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ORIGINAL ARTICLE

Evaluation of Context-Specific Early Identification of Autism Models Involving Multiple Stakeholders: Examples From Three Areas of England

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Abstract

Purpose Demand for autism assessment has increased substantially in recent years, while diagnostic capacity has not kept pace. As a result, alternative approaches to early screening and support for children with social communication difficulties are required.

Method We conducted a convergent mixed-methods multiple case study evaluating three locally developed, school-based early identification models for autism in England. The models were responsive to local priorities and involved collaboration between education and health professionals, schools, families and children. Quantitative referral and diagnostic outcome data were analysed alongside qualitative data from focus groups and interviews with education and health professionals.

Results Across the three cases, stakeholders perceived the models positively, particularly in relation to improved inter-professional collaboration, earlier access to support, and professional learning within schools, although concerns were raised in one area regarding potential over-identification. Involvement of school staff was viewed as essential, enhancing understanding of autism and confidence in working with families. Follow-up interviews demonstrated sustained commitment to, and further development of, the models despite the absence of continued funding.

Conclusion Overall, findings highlight the importance of locally responsive early identification systems that are not solely diagnosis-focused, alongside ongoing challenges relating to inconsistent assessment frameworks and long-term sustainability.

Keywords Autism · Early identification · Diagnosis · Schools

Autism and Diagnostic Context

Autism is a lifelong neurodevelopmental condition characterised by differences in social communication and interaction, alongside restricted and repetitive behaviours and interests (American Psychiatric Association (APA), 2022). Recent national estimates indicate that autism affects 1.32% of the population in England (NHS England, 2024). Autism is diagnosed more frequently in males than females (Loomes et al., 2017), though growing evidence indicates that this disparity may reflect under-identification in females due to differences in presentation and limitations in current diagnostic practices (Hull et al., 2020; Lockwood Estrin et al., 2021).

Internationally, autism diagnosis is typically conducted through multidisciplinary assessment processes integrating developmental history, caregiver report, and direct observation (e.g., Lord et al., 2012). While such approaches are considered best practice, they are resource-intensive and often associated with lengthy waiting times (Crane et al., 2016; Daniels & Mandell, 2014). Delays in diagnostic assessment have significant implications for children and families, including increased parental stress and reduced access to timely support.

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The Importance of Early Identification

Early identification of autism is widely recognised as important for enabling access to appropriate support and intervention. Evidence suggests that intervention in early childhood can positively influence communication, adaptive functioning, and social engagement (Zwaigenbaum et al., 2015). Despite improvements in awareness and policy, delays in identification remain common, with age at diagnosis varying considerably across regions and contexts (Daniels & Mandell, 2014). Barriers to timely identification include variability in symptom presentation, limited service capacity, and challenges in recognising early signs, particularly among females and children from diverse cultural backgrounds (Lockwood Estrin et al., 2021).

Conceptualising Screening Within Broader Early Identification Systems

Although often used interchangeably, screening, early identification, and diagnostic assessment represent distinct but related processes. Screening typically involves standardised tools administered at a population level to identify individuals at increased likelihood of a condition. Early identification refers to a broader and more flexible process of recognising developmental differences or emerging needs using multiple sources of information, often within naturalistic settings such as schools. Diagnostic assessment involves a comprehensive, specialist-led evaluation to determine whether an individual meets formal diagnostic criteria.

While screening tools may contribute to early identification, they are not synonymous with it and are not universally recommended in autism due to concerns regarding accuracy and feasibility. Although some screening tools demonstrate acceptable sensitivity and specificity, their performance varies depending on child age, context of use, and the heterogeneity of autism presentations (Guthrie et al., 2013; Johnson & Myers, 2007). Consequently, screening is most appropriately understood as one component of broader systems of developmental monitoring and multi-informant assessment, rather than as a standalone approach (Johnson & Myers, 2007).

Early Identification as a Multi-Informant, Systems-Level Process

There is increasing recognition that effective early identification requires integration of information from multiple sources across settings. Input from parents, teachers, and other professionals provides insight into children's development across contexts and over time, supporting more informed referral decisions and more efficient diagnostic pathways. Recent evidence indicates that incorporating such multi-informant information improves the quality and efficiency of autism assessments (Parr et al., 2024).

Educational settings play a particularly important role in this process. Early years practitioners and school staff are well placed to observe children's social communication, play, and behaviour within peer contexts over sustained periods. When supported by structured processes and collaboration with health and local authority services, schools can act as key contributors to early identification systems.

