within Education. Developmental Language Disorder (DLD) would be assessed by Speech and Language Therapy. Visual Stress can be assessed by a behavioural optometrist.

It is also the case that much of the information that is required to make an assessment will lie within the child or young person’s context (i.e. home and school).This means that specialist assessment for other NDDs e.g. ASD or ADHD will require information about assessment and observations from home school and other contexts to support their processes.

## Appendix B: NDD summaries

### B.1 ADHD

**ADHD ICD11 criteria**

Summary:

Must be evidence of persistent (at least 6 months) and pervasive (‘seen across multiple situations) difficulties with:

* Inattention
* Hyperactivity
* Both

That have a ‘direct negative impact on’:

* Academic functioning, or
* Occupational functioning, or
* Social functioning

Difficulties must be apparent before age 12. Likely manifest in early to mid-childhood. Individuals older than 12 may only seek clinical services once symptoms become more limiting with increasing social, emotional, and academic demands. Or sometimes may need to query ADHD in the context of an evolving co-occurring Mental, Behavioural, or Neurodevelopmental Disorders that results in an exacerbation of Attention Deficit Hyperactivity Disorder symptoms**.**

Difficulties must be beyond what would be expected for age and level of intellectual functioning. (i.e. children with developmental delay would be expected to show the levels of activity and inattention appropriate for their stage of development not their chronological age).

Difficulties should not be better explained by another difficulty (e.g. ASD, Dyslexia etc.) or the effect of substances or medication.

*Additional information from the authors of this guidance:*

*While most people are familiar with the ADHD profile (which has high levels of over activity and impulsivity) it is also possible for pupils to have attention issues without the hyperactivity part. If you suspect that a pupil may have an Attention Deficit Disorder it may still be appropriate to make a referral to ask for further assessment. See the observation tool in Appendix C.4 for further guidance.*

*Professionals who work with and/or assess pupils who have attention issues are aware that the general environment of school may be set up to support difficulties for concentration or short term memory issues, which may mean that parents see more difficulty at home than would be evident at school. These discrepancies in presentation should not be a barrier to the TAC gathering initial assessment information or making a referral for further assessment. Make sure that a clear outline of the general support strategies are included in the paperwork to explain why there may be a discrepancy.*

### B.2 ASD

**ASD ICD11 criteria**

Summary

Characterised by:

**A - Persistent deficits in social communication and social interaction across multiple contexts as outlined below:**

* **Deficits in social-emotional reciprocity (back and forward social interaction)** across the range **(**e.g: abnormal social approach; failure of normal back-and-forth conversation; reduced sharing of interests, emotions, or affect; failure to initiate or respond to social interactions)
* **Deficits in nonverbal communicative behaviours used for social interaction,** (e.g: poorly integrated verbal and nonverbal communication; abnormalities in eye contact and body language; deficits in understanding and using gestures; total lack of facial expressions and nonverbal communication).
* **Deficits in developing, maintaining, and understanding relationships,** (eg: difficulties adjusting behaviour to suit various social contexts; difficulties in sharing imaginative play; difficulties making friends; absence of interest in peers).

**AND**

**B - Restricted, repetitive patterns of behaviour, interests, or activities, manifested by at least two of the following, currently or by history, i.e.:**

* **Stereotyped or repetitive motor movements, use of objects, or speech** (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
* **Insistence on sameness, inflexible adherence to routines, or ritualised patterns of verbal or nonverbal behaviour** (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals need to take same route or eat same food every day).
* **Highly restricted, fixated interests that are abnormal in intensity or focus** (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
* **Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment** (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

**Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities; or may be masked by learned strategies in later life).**

**Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. These disturbances are not better explained by intellectual disability** (intellectual developmental disorder) **or global developmental delay.** Intellectual disability and autism spectrum disorder frequently co-occur. To make co-morbid diagnoses of autism spectrum disorder and intellectual disability, **social communication should be below that expected for general developmental level.**

*Additional information from the authors of this guidance:*

*Professionals who work with and/or assess pupils who have an ASD are aware that sometimes presentation between home and school may be very different. Some pupils with ASD may engage in the strategies of masking and/or social camouflage and so their issues may not be apparent in school. Sometimes the general environment of school may be set up to support difficulties (such as for concentration or short term memory issues) which may mean that parents see more difficulty at home than would be evident at school. These discrepancies in presentation should not be a barrier to the TAC gathering initial assessment information or making a referral for further assessment.*

### B.3 Developmental Motor Coordination Disorder (previously dyspraxia)

 **ICD11 criteria**

Characterised by a significant delay in the acquisition of gross and fine motor skills and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness, or inaccuracy of motor performance.

Coordinated motor skills are markedly below that expected given the individual's chronological age and level of intellectual functioning.

Onset of coordinated motor skills difficulties occurs during the developmental period and is typically apparent from early childhood.

Coordinated motor skills difficulties cause significant and persistent limitations in functioning (e.g. in activities of daily living, school work, and vocational and leisure activities).

Difficulties with coordinated motor skills are not solely attributable to a Disease of the Nervous System, Disease of the Musculoskeletal System or Connective Tissue, sensory impairment, and not better explained by a Disorder of Intellectual Development.

Essential criteria:

* Significant delay in the acquisition of gross or fine motor skills and impairment in the execution of coordinated motor skills manifesting as clumsiness, slowness, or inaccuracy of motor performance.
* Coordinated motor skills are markedly below that expected on the basis of age.
* Onset of coordinated motor skill difficulties occurs during the developmental period and is typically apparent from early childhood.
* Coordinated motor skills difficulties cause significant and persistent limitations in activities of daily living, school work, vocation and leisure activities, or other important areas of functioning.
* Difficulties with coordinated motor skills are not are not better accounted for by a Disease of the Nervous System, Disease of the Musculoskeletal System or Connective Tissue, sensory impairment, or a Disorder of Intellectual Development.