Educational Data and Early Indicators of Autism

Recent research has explored whether routinely collected educational data may support early identification of autism. Using data from the Born in Bradford (BiB) cohort, Wright et al. (2019) found that lower scores on the Early Years Foundation Stage Profile (EYFSP) were associated with increased likelihood of later autism diagnosis. While these findings are correlational and do not support the use of the EYFSP as a standalone screening tool, they highlight the potential contribution of educational data within broader identification processes when used alongside other sources of information.

Rationale for the Current Study

Rising demand for autism assessments, combined with persistent capacity constraints within diagnostic services, has prompted increased interest in developing more proactive and efficient approaches to early identification. In England, the Department for Education (DfE) funded several regional initiatives aimed at designing and implementing early identification models within mainstream school systems. These initiatives were informed in part by emerging evidence suggesting that educational data, including EYFSP information, may support identification when integrated with professional judgement and other indicators (Wright et al., 2019).

Funded areas were tasked with developing models that connected schools, local authorities, and health services, drawing on existing systems and data to support earlier recognition of need. These models incorporated elements of screening and broader identification processes, reflecting a systems-level approach rather than reliance on any single assessment tool.

Despite growing policy and practice interest, limited research has examined how such early identification models operate in real-world contexts, how they are experienced by professionals, and which factors influence their sustainability beyond initial funding periods.

The Current Study

This study evaluates the Early Identification of Autism project implemented across three regions in England (Areas A, B, and C). The project aimed to test the feasibility of locally developed approaches to screening and early identification within mainstream school systems, with a particular focus on strengthening collaboration between education, health, and local authority services. These approaches drew on existing systems and data, including the EYFSP, alongside other tools and professional judgement.

This study does not evaluate the psychometric properties or diagnostic accuracy of the EYFSP, Social Communication Questionnaire (SCQ), or any individual screening tool. Rather, it examines how different locally developed early identification models incorporated existing educational data and screening tools within broader, multi-informant systems of identification and referral. The focus is therefore on service design, implementation processes, and outcomes within real-world education-health systems.

The evaluation was guided by three overarching evaluation questions:

1. How were locally developed early identification models implemented within mainstream school systems across three regions in England?
2. How did the incorporation of educational data and screening tools within these models contribute to the identification of children with autism?
3. How did key stakeholders perceive the impact, feasibility, and sustainability of these models?

Methods

Study Design

The study used a convergent mixed-method multiple case study design, in which qualitative and quantitative data were collected within the same timeframe and integrated during analysis and interpretation (Creswell & Plano Clark, 2018; Yin, 2018). This design enabled examination of both implementation processes and outcomes across cases and allowed interpretation of quantitative diagnostic outcomes in relation to local contextual and professional experiences.

Case Selection and Context

The DfE commissioned three Opportunity Areas in England (now referred to as Priority Areas) to develop locally responsive models for early autism identification. These models built on the BIB approach (Wright et al., 2021) by incorporating EYFSP data alongside the SCQ (Rutter et al., 2003). Each area tailored its model to local needs, resulting in variations in focus (e.g., autistic girls, specific age groups), referral criteria, and the involvement of Child and Adolescent Mental Health Services (CAMHS) or external providers.

Each area constituted a distinct case, reflecting differences in local priorities, referral pathways, stakeholder configurations, and screening and identification tools. Embedded units of analysis focused on:

1. the characteristics of the early identification model in each area and factors which influenced its development and implementation over time; and.
2. the outcomes of each model, including both quantified diagnostic outcomes and stakeholders' perceived impacts.

Data Collection

Data were collected in three phases (Fig. 1).

Phase 1: Qualitative Data Collection - Focus Groups With Key Stakeholders (December 2022 – January 2023)

Phase 1 explored stakeholder perspectives on the design, implementation and perceived impact of the early identification models. Participants were professionals directly involved in the development, delivery, or operationalisation of the models within each area, including Area Leads, school-based professionals (e.g. SENCOs, assistant headteachers, inclusion leads), and health partners involved in assessment processes.

Participants were recruited through purposive sampling, facilitated by Area Leads, to ensure representation of key stakeholder groups within each local model. Focus groups were conducted online, facilitated by a trained moderator (RJ or LV) with support from a research assistant (RF), and lasted approximately one hour. A semi-structured topic guide aligned with the study aims was used to encourage in-depth discussion and ensure consistent coverage across groups (Parker & Tritter, 2006). The guide included 6–10 open-ended questions, with prompts, and was tailored to stakeholder group (school staff vs. Area Leads and health professionals). Questions covered model development and rationale, use of screening tools (including EYFSP and SCQ), multidisciplinary working, perceived impacts on children, families and professional practice, facilitators and barriers to delivery, and sustainability beyond the funded project. Questions were mapped directly to the evaluation aims and case study propositions, ensuring that data

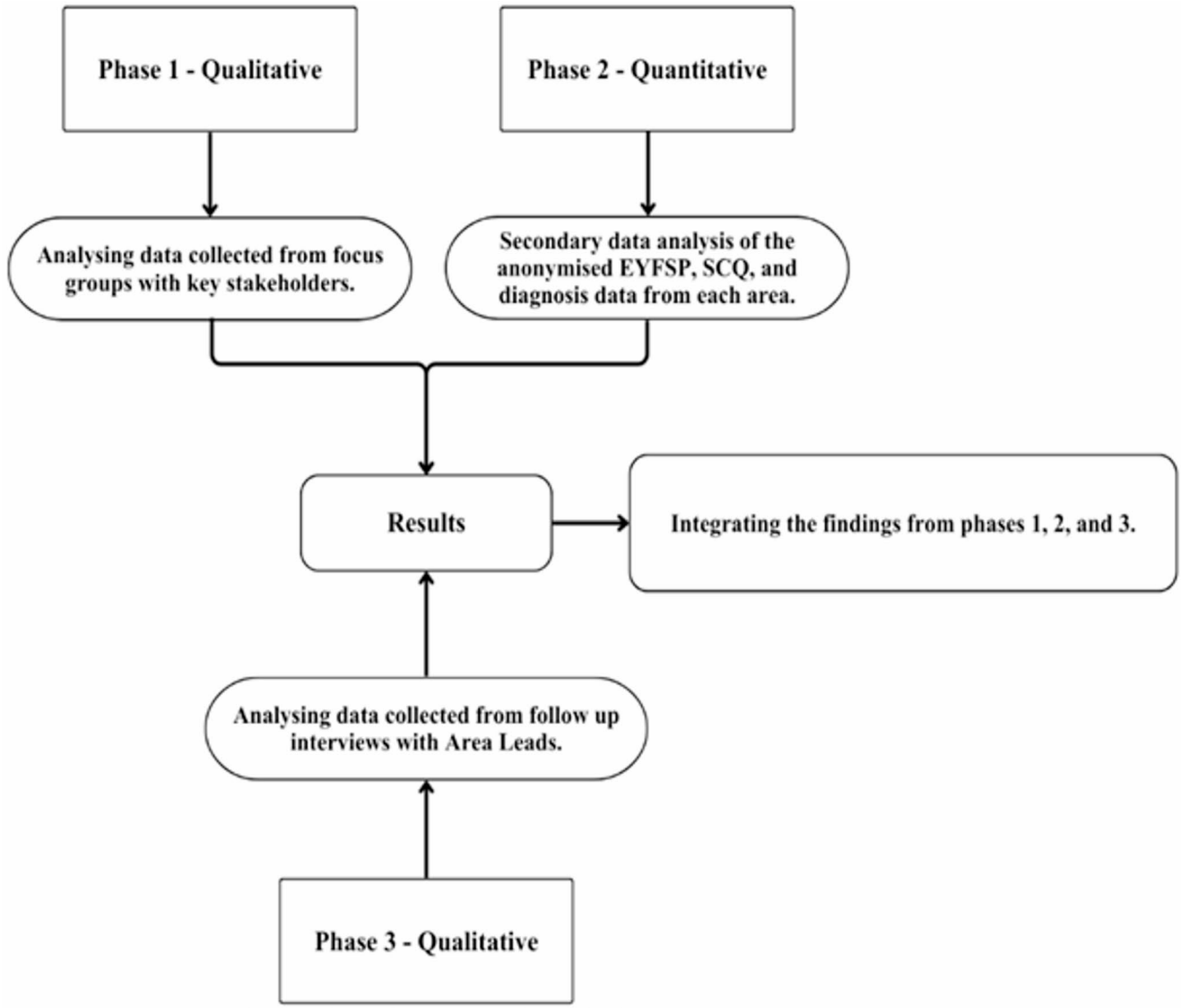


Fig. 1 Phases of data collection informing the evaluation

collection systematically addressed implementation processes, outcomes, and sustainability across cases.

Table 1 provides an overview of participant involvement across qualitative study phases by area and stakeholder group. Phase 1 focus groups were organised separately for Area Leads and health partners, and for education partners.