*Additional information from the authors of this guidance:*

*There may be other routes to seeking assessment of DCD, however it is now considered to be part of the NDD family of difficulties. This means that it may be considered as part of a broad NDD assessment when a pupil is referred.*

### B.4 Learning Disability/ Disorders of Intellectual development

Summary:

Disorders of intellectual development:

* are a group of etiologically diverse conditions (i.e. can be caused by many different conditions)
* originate during the developmental period (i.e. become apparent during childhood)
* characterised by significantly below average intellectual functioning and adaptive behaviour. When measured on standardised assessment both areas are approximately two or more standard deviations below the mean (approximately less than the 2.3rd percentile),
* Assessment using appropriately normed standardised assessment is preferred wherever possible. (Assessment without is possible, but needs greater reliance on clinical judgement based on appropriate assessment of comparable behavioural indicators (ICD 11 provides tables to support this).

Adaptive behaviour refers to the set of *conceptual, social, and practical* skills that have been learned and are performed by people in their everyday lives.

* Conceptual skills involve the application of knowledge (e.g., reading, writing, calculating, solving problems, and making decisions) and communication;
* *social skills* include managing interpersonal interactions and relationships, social responsibility, following rules and obeying laws, as well as avoiding victimisation;
* *practical skills* are involved in areas such as self-care, health and safety, occupational skills, recreation, use of money, mobility and transportation, as well as use of home appliances and technological devices

Adaptive functioning can be modified/supported/impacted by contextual factors.

*Additional information from the authors of this guidance:*

*Not all learning difficulties are assessed by health, i.e. specific learning difficulties such as Dyslexia and Dyscalculia are assessed by schools. If assessment has been completed by school which provides a clear outline of learning (e.g. standardised scores from a Dyslexia Screener, or level attained in the Curriculum for Excellence (CfE)) it is helpful to include this information in the referral - usually in the Form 2. (It may be necessary to explain how the achieved level of the CfE compares to the performance of their peers). That will make it easier for the NDD assessment team to screen to see if LD should be considered or can already be ruled out.*

### B.5 Tic disorders

**Summary:**

Tics are:

* Sudden, rapid, non-rhythmic, and recurrent movements or vocalisations.
* Mostly likely to emerge during childhood (developmental period)

Tics can be:

* transient (lasting less than one year) or
* chronic (lasting more than one year).
* vocal (e.g. throat clearing, grunting, squeaking, or more complex vocal behaviours such as echoing language, coprolalia (swearing)
* Motor (eye blinking, head jerking, more complex gestures or movement of the limbs)
* co-occurring with other Neurodevelopmental difficulties (e.g. Tourettes and ADHD, motor tics with ASD).
* voluntary suppressed for a period, may be exacerbated by stress and reduce during periods such as sleep or focused activity
* Suggestible - i.e. can be triggered by talking about them (even tics which had previously passed)
* Manifested inconsistently (i.e. they can change and appear then disappear only to pop up again after a period of absence).

If both motor and vocal tics are present and have lasted more than one year Tourettes Syndrome may be present.

Tourettes symptoms are likely to be most severe between the ages of 8-12 years. Simple motor tics appear first and vocal tics likely to appear 1-2 years after onset of motor tics, coprolalia (swearing & profanities) are most likely to emerge in adolescence.

Other difficulties that may be assessed by the NDD Pathway

### B.6 Foetal Alcohol Syndrome/Foetal Alcohol Syndrome Disorder (FAS/FASD):

“FASD results when prenatal alcohol exposure affects the developing brain and body. FASD is a spectrum. Each person with FASD is affected differently. While more than 400 conditions can co-occur, FASD is at its core a lifelong neurodevelopmental condition. All people with FASD have many strengths. Early diagnosis and appropriate support are essential, especially for executive functioning.”

(Source: FASD: Preferred UK Language Guide, Seashell Trust/National FASD, 2020)

*Additional information from the authors of this guidance:*

*The authors of this guidance recognise that it may not be possible or appropriate for staff in schools to ask questions about potential exposure to alcohol during pregnancy. The description above has been provided for information as FAS/FASD is something that may be considered as part of an NDD assessment. Further information can be found on the NHS website here:*

[*https://www.nhs.uk/conditions/foetal-alcohol-spectrum-disorder/*](https://www.nhs.uk/conditions/foetal-alcohol-spectrum-disorder/)

## Appendix C: Example paperwork

### C.1 Form 2A: Wellbeing Observations and Assessment

|  |  |
| --- | --- |
| **Child/Young Person’s Name** |  |
| **Date of Birth** |  |
| **CHI Number** |  |
| **Date of Assessment** |  |

|  |  |  |
| --- | --- | --- |
| **Named Person** | **Contact Details** | **Agency** |
|  |  |  |

**Reason for completion: In this section make it clear that you are making a request for a neurodevelopmental assessment for example ASD, ADHD, ADD etc.**

**Name and Contact Details of person(s) completing form:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Designation** | **Contact Details** | **Date** |
|  |  |  |  |

**1. Description of Child/Young Person’s Wellbeing**

|  |
| --- |
| ***Is there anything getting in the way of this child/young person’s wellbeing?******(Include evidence of strengths and concerns within each relevant domain)*** |

| [***Safe***](#bookmark=id.1pxezwc)In this section only include details relevant to potential NDD for example impulsivity, lack of cause and effect reasoning, awareness of dangers. Be aware of over adherence to rules and overgeneralisation of rules for example ‘hold hands to be safe’ but then wants to hold hands everywhere. PICA (i.e. the eating of non-food items)You do not need to include information about risks that are developmentally appropriate (e.g. “wears helmet when cycling” or “holds hands at a busy road”).  |
| --- |
|  |

| [***Healthy***](#bookmark=id.49x2ik5) |
| --- |
| Include relevant information about restrictive diet, issues with sleep, issues with toileting, sensory processing difficulties (e.g. over or under sensing and how well they can regulate this for themselves). Mental health issues such as anxiety, self-harm, depression (this may be particularly relevant for older pupils and girls).This is the place to include any relevant developmental history information (if known) which might indicate potential NDD issues e.g. late to talk, sensory issues. Issues that are now resolved but might suggest there are difficulties.This may be the place to describe levels of inflexibility and rigidity where it impacts on social development.No need to include issues typical for developmental stage e.g. toileting for infants unless unusual behaviours. |