Phase 2: Quantitative Data Collection - Secondary Data Analysis (February 2023)

Phase 2 involved secondary data analysis of quantitative data routinely collected during the first year of project funding. Area Leads provided anonymised, aggregated data on the number of pupils identified through each model, the number referred for autism assessment, and diagnostic outcomes. Data were analysed descriptively to examine referral patterns and proportion of pupils receiving a diagnosis within each case, rather than to test hypotheses, in line with the evaluative aims of the study.

Phase 3: Follow Up Interviews (July 2024)

Follow up interviews with Area Leads were conducted approximately two years after the initial project concluded. Interviews followed a semi-structured format, adapted to reflect each area's original focus and implementation process. The interview guide focused on project legacy, adaptation over time, and reflections on long-term impact. Recruitment was conducted through existing contacts. Paired interviews were held with Leads in Area A and B, while only one Lead from Area C participated in an individual interview due to staff changes.

Table 1 Overview of participants across qualitative study phases by area and stakeholder group

Phase	Area	Stakeholder group	Roles represented	*n*
Phase 1 (Focus Groups)	Area A	Area Leads & Health	2 Area Leads; 1 Health Partner	3
		Education Partners	SENCOs; Inclusion Leads; AHTs	4
	Area B	Area Leads & Health	Area Lead; CAMHS professionals	3
		Education Partners	SENCOs; Assistant Headteachers; Teaching Assistant	4
	Area C	Area Leads & Health	2 Area Leads; Consultant Community Paediatrician	3
		Education Partners	SENCOs; Deputy Heads; Assistant Headteachers	3
Phase 3 (Follow-up interviews)	Area A	Area Leads	Area Leads	2
	Area B	Area Leads	Area Leads	2
	Area C	Area Leads	Area Leads	1

SENCOs Special Educational Needs Coordinator, *CAMHS* Child and adolescent mental health services, *AHTs* Assistant Head Teachers

Data Analysis

All focus group discussions and follow-up interviews were transcribed and analysed using content analysis (Bengtsson, 2016). Analysis was guided by a deductive coding framework developed in advance, informed by the case study propositions (Yin, 2018), the evaluative aims of the study, and the research team's familiarity with the design and implementation of the early identification projects. The initial framework focused on: (1) how locally tailored early identification models were shaped by existing service configurations and professional relationships; (2) how integration of educational and health data influenced perceived and observed outcomes; and (3) how sustainability was influenced by capacity building within schools rather than reliance on diagnostic throughput.

Three members of the research team, each with primary responsibility for one area, independently applied the initial deductive framework to one transcript from their assigned area. This enabled testing and refinement of the framework against empirical data. The analysts then met to compare coding, discuss areas of divergence, and refine code definitions. Through this iterative process, the framework was expanded to incorporate additional inductively generated codes arising from the data while retaining alignment with the original analytic propositions.

The revised coding framework was then applied consistently across all Phase 1 focus group transcripts, with each transcript double-coded by two researchers. Coding decisions and discrepancies were discussed within the wider research team to enhance analytic coherence across cases. Phase 3 follow-up interview data were analysed separately, reflecting their different temporal foci and emphasis on sustainability and longer-term impact, using the same analytic framework with further inductive coding undertaken as required. In reporting Phase 1 findings, quotations are attributed using participant number and role. For Phase 3 interviews, quotations are not linked to participant identifiers to preserve anonymity.

Quantitative data from Phase 2 were analysed descriptively at the individual case level, focusing on the number of pupils assessed and the proportion of assessed pupils who received an autism diagnosis within each area. These data were used to contextualise qualitative findings and support interpretive synthesis rather than to evaluate diagnostic accuracy or model effectiveness.

Integration of Qualitative and Quantitative Data

Integration occurred at the analysis and interpretation stages. Quantitative outcome data were analysed at the individual case level and examined alongside qualitative findings to contextualise and explain observed patterns (e.g. proportion of assessed pupils receiving a diagnosis and perceptions of over- or under-identification) within each area. An interpretative cross-case synthesis was undertaken in the Discussion to identify and reflect on patterns and contrasts across the three areas, focusing on how differences in local context, model design, and implementation processes shaped outcomes and stakeholder experiences rather than formal comparison of effectiveness.

Methodological Rigour

Several strategies were employed to enhance the quality and rigour of the study. Triangulation across qualitative and quantitative data sources (focus groups, interviews, and quantitative outcomes) supported the credibility of the findings. Qualitative data were double-coded, with transcripts coded by two researchers. Coding decisions and discrepancies were subsequently resolved through team discussion to ensure analytic consistency. Thick description of case context was used to support analytical transferability of findings, rather than statistical generalisation.

Ethical Considerations

Ethical approval for the research was granted by The University of Manchester (Ref: 2022-15141-25823). All participants provided written informed consent prior to taking part in a focus group or interview.

Results

The three case studies are presented here with stakeholder perspectives highlighting the impact of the different aspects of each model.

Area A

Area A is a densely populated, ethnically diverse borough in the North West of England with high levels of deprivation. The model was led by two Special Educational Needs and Disabilities (SEND) experts from specialist schools and aimed to equip mainstream schools with the skills to identify unmet needs using EYFSP and SCQ scores. It also aimed to enhance support for children and families. Thirteen primary schools, and one secondary school participated in the initial phase.

Process

SENCOs used existing EYFSP scores to identify children scoring below 10 in domains relevant to autism and who were not already receiving SEND support. They also considered each child's social, developmental and family context. They then informed Special Leaders of Education (SLEs) about the children to be further screened using the SCQ, which was completed with families. Year 3 children scoring > 15 were referred for further assessment by a multidisciplinary team (MDT) from a private provider offering CAMHS-type services. Assessments were conducted in schools over one day, with the parent, child, clinician, and either the SENCO or a TA present. Diagnosis decisions were made during an online MDT meeting involving Health Care Professionals (HCPs) and SENCOs. Parents were informed of the outcome by SENCOs at the end of the assessment day.

Upskilling School Staff

Area Leads delivered specialist training on identifying needs, best practice and liaising with health professionals, and facilitating networking for school SEND staff. SENCOs, supported by SLE's, then developed and delivered training to wider school staff, based on the specific needs of each school.

Parental Support

Parents of children with potentially unmet needs were referred to a parent-led charity offering forums and workshops to support them in meeting their child's needs. Workshops were delivered in community languages to improve accessibility.

Outcomes

Across 13 primary schools, 10 Year 3 pupils received assessments, with 8 diagnosed with autism (80%).

Stakeholder Perspectives

Stakeholders indicated that, compared to existing diagnostic pathways, this model provided a clearer and timelier route to assessment, and made effective use of existing data: "*I think that masking showed earlier in the data that didn't show in other ways*." (P06, Inclusion lead).

However, the process was more challenging for the secondary school involved, due to difficulties accessing EYFSP data from feeder schools: "…*to get their early years data was very difficult*, *and that was a bit of a challenge… we went to the realms of GDPR (General Data Protection Regulation)*." (P02, Area Lead).

Being involved in MDT assessments was beneficial for SENCO's professional development: "*I was a part of all those meetings*, *and then obviously I'm much more clear now what they look for*, *what autism actually involves*" (P08, SENCO & AHT). Enhanced understanding also supported the SENCOs communication with families: "…*we were involved in this process of assessment*, *and we were able to deliver that news to parents and have an answer… whatever that diagnosis was*, *that*, *to me*, *was a really useful thing*" (P04, SENCO).

Although Area A had attempted to involve their local National Health Service CAMHS service, this was not possible due to communication and staffing issues. As a result, the private company contracted to provide autism assessments did not fully understand the needs of the area, which led to issues with translation and interpretation during assessments: "*It felt to me like it needed to be a proper translator*, *who could fully*, *effectively translate all those medical languages*." (P04, SENCO).

SENCOs noted that the training schools received made teachers more aware of inclusive practices: "…*making those adaptations that's really worked well for the class teachers*, *and we can see the impact on the children*…" (P08, SENCO and AHT). The support parents received was also seen as valuable, with SENCOs observing that families were able to access help sooner than through the usual pathway.

Follow Up

After the funding ended, Area Leads collaborated with a teaching school and the DfE to extend the model as a Continuing Professional Development (CPD) programme for schools. Two new cohorts of primary and secondary schools joined the programme. While the core structure of the model

remained intact, training content was adapted to reflect the specific needs of participating schools. The revised programme did not include formal diagnostic assessments. Instead, the focus shifted more heavily towards early identification and equipping schools to gather evidence that could support families seeking a diagnosis through other pathways.

Despite the absence of formal funding, Area Leads successfully secured additional funding from the DfE to roll out the programme to secondary schools within the borough. Challenges persisted, particularly around accessing pupil data and navigating funding delays. However, Area Leads described the second phase as more autonomous and responsive: "*we had autonomy… we were in charge of its destination and could determine it*". This enabled them to use their experience to adapt the programme in line with the needs of the schools enrolled: "*the fundamental structure of the program has remained the same*, *but the content… had to be responsive to the individual needs of the school. So therefore*, *the content is driven by the schools' areas for development*."