| [***Achieving***](#bookmark=id.2p2csry) |
| --- |
| This is the section to include information about difficulties with attention, organisation and distractibility.Also include a statement in this section about levels of attainment. If you are not worried about learning, make this clear as it is important to show if difficulties might be expected for level of intellectual ability or developmental stage OR if it is unexpected for the abilities shown in other areas of development.Include strategies here that are used/have been tried to support learning. This is the place to describe all the ASD-friendly strategies you are using. Or the support for executive functioning (planning and carrying out of tasks).If there are other learning issues already identified (e.g. Dyslexia or Speech & Language Therapy issues) please outline them here.Is there evidence of particular interest? Is there evidence of highly restricted, repetitive interests?Describe their social communication here. This is where to show that they are not managing social interactions as would be expected for their other abilities.This is the place to describe how they benefit (or not) from incidental learning opportunities.Things to consider:Can the pupil generalise skills from one context to another?How much support is required to learn? If you are having to put lots of support in place, mention it here?Do they manage better with concrete and visual support?Do they need tasks chunked and support to complete steps of processes?Do they have levels of inflexibility that impacts on their ability to learn and demonstrate skills?You don't need to include high levels of detail about attainment. Attainment is only to demonstrate if they are achieving what is expected for same age peers, or if there is a discrepancy from their other areas of ability.You do not need to include individual ‘round robin’ reports from class teachers (e.g. at secondary) a summary of their overall profile is all that is required. |

| [***Nurtured***](#bookmark=id.147n2zr)Only include information here that is factual and record in a way that families are in agreement with. Only include information here that is relevant to a potential NDD. This might include a description of the support that has been observed that the family are putting in place.You can include information here about the quality of relationships with adults in school, how adults need to accommodate to them to help them manage their school day and the quality of strategies that work better.You don’t need to include lots of detail about family members and extended family if it is not relevant to potential NDD.You don’t need to include lots of detail about family life if not relevant to potential NDD. |
| --- |
|  |

| [***Active***](#bookmark=id.3o7alnk) |
| --- |
| Include information about activity levels if you think there might be hyperactivity. Include information about activity that might be describing sensory processing issues (e.g. are they under sensing and seeking sensory stimulation). Is there evidence of self-stimming behaviours?You might include descriptions of out of school and out of home activities if this illustrates how well (or not) the pupil can engage with peers, structured activities in another setting. Are there sensory elements of that environment that provides a challenge or supports them?You don’t need to provide lots of detail about how active they are just to show they are engaging in healthy levels of activity or have access to out of school clubs. |

| [***Respected***](#bookmark=id.23ckvvd) |
| --- |
| Is the pupil encouraged to share their voice? How is this done? (e.g. talking mats?) . Do they need a high level of support to do this? If so describe.Are they given opportunities to make choices, express preferences? Are they supported to advocate for their needs, wants and wishes?Do not include information here about how their peers interact with them - this would be better described in the ‘Included’ section. |

| [***Responsible***](#bookmark=id.ihv636) |
| --- |
| This section should be used to describe how well the pupil can follow rules and routines independently.You might also provide descriptions about what level and what type of support would be required to help a pupil behave responsibly. If they have high levels of impulsivity or difficulty with cause/effect learning which means they need higher levels of supervision this would be the place to mention.Can they engage in self-directed learning? Can they stay on task? Can they get started on tasks?Can they organise their own possessions (as would expected for their same age peers or for their developmental level)?This is the place to describe their self-care ability.You don’t need to describe the responsible tasks you give them in school, unless this is an example of difficulty or the type of support they require.Only include information about the wearing of school uniform if it is relevant to some form of sensory difficulty or evidence of rigidity and inflexibility. (E.g. will only wear leggings because of seams and labels. Insists on wearing hoodie to pull over their head). |

| [***Included***](#bookmark=id.32hioqz) |
| --- |
| What is in place in the environment to ensure the pupils is meaningfully included?This section is the place to describe any barriers to them being included and what steps are in place to reduce them.This section is the place to describe how their peers interact with them. Are they supportive? Is there any evidence of peers excluding them? Bullying? (Be clear if there is evidence of bullying or if this is an example of the pupils misperceiving other people’s intentions). You may want to describe the quality of friendships here. Have the peers tried to include them but the pupil is not able to be flexible enough to join in or sustain friendships?Are they able to access any extracurricular activities? How do they manage family occasions? Only discuss attendance if it is a relevant example to illustrate potential difficulties.Don't give examples that they don’t have any choice over. |

**2****.** [**Risk and Protective Factors**](#bookmark=id.1hmsyys) **and Analysis (use resilience matrix and toolkit)** 

* **What are the risks to the child/young person?**

Comment here about possible risks to mental health that relate to the referral e.g. difficulties developing relationships. Risks of exclusion socially or from school.

Possible impact of impulsivity on safety and wellbeing

Vulnerability due to behaviour of others e.g. peer exclusion, bullying, taking advantage, potential exploitation. Consider the impact of potential neurodevelopmental difficulties when coming into contact with adult services, criminal justice services and employability.

Include any risks to pupil’s learning and barriers they might face e.g school refusal, attention level, sensory overload, autistic burnout

This is not the place to include child protection or welfare concerns; they should be reported on a different form and to a different place. You do not need to comment about socioeconomic issues unless relevant to request e.g. comment such as “local appointments would be beneficial”

* **Identify any risks from the child/young person?**

Where relevant to potential assessment include incidents of violence and aggression and disruption of the learning environment. Consider if physical and verbal behaviours pose risk to family members and the wider community. If so include details, if not no comment required

* **Analysis**

This section should be used to provide a succinct summary of what you think is going on e.g.