The teacher training component continued to be seen as particularly impactful. Area Leads emphasised how it provided a protected space for educators to step away from everyday pressures and plan effectively. This space enabled SENCOs to build confidence and gain credibility within their schools: "*what we've done is given them permission and confidence to take things forward. It's given them a presence within their school*, *and credibility*." This sense of ownership fostered a dynamic and collaborative atmosphere. One Area Lead described how the protected space helped participants feel prepared and energised:

> "The nature of schools [is] that it's just so many plates spinning. So we kind of guarded this space so that they could go away from it, knowing, 'right, I'm ready to rock now, I've got my session planned. I know exactly what I'm doing. I'm excited to deliver this to my school' and then that's contagious… that energy of we can do this is really contagious"

Area B

Located in the East Midlands, Area B includes rural and suburban communities. The project was led by two SEND specialists from the local authority, who developed a bespoke screening tool focused on identifying student needs rather than prioritising diagnosis. Nine primary schools were initially selected based on levels of SEND and Communication and Interaction (C&I) referrals.

Process

Schools identified up to 10 pupils based on criteria provided by Area Leads, relating to possible autism or C&I needs. The screening tool covered autism-related domains and included questionnaires for parents, school staff, and pupils to create a triangulated representation of each child's needs. EYFSP data was not used, as it was unavailable.

Area Leads separately analysed and scored the questionnaires, moderated results, and ranked pupils by level of need. The questionnaires were then shared with a private provider offering CAMHS-type support, to inform the diagnostic process. Once assessments were agreed, a MDT was formed, including a Speech and Language Therapist, clinical psychologist, parent/carer, SENCO, class teacher and TA. Diagnosis decisions were made during an online MDT meeting involving healthcare professionals and school staff.

Upskilling School Staff

Schools accessed autism training through the Autism Education Trust, a national organisation providing autism resources and training.

Parental Support

SENCOs and Area Leads hosted coffee mornings at schools for parents. Additional support was provided by a parent charity and HCPs.

Outcomes

During the project, 67 pupils received autism assessments, with 56 diagnosed (84%). The remaining 11 were referred for alternative assessments (e.g., ADHD).

Stakeholder Perspectives

Participants highlighted that the project offered a more efficient pathway, resulting in faster assessment and diagnosis. This was seen as beneficial for children and families, who received support sooner: "*…it's been identified early*, *and so we can now make sure we've got all of things that child needs in place… I think that will make transition… much easier.*" (P11, TA).

HCPs were able to run school-based post-assessment support sessions, which staff felt were accessible and encouraged engagement from local parents who might not otherwise participate. School staff suggested that support could be improved through one-to-one sessions with HCPs to help parents understand the assessment reports. Being involved in the assessment process was valued by staff, as

it enhanced their understanding of autism and their pupils: "*the fact that we sat through some of the 'ADOS' [Autism Diagnostic Observation Schedule] assessments*, *has fine-tuned our knowledge of what we're looking for in children in that kind of environment. And that was really helpful*." (P11, TA). This knowledge empowered schools to improve inclusive practice and boosted staff confidence when communicating about neurodiversity: "*it's made us more confident… it's made us open up our views of autism*, *…and the way to sort of talk to parents*, *and the staff and children about it*." (P11, TA).

HCPs also valued the involvement of school staff, noting that their insights and evidence were crucial during MDT assessments. Collaborative completion of screening questionnaires with parents helped build strong relationship and deepen understanding of pupils: "*what was really lovely was that [schools] built those relationships… I think a lot of schools were quite surprised by what the parents were dealing with and that's definitely a really big characteristic was that girls masking*." (P25, Private CAMHS Professional).

Conducting the assessments within schools was considered to lead to more accurate outcomes: "… *we had children with a potential autism diagnosis in a familiar safe environment made for probably really rich information… because they weren't frightened or anxious*, *or stressed with being in an alien environment like a clinic*." (P15, Area Lead).

Despite positive outcomes, there were challenges. These included long waiting times for children referred for alternative assessments and pressure on school staff to go beyond contracted hours to meet project deadlines, which was not sustainable.

Follow Up

At follow up, Area Leads noted that support for school staff, families and young people initially continued but eventually ceased due to time pressures. Although no funding was available for new schools or further assessments, this was not seen as a barrier as: "*it was never about identification of autism. It was about identification of need*."

Leads felt this focus was supported by the screening tool: "*it was looking within the three areas of difference […] and it would then give us an insight into the needs of the young person as opposed to whether or not they get a diagnosis*."

Area B leads reflected on several facilitators and barriers. Key facilitators included their expertise as former SEND specialists within the local authority and the ability to work alongside external stakeholders in familiar school environments rather than clinical settings.

However, barriers at the local authority level were also noted: "*we jumped through the hoops …. and there were many…because as a local Authority there's so much bureaucracy*". This was perceived to have limited the project's wider impact: "[*The project had] no impact on the local authority*." Communication issues also led to unrealistic expectations being placed on schools which negatively impacted engagement: "*The will from schools dwindled away… because schools are just too busy*".

Despite these barriers, both Area Leads reported that the project had a positive impact on parents, young people and school staff. Area Leads relayed feedback from school staff around the training and the wider impact of this: "*the best CPD they've done*"; "*After the project*, *not one pupil had accessed extra funding… because their needs were being met and… understood*." The project also positively impacted parents, with Area Leads organising summer activities to build relationships and provide safe spaces for families: *"[we] put out lots of activities over the summer [to] build that relationship and also give them time as a family to be able to go somewhere that was a safe space for them*." Finally, Area Leads emphasized the importance of empowering young people: "*If you can get their voice about what they feel*, *they're struggling within school*, *then you can put the support in that will benefit them*".

Area C

Area C included a mix of rural and urban communities in the East of England. Led by two SEND specialists from the local authority, the project focused on identifying unmet needs in girls who may be masking neurodivergent traits in school. A screening protocol was developed to gather more relevant information and enable more efficient diagnoses.

Process

Area Leads reviewed EYFSP data for an agreed cohort of girls in Years 5 and 6 across 15 schools, as well as from current assessment waiting lists. The EYFSP data were analysed using adapted criteria based on the EYFSP of girls who had later been diagnosed with autism in the area. These adapted criteria allowed girls to score higher in certain areas of the EYFSP to account for masking.

Fifty-six girls were identified and discussed with their school SENCOs. Where unmet need was suspected, further screening was conducted using parent and school questionnaires, observations, a pupil voice tool, the SCQ, and developmental history. This informed the MDT assessment and diagnostic process.

Working relationships were established between Area Leads and health partners, including paediatricians, clinicians, speech and language therapists. Online MDT assessments involved HCPs, Area Leads, SENCOs, and teachers. The aim was to reach a diagnosis more quickly based on

the information gathered. If there was uncertainty within the MDT, an ADOS was completed.

Upskilling School Staff

Area Leads provided an information session to SENCOs on completing screening materials with families and pupils. Towards the end of the project, SENCOs were offered online training on autism in girls.

Parental Support

SENCOs and Area Leads ran a support group for parents of diagnosed children, offering practical strategies for home support, and to build confidence and empowerment for parents and children at key transition points.

Outcome

35 Year-5 and 21 Year-6 girls underwent assessment ($n = 56$). Of these, 21 Year-5 and 6 Year-6 pupils received a diagnosis ($n = 27$, 48%).

Stakeholder Perspectives

Organising the assessments was resource intensive for schools and Area Leads. Despite this, it facilitated collaboration between schools, parents and MDTs resulting in identifying unmet need:

> "*it was only in during that 6 months of parents telling us exactly what was going on at home for her … that I started to think 'my gosh*, *okay*, *we've got a little girl here who's masking and it was very*, *very significant'. The impact for them at home was quite massive. And we had no idea at school at all*." (P23, SENCO/deputy head).

The adapted criteria allowed girls to score higher than expected in certain EYFSP areas (e.g., physical development) and still be considered for diagnosis and support:

> "*So*, *for example*, *things like speaking*, *we thought our girls might score in line with their peers on the foundation stage for that*, *but the making relationships might be trickier. …. So*, *we applied a slightly different formula to get the girls*." (P16, Area Lead).

However, tight timelines meant that the process was not followed exactly for all girls identified through EYFSP which may explain the relatively high percentage of girls not receiving a diagnosis: "*we just didn't have time to filter to that stage*, *so we took pretty much all of them*" (P16, Area Lead).

Collaboration between clinicians and school staff was highly valued. Clinicians appreciated the insights provided by school staff, which helped them to feel confident in their diagnostic decisions. SENCOs valued having a direct voice in the assessment process, alongside parents. School staff also noted that the project successfully raised awareness of autism within schools: "*I've had so many discussions with different members of staff since who are sort of saying I'm a bit worried about*, *or I've seen traits like this in*, *and it's definitely raised awareness*" (P23, SENCO/deputy head).