“Based on all the evidence available at this point the TAC agree there may be an underlying neurodevelopmental difficulty that requires assessment”

Try to avoid simply repeating details already given above unless using specific illustrations.

* **Date child last seen and by whom**

**3. The following discussions/actions have taken place to date:-**

In a brief summary give relevant information about:

* meetings- including incident discussions and proposed resolutions
* A summary of the input and views from other agencies if currently involved.
* Relevant information about previous strategies implemented following advice from agencies who may no longer be involved
* Describe parental contribution
* Any assessment or screenings completed by school

Do not include every detail of previous incidents. Only describe ‘the headlines’ of previous discussions or assessments. Do not include detail that is irrelevant to the assessment question - ‘round robin’ information from every class teacher provides too much detail, which may not be relevant.

**4. The child/young person has the following views about this assessment:**

Gather the views of the c/yp in a relevant and appropriate manner e.g verbally, using visuals, observed behaviour does the child seem happy attending school what are favoured activities

**5. The parents/carers have the following views about this assessment:**

Do parents/carers agree with this assessment, do they feel their experiences have been represented fairly. A parental statement could be included here to give additional information not previously mentioned.

**6****.** [**Desired outcomes identified with the family**](#bookmark=id.41mghml)

Describe what the TAC have agreed the desired outcomes are (including the family view).

**7. Next Steps/Recommendations**

Be specific about making a request to the NDD pathway here. Be clear about why the request is being made.

Outline that support will stay in place and is not dependent on making a request for assessment or the outcome of it.

**8. Contributors to Assessment**

|  |  |  |
| --- | --- | --- |
| **Name** | **Designation** | **Contact Details** |
| This is where to list everyone in the TAC  |  |  |

**9. Forwarded to:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Designation** | **Contact Details** | **Date** |
| TBC |  |  |  |

**10. Signature:**  **Date:**

### C.2 Form 6: Record of Child/Young Person’s Meeting

|  |  |
| --- | --- |
| **Child/Young Person’s Name** |  |
| **Date of Birth** |  |
| **CHI Number** |  |

|  |  |
| --- | --- |
| **Date of Meeting** |  |
| **Venue** |  |

|  |  |  |
| --- | --- | --- |
| **Named Person** | **Contact Details** | **Agency** |
|  |  |  |

**Purpose:**

|  |
| --- |
|  |
| **Education Establishment****(if applicable)** | **Stage of Intervention** **(if applicable)** | **CSP** | **Legal Status** |
|       |       | Yes ☐No ☐ |        |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | [**Designation**](#bookmark=id.3tbugp1)**/Role** | **Present or****Apologies**  | **Report submittedYes/No** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |



**1****. Integrated** [**Summary of Progress and Impact on Child/Young Person**](#bookmark=id.28h4qwu)

Provide a summary of any concerns, interventions and progress to date. For the purpose of making request for NDD assessment, include relevant information that may have been discussed at previous meetings.

Provide a summary of the action points from the last meeting and any up-dates.

Provide an outline of why the meeting has been called.

For the purpose of making a request for NDD assessment, mention here if any other relevant assessment information has been gathered in additional formats and it is to be appended to the minutes. (E.g. any existing screeners or checklists, observation sheets or other planning assessment tools that have been used may be appended as supporting evidence). **PLEASE NOTE - it is not necessary that additional screeners and checklists have been completed to make a request for assessment.**

**2. Key Points from Discussion (including any significant events)**

This is the space to summarise:

* The key points raised by members of the team. Please explicitly record the views of other professionals (if at the TAC). If another professional has provided a Form 5, this may be referred to here and attached to the minutes (please ask for parent/carers consent to do this and record it here)
* Difficulties that the young person is currently experiencing,
* Response to strategies,
* What adaptations are currently needed to meet their learning needs,
* A summary of any new strategies or interventions that are being proposed.
* (Where appropriate) discussion of Form 4 targets,
* Any concerns, successes or relevant information from home.

**3****.** [**Views of the Child/Young Person on Progress**](#bookmark=id.nmf14n)

Gather the views of the c/yp in a relevant and appropriate manner e.g verbally, using visuals, observed behaviour does the child seem happy attending school what are favoured activities. Where appropriate, include here if the c/yp has given consent for professionals’ reports to be attached to the minute.

**4****.** [**Views of Parent/Carer on Progress**](#bookmark=id.37m2jsg)

Do parents/carers agree with this discussion, any proposed strategies **and the TAC making a request for NDD assessment?** Do they feel their experiences have been represented fairly? A parental statement could be included here to give additional information not previously mentioned. Include here if the parent/carer(s) has given consent for professionals’ reports to be attached to the minute.

**5****.** [**Decisions**](#bookmark=id.1mrcu09)

Record all the main decisions of the meeting

**Make it clear that the TAC have agreed to make a request for NDD assessment.**

**6. Is everyone in agreement with the decisions? – If not, please specify areas of disagreement**

**Chairperson/Lead Professional Signature**

**Signature:**  **Date:**

**Date, Time and Venue of Next Meeting (if applicable):**

**Additional Distribution List**

|  |  |
| --- | --- |
| **Name** | **Designation** |
|  |  |
|  |  |
|  |  |
|  |  |

### C.3 ASD home-school observation tool (ICD-11 criteria)

[These grids are best printed in A3]

ASD profile for (name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (d.o.b)\_\_\_\_\_\_\_\_\_\_\_

Parent/carer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class:\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Essential Features of Autism Spectrum Disorder ICD 11** (draft) | **Evidence of pervasive nature of difficulties** | **Evidence of persistence** |
| 1. **Persistent deficits in the capacity to initiate and sustain reciprocal social interactions and social communication due to reduced interest or ability, eg:**

**(Required features** include): | **Seen at home? If so provide examples** | **See at school? If so provide examples** | **Seen over** **time in both?** **y/n** |
| * limited understanding and use of language in context
 |  |  |  |
| * frequent inappropriate responses to other’s verbal and nonverbal communication
 |  |  |  |
| * deficits in shared interests
 |  |  |  |
| * inappropriate responses to the emotional state of others
 |  |  |  |
| * lack of modulation of behaviour according to social context
 |  |  |  |
| * poor integration of spoken language with nonverbal cues (eye contact, conventional gestures, facial expression, body language)
 |  |  |  |
| * Poor ability to initiate and sustain social conversation
 |  |  |  |
| * Difficulty forming maintaining friendships or other close relationships
 |  |  |  |
| 1. **Persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities (Required features** include):
 | **Seen at home? If so provide examples** | **See at school? If so provide examples** | **Seen over** **time in both?** **y/n** |
| * + **Excessive and persistent ritualistic patterns of behaviour**, lining up or sorting objects in a particular way
 |  |  |  |
| * + **Repetitive and stereotyped motor movements** eg:
* whole body movements (e.g. rocking)
* atypical gait (e.g., walking on tiptoes)
* unusual hand or finger movements
* posturing
* repetitive and stereotyped language
 |  |  |  |
| * **Distress over trivial changes to familiar environment, or in response to unanticipated events**
	+ inflexible adherence to following particular routines, eg. geographic (following familiar routes)
	+ precise timing (e.g. mealtimes, transport)
 |  |  |  |
| * **Excessive and persistent preoccupation** with:
* one or more special interests
* parts of objects
* other types of stimuli (e.g. film-clips or video-material including games)

unusually strong attachment to particular objects (excluding typical comforters) |  |  |  |
| * **Excessive and persistent**
* hypersensitivity or hyposensitivity to some sensory stimuli
* unusual interests in a sensory stimulus (may include actual or anticipated sounds, light, textures, especially clothing and food, smells, tastes, heat, cold, or pain)
 |  |  |  |
| **The essential features of ASD may change in intensity, frequency and focus over the course of development.** **They are usually a pervasive feature of the individual’s functioning in all settings, although they may vary in degree according to the social, educational, or other context.**  |
| **Individuals with Autism Spectrum Disorder may exhibit limitations in functional language (the capacity to use language for instrumental purposes: to express personal needs and desires).** **Social deficits are intrinsic to ASD, so the assessment of functional language skills should emphasise instrumental usage rather than social communication skills, because these will inevitably be impaired.** |
| **Co-occurring conditions should be specified,** e.g. co-occurring impairment of intellectual ability and functional language |

**Contributors to this assessment:**

**Name: Date:**

**Name: Date:**

### C.4 ADHD home-school observation tool (ICD-11 criteria)

[These grids are best printed in A3]

|  |
| --- |
|  **Criteria for ADHD ICD11****Essential Features:****A persistent pattern (e.g., at least 6 months) of inattention symptoms and/or a combination of hyperactivity and impulsivity symptoms that is outside the limits of normal variation expected for age and level of intellectual development. Symptoms vary according to chronological age and disorder severity.** |
| **Inattention symptoms** | **Comparison between presentation at home and in other settings (e.g. education, other social situations)** |
|  | **Several symptoms of inattention that are persistent, and sufficiently severe that they have a direct negative impact on academic, occupational, or social functioning. Symptoms are typically from the following clusters:** | **Is there evidence these behaviours have been observed at home (✔/🗶)** | **Describe examples of behaviours seen at home.**  **(Include evidence for persistence over time)** | **Is there evidence these behaviours have been observed out with the home (✔/🗶)** | **Describe examples of behaviours seen in other settings – nursery, school, shopping, parties etc.****(Include evidence for persistence over time)** |
| 1 | **Difficulty sustaining attention to tasks that do not provide a high level of stimulation or reward or require sustained mental effort; lacking attention to detail; making careless mistakes in school or work assignments; not completing tasks.** |  |  |  |  |
| 2 | **Easily distracted by extraneous stimuli or thoughts not related to the task at hand; often does not seem to listen when spoken to directly; frequently appears to be daydreaming or to have mind elsewhere.** |  |  |  |  |
| 3 | **Loses things; is forgetful in daily activities; has difficulty remembering to complete upcoming daily tasks or activities; difficulty planning, managing and organising schoolwork, tasks and other activities.** |  |  |  |  |

|  |  |
| --- | --- |
| **Hyperactivity symptoms** | **Comparison between presentation at home and in other settings (e.g. education, other social situations)** |
|  | **Several symptoms of hyperactivity/impulsivity that are persistent, and sufficiently severe that they have a direct negative impact on academic, occupational, or social functioning. These tend to be most evident in structured situations that require behavioural self-control. Symptoms are typically from the following clusters:** | **Is there evidence these behaviours have been observed at home (✔/🗶)** | **Describe examples of behaviours seen at home.****(Include evidence for persistence over time)** | **Is there evidence these behaviours have been observed out with the home (✔/🗶)** | **Describe examples of behaviours seen in other settings – nursery, school, shopping, parties etc.** **(Include evidence for persistence over time)** |
| 1 | **Excessive motor activity; leaves seat when expected to sit still; often runs about; has difficulty sitting still without fidgeting (younger children); feelings of physical restlessness, a sense of discomfort with being quiet or sitting still (adolescents and adults).** |  |  |  |  |
| 2 | **Difficulty engaging in activities quietly; talks too much.** |  |  |  |  |
| 3 | **Blurts out answers in school, comments at work; difficulty waiting turn in conversation, games, or activities; interrupts or intrudes on others conversations or games.** |  |  |  |  |
| 4 | **A tendency to act in response to immediate stimuli without deliberation or consideration of risks and consequences (e.g., engaging in behaviours with potential for physical injury; impulsive decisions; reckless driving)** |  |  |  |  |
| General considerations | Please provide comments, observations or outline relevant evidence for the general considerations listed below. This might include a description of any interventions and the response to those interventions.  |
| A | **Evidence of significant inattention and/or hyperactivity-impulsivity symptoms prior to age 12, (though some individuals may first come to clinical attention later in adolescence or as adults, often when demands exceed the individual’s capacity to compensate for limitations).** |  |
| B | Difficulties must be beyond what would be expected for age and level of intellectual functioning. (i.e. children with developmental delay would be expected to show the levels of activity and inattention appropriate for their stage of development not their chronological age). |  |
| C | **Symptoms are not better accounted for by another mental disorder (e.g., an Anxiety or Fear-Related Disorder, a Neurocognitive Disorder such as Delirium), learning difficulty or the effect of substances or medication** |  |
| D | **Manifestations of inattention and/or hyperactivity-impulsivity must be evident across multiple situations or settings (e.g., home, school, work, with friends or relatives), but are likely to vary according to the structure and demands of the setting.** |  |

### C.5 Sensory Checklist

Our brains are constantly processing information from all our senses. A nervous system that is functioning well is able to respond to some stimuli while ignoring others (e.g. ignore the hum of the heater to listen to someone speaking).

The point at which we might see a behavioural response to a stimulus is called a threshold (i.e. the level at which the stimulus has been sensed). Where a threshold is below or above the expected normal range we may see behaviours that can be described as sensory processing/sensory integration difficulties. For some, these difficulties can make it much harder to concentrate and focus on the task at hand. In school, this can have an impact on learning and social situations.

Where there is a *High* T*hreshold* people are under-responsive and require a lot of stimulus to reach their threshold. They could also be described as ‘under sensitive’. Where there is a *Low Threshold,* people are overly responsive to very little stimulus and distracted by everything. They could also be described as over sensitive.

The tables below give examples of things that might be observed for each of the senses and can be used as a handy checklist to identify areas of potential difficulty.

Once the checklist has been completed it can be used to identify areas that would benefit from appropriate strategies for home and school, but may also support consultations with other services or referrals for broad neurodevelopmental difficulties.

The “Making Sense of Sensory Behaviour” leaflet was created by Occupational Therapists within Forth Valley and has some advice that can be shared with parents for pupils who present with different sensory challenges. The leaflet can be downloaded from the link below:

<https://www.falkirk.gov.uk/services/social-care/disabilities/docs/young-people/Making%20Sense%20of%20Sensory%20Behaviour.pdf?v=201906271131>

Reading the signs - checklist

Hearing

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs they are over sensitive?** | **Please tick any observed** | **Signs they are under sensitive?** | **Please tick any observed** |
| noise levels feel magnified |  | enjoys really loud noise |  |
| dislikes like loud noise |  | fails to pick up expected cues |  |
| Is easily startled |  | may appear oblivious to what is going on around them |  |
| likes to 'chew' to damp down noises |  | lack of response to name |  |
| is anxious before expected noise (school bell) |  | Makes loud, rhythmic noises |  |
| talks loudly |  |  |  |
| covers ears |  |  |  |
| makes repetitive noises to block out others sounds |  |  |  |
| **Other things observed that may indicate issues:** | **Other things observed that may indicate issues:** |

Vision

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs they are over sensitive?** | **Please tick any observed** | **Signs they are under sensitive?** | **Please tick any observed** |
| dislikes bright lighting; |  | takes more visual information to react; |  |
| prefers dark environment; |  | likes bright environment, reflective or spinning light. |  |
| is distracted by visual information. |  | moves fingers/objects in front of eyes |  |
| finds the contrast of dark/bright uncomfortable |  | looks intensely at objects or people |  |
| looks at minute particles or parts of objects |  |  |  |
| covers/closes eyes at bright lights |  |  |  |
| looks down most of the time |  |  |  |
| **Other things observed that may indicate issues:** | **Other things observed that may indicate issues:** |

Taste/Smell

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs they are over sensitive?** | **Please tick any observed** | **Signs they are under sensitive?** | **Please tick any observed** |
| dislikes strong tastes |  | eats non-food items |  |
| likes only bland tastes |  | has lots of hard, crunchy food in diet |  |
| tastes or smells objects, clothes etc |  | craves strong tastes |  |
| smells people |  | under-reacts to strong, bad or good smell. |  |
| likes consistent temperature of food or really cold or really hot |  |  |  |
| over-reacts to new smells (can become very irritated when exposed to certain smells e.g. perfume, cooking smells, art materials) |  |  |  |
| gags easily. |  |  |  |
| may eat only a restricted range of foods |  |  |  |
| **Other things observed that may indicate issues:** | **Other things observed that may indicate issues:** |

Touch

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs they are over sensitive?** | **Please tick any observed** | **Signs they are under sensitive?** | **Please tick any observed** |
| fussy |  | takes firm touch to respond to stimulus/may not notice light touch |  |
| avoids |  | is sometimes heavy handed |  |
| loves or hates hugs |  | over-grips objects |  |
| mouths objects |  | is sometimes too close to others |  |
| only likes certain textures, clothes |  | has difficulty responding to pain/temperature. |  |
| dislikes or really likes messy play |  | often associated with low muscle tone |  |
| can react aggressively to another's touch |  | may bite or hit themselves when frustrated |  |
| feels pain and is very sensitive to temperature. |  | enjoys rough and tumble |  |
| Can struggle with certain self-care activities (e.g. cutting nails/hair, washing) |  | likes or seeks pressure e.g. tight elastic at wrists, legs, waist |  |
| Avoids wearing shoes |  |  |  |
| Layers clothing or strips off clothing |  |  |  |
| Touch may be uncomfortable, particularly if unexpected |  |  |  |
| may only eat a restricted range of textures in food |  |  |  |
| **Other things observed that may indicate issues:** | **Other things observed that may indicate issues:** |

People know about the five senses but there are two other senses that help us make sense of all the information we receive. These are our sense of movement and body awareness.

Movement (vestibular system)

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs they are over sensitive?** | **Please tick any observed** | **Signs they are under sensitive?** | **Please tick any observed** |
| hates spinning, jumping |  | is always on the go |  |
| becomes dizzy easily ornot at all |  | has difficulty sitting still |  |
| hates a busy place full of movement |  | is constantly fidgeting/tapping |  |
| avoids feet off ground (e.g.avoids swings.) |  | runs rather than walks |  |
| may move the whole body not only the head |  | takes risks |  |
|  |  | is fast but not always well coordinated |  |
|  |  | spinning, running walking (constantly seeking large movement) |  |
|  |  | walks with a bouncing gait |  |
|  |  | enjoys sudden spurts of movement |  |
| **Other things observed that may indicate issues:** | **Other things observed that may indicate issues:** |

Body Awareness (proprioceptive system)

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs they are over sensitive?** | **Please tick any observed** | **Signs they are under sensitive?** | **Please tick any observed** |
| does not like others being too close |  | bumps into or trips overthings/people (may be described as clumsy) |  |
| creates own boundaries,sometimes inappropriately e.g. young person may always need to go at the end of the school line |  | stands close to others |  |
| removes self from crowds (e.g. crowded shops/busy queues). |  | puts self in too small spacesor pushes against corners ofthe room |  |
|  |  | may have low muscle tone |  |
|  |  | may stumble or fall frequently |  |
|  |  | tires easily |  |
|  |  | weak grasp |  |
|  |  | toe-walking |  |
|  |  | grinds or clenches teeth |  |
|  |  | bites hands/arm/wrist |  |
| **Other things observed that may indicate issues:** | **Other things observed that may indicate issues:** |

###

### C.6 Example covering letter

Please edit this letter where appropriate and paste into the email when submitting your request for assistance to the NDD pathway.

Dear sir/madam

Re: name of pupil, d.o.b, address

Please find attached information from the most recent Staged Intervention/Team Around the Child (TAC) meeting for the above named child. Those contributing to the meeting have gathered initial information which indicates that further assessment for a possible neurodevelopmental difficulty would be helpful.

In this instance the TAC are wondering if [name of pupil] might meet the criteria for [name of difficulty here e.g. ASD/ADHD].

The following documents have been attached:

Form 1/SEEMiS print out (contact information)

Form 2 SHANARRI assessment

Form 6 minutes of relevant TAC meetings

[list here any additional screeners or observation tools to be included]

Yours sincerely,

Name of TAC chair person

##

##

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## Appendix D: Glossary of Terms

While some terms are universal across all three Forth Valley (FV) Local Authorities (LAs), each LA may have some unique terms to describe the same or similar paperwork and processes to that used by their neighbours

This glossary is intended to explain terms and definitions for all three LAs to support mutual understanding between them and also for colleagues in Health, to facilitate comprehension of terms for all using this guide.

### D.1 Education terms

|  |  |  |
| --- | --- | --- |
| **Acronym** | **Phrase/title** | **Description (where required)** |
| ASL | Additional Support for Learning | Education term for additional support needs. The process of identifying and supporting these needs is outlined in the Education (Additional Support for Learning) Scotland Act (2004 & 2009). |
| ASN | Additional Support Needs | A child or young person is said to have additional support needs (ASN) if they need more - or different support - to what is generally provided in educational establishments to children or young people of the same age. |
| ASN provision | Enhance Provision (EP)Autism Provision (AP)Additional Support Centre (ASC)Stirling Inclusion Support Service (SISS)Clackmannanshire Schools Support Service (CSSS) | Specialist provision provided for those children/young people whose additional support needs mean they need a highly adapted environment, curriculum and communication support that is not mainstream. These provisions are usually also specialised around a particular type of difficulty. Some of these provisions are situated with mainstream schools while others are stand-alone schools. |
| CfE (levels) - | Curriculum for Excellence | Scottish Education’s Curriculum.Early level: Age 3 to P1First level: P2, P3, P4Second level: P5, P6, P7Third/Fourth level: S1, S2, S3Senior phase: S4, S5, S6 |
| CYP | Child/Young Person |  |
| EAL | English as an Additional Language |  |
| EPS | Educational Psychology Service | The Educational Psychology Service is provided by the Local authority. They provide consultation, assessment, intervention, training and research to individuals, at establishment and authority/government level. |
| GIRFEC | Getting it Right for Every Child | GIRFEC provides Scotland with a consistent framework and shared language for promoting, supporting, and safeguarding the wellbeing of children and young people. |
| LAC/LAAC | Looked After Child/Looked After and Accommodated Child (Care Experienced) | Terms for children/young people who have support from Child Care Services (on either a voluntary or statutory basis). Children/young people who are LAC are ‘looked after’ at home. LAAC refers to children/young people who are ‘looked after’ away from their family home. Children and young people who have been supported through being looked after prefer the term ‘Care Experienced’ |
| Plans | CPCSPIEPForm 4 | Paperwork may make reference to various plans. Plans usually identify specific learning targets and the supports that will help to achieve them. Plans may have input from only school or include input from other agencies such as social work or Health |
| RFA | Request for Assistance | Term used within health to describe the process of making a referral to a department. Information in the request is used to decide how the service will respond. |
| SCRA | Scottish Children’s Reporter Administration (Children’s Reporter) |  |
| SEBN | Social Emotional and Behavioural Needs | Used to describe a range of difficulties with emotional and behavioural regulation which present as behavioural issues in school. These difficulties can have a broad range of causes. |
| SHANARRI | Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included (Wellbeing indicators) | These are the wellbeing indicator headings used under the GIRFEC |
| SI | Staged Intervention | The process used in some education authorities to assess, plan and review a child/young person’s support needs. In those authorities who use this approach the stage does not indicate the level of difficulty a child/young person is experiencing. A pupil with a high level of needs that is supported from within school resources could be on Stage 2 for example. In Stirling and Clacks if a pupil is in a specialist provision or has a CSP they will be on Stage 4. |
| TAC | Team Around the Child | Used to describe meetings held to support assessment, planning and review of a child/young person’s additional support needs. A TAC can be as small as the school and the family or have a wide multi-agency membership. - Membership of a TAC will change depending on the needs of the child. |

### D.2 Health Terms

|  |  |  |
| --- | --- | --- |
| **Acronym** | **Phrase/title** | **Description** |
| AAC | Alternative Augmentative Communication | Specialised support for communication. Can be low tech or high tech but is designed to support a child/young person to communicate and understand. |
| ADD | Attention Deficit Disorder | See Appendix B for a summary of NDDs |
| ADHD | Attention Deficit and Hyperactivity Disorder | See Appendix B for a summary of NDDs |
| ASD | Autism Spectrum Disorder | See Appendix B for a summary of NDDs |
| CAMHS | Child and Adolescent Mental Health Services |  |
| DLD | Developmental Language Disorder |  |
| DMCD/DCD | Developmental Motor Coordination Disorder/Developmental Coordination Disorder | Previously known as dyspraxia. See Appendix B for a summary of NDDs |
| IAF | Integrated Assessment Framework | A Scottish Government initiative as part of Health for All 4 guidance. Intended to create a common framework across all professionals who may be involved in assessing a child/young person’s needs. It uses the wellbeing indicators (SHANARRI) as headings for professionals to report under. In Forth Valley a suite of common paperwork was created to support this process. |
| LD, IDD, DID | Learning Disability, Intellectual Developmental Disorders (DSM-V), Disorder of Intellectual Development (ICD-11) | See Appendix B for a summary of NDDs |
| NAIT | National Autistic Implementation Team | The NAIT Team are professionals from Education, Speech and Language Therapy, Occupational Therapy and Psychiatry, who have considerable experience and expertise in working with autistic individuals of all ages, their families and others who support them. |
| NDD | Neurodevelopmental difficulties | Overarching term for a group of specific learning differences which appear during a child/young person’s development. They include differences such as ASD, ADHD, multiple tics, and learning disability for example. Not all NDDs are assessed by health, i.e. specific learning difficulties such as Dyslexia and Dyscalculia are assessed by schools.For a description of the NDDs assessed by the NDD assessment pathway see Appendix B |
| NDD assessment pathway | Neurodevelopmental Assessment Pathway | Proposed 0-18 assessment pathway within Health to assess for broad neurological developmental difficulties (such as ASD or ADHD). |
| NHS | National Health Service |  |
|  | Pica | An eating disorder where individuals eat non-food items. |
|  | Masking | Strategy used by a neurodivergent individual to hide their differences, to blend in social situations. E.g. Often described in ASD, particularly (but not only) girls. [Autistic people and masking (autism.org.uk)](https://www.autism.org.uk/advice-and-guidance/professional-practice/autistic-masking) |

### D.3 Professional titles

|  |  |  |
| --- | --- | --- |
| **Acronym** | **Phrase/title** | **Description** |
| CSW | Communication Support Worker |  |
| CT | Class Teacher |  |
| CWDT | Children With Disabilities Team | Team within Child Care Services (social service) who have a remit to assess and identify supports (outwith education) for children with additional support needs. |
| DHT | Depute Head Teacher | Part of the senior leadership/management team in school. |
| EP | Educational Psychologist  | Deliver psychological services and advice within an education context. They have a broad remit and can work with individuals, establishments and at authority/government level. |
| HT | Head Teacher | Part of the senior leadership/management team in school. |
| HV | Health Visitor | A Health Visitor is a qualified nurse or midwife who has completed specialist training in children and family health. |
| LAs/SLA/SfLA | Learning Assistants (Clacks), Support for Learning Assistant (Stirling), Support for Learning Assistant (Falkirk) | Support staff who can help children or young people in school or nursery who need some extra help with their education. |
| OT | Occupational Therapist | Occupational Therapists provide advice, reassurance, support, assessment and intervention to help children and young people develop their skills in everyday activities. |
| Physio | Physiotherapist | Physiotherapy is beneficial for children who present with any condition which impairs their physical development and therefore functional potential. |
| PT | Principal Teacher |  |
| QIO | Quality Improvement Officer |  |
| SEYW | Senior Early Years Worker |  |
| SLT (sometimes SALT) | Speech and Language Therapist | Professionals who work with children and young people with a range of speech, language, communication, and/or eating and drinking difficulties |
| SpfLT | Support for Learning Teacher | Specialist teacher working within mainstreams. How they are used will depend on the needs within the school and whether or not they are peripatetic. They will be involved in the assessment of specific learning difficulties with literacy and numeracy. |
|  | Outreach | Staff attached to support services who can come out to provide additional support in schools for individuals and in small groups. |
|  | Guidance | Staff with pastoral responsibility for pupils in secondary schools |

### D.4 IAF paperwork section

|  |  |  |
| --- | --- | --- |
| **Acronym** | **Phrase/title** | **Description** |
| Form 1a  | Pupil enrolment form (primary & secondary) | This give information such as address, doctor details and any known medical conditions |
| Form 2a  | Wellbeing observations and assessments | This uses the SHANARRI headings to record information about pupils strengths and difficulties  |
| Form 2b | Notification of Child protection concern | This is to be used when notifying Social Work of Child Protection concerns. |
| Form 3 | My world assessment | This uses my world triangle and resilience matrix to record and analyse pupils' growth and development.  |
| Form 4 | Child/Young Person’s Action Plan | This document for recording intended and desired outcomes for the child/young person. |
| Form 4b | Child Protection Registration | These forms are used by Child care services  |
| Form 4c | Throughcare and Aftercare | These forms are used by Child care services |
| Form 5 | Report for Child/Young Person’s Meeting | This document provides a framework for professionals to record relevant information about their involvement or assessment. This may be in preparation for a meeting or to provide a formal record.  |
| Form 6 | Record of Child/Young Person’s Meeting | This meeting record is a structure for recording all meetings about children/young people, who was there and what action was agreed. |
| Form 7 | Chronology | This form is used to record to record concerns, events or incidents that impact (positively or otherwise) on a child or young person's wellbeing |
| Form 8 | Non-disclosure information |  |
| Form 9a | Placement Arrangement |  |
| Form 9b | Placement Agreement |  |

## Appendix E

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### E.1 Pre Education Children Process Map