Follow Up

At follow up, Area Leads were still delivering their "Autism and girls" training tool to schools in the area for free and had remaining funding to provide further assessments: "*we just had loads of funding leftover… And basically*, *I think took about 40 kids off their [waiting] list in a couple of months*."

Remaining funding was also used to commission support networks for girls. An educational psychologist worked with girls diagnosed during the project to explore what the diagnosis meant to them. Some health and education colleagues were also funded to attend 'Coping with Uncertainty in Everyday Situations' training.

Reflecting on the initial project, pupil voice was emphasised as a valuable aspect for all stakeholders: "*So you know it just is important to have a pupil's voice…. those pupils could just…. explain better than anybody else could what they were experiencing*."

Area Leads emphasised the importance of a need-led model, noting that: "*we're trying to do needs led work*, *so that people don't have to have a diagnosis… you shouldn't have to have one if you don't want one*, *your school or your setting should be able to support you*". They also reflected on the potential longer-term impact of the project, suggesting that it could help reshape services:

> *I suppose the legacy of things like the training that we've got*, *the observation tools that we've got and then if we become in a position to rethink how we reshape services… then we've got that piece of learning that we might use because that multidisciplinary was a good way of working*.

Discussion

This evaluation highlights both the promise and complexity of context-specific early autism identification models implemented across three English regions. Locally tailored

models improved assessment timeliness, strengthened collaboration between education and health professionals, and enabled earlier support for families. These findings align with national calls for more integrated and responsive autism services (e.g. NICE, 2011; BMA, 2019; N8 Research Partnership, 2024) and underscore the need for innovation in response to rising demand and long waiting times (NHS England, 2024). This study contributes to the autism assessment literature by providing case-based, real-world evidence on how different early identification models operate within school-based systems, highlighting trade-offs between diagnostic throughput, stakeholder experience, and service sustainability.

Each area employed distinct strategies, associated with differences in referral and diagnostic outcomes within their local contexts. Area A used EYFSP and SCQ data to target Year 3 pupils not receiving SEND support, with 80% of assessed pupils receiving an autism diagnosis from a relatively small cohort. In Area B, a bespoke needs-led approach was implemented, with 84% of assessed pupils receiving a diagnosis across a larger sample. In Area C, adapted EYFSP criteria were applied to account for masking in girls, identifying 56 pupils, of whom 48% received an autism diagnosis.

The use of EYFSP and SCQ data in Areas A and C builds on previous research suggesting these tools can help identify children at elevated likelihood for autism (Wright et al., 2019; Rutter et al., 2003). Wright et al.'s BiB study demonstrated that children with lower EYFSP scores were more likely to score above the SCQ threshold and receive an autism diagnosis, supporting the feasibility of using educational data as part of broader early identification systems. This approach is particularly relevant given the NICE (2011) guidance, which acknowledge the value of tools that help identify children at increased likelihood of autism, while not recommending any single screening tool due to variability in presentation.

Area B's needs-based model reflects critiques of diagnostic-driven approaches and aligns with calls for more inclusive and flexible support systems (Zwaigenbaum et al., 2015; NAS, 2021). By focusing on unmet need rather than diagnostic categorisation, the models supported more timely access to support, potentially reducing reliance on diagnosis as a gateway to intervention. Providing support without diagnosis may help mitigate the consequences of delayed assessments (e.g., Zwaigenbaum et al., 2015), and unlock the benefits of early intervention (e.g., Dawson et al., 2010; Remington et al., 2007; Vivanti et al., 2016).

The models also offered valuable opportunities for professional development. School staff gained confidence in identifying and supporting autistic pupils, while health professionals valued educators' contextual insights. This reciprocal learning fostered a more holistic understanding of children's needs and contributed to more inclusive school environments, echoing previous research on multidisciplinary collaboration and embedded professional learning (Parr et al., 2024; Wright et al., 2021). However, in Area A, challenges were reported in engaging NHS CAMHS, resulting in reliance on private providers with more limited local knowledge. This illustrates both the potential and the constraints of cross-sector collaboration, particularly when external services are not embedded within local systems.

Parental engagement was a consistent feature across all areas. Each model strengthened connections between families and schools and demonstrated the value of early, school-based support for pupils with special educational needs (Walker & Bond, 2025). However, parent/carers were not directly involved in the evaluation due to recruitment challenges. Future research should explore early identification models from their perspectives to better understand family experiences and support needs.

Several challenges emerged that complicate the sustainability of such models. A key contextual factor was the Government's proposed changes to EYFSP scoring during the project (DfE, 2025), which created uncertainty for project leads and raised concerns about the continued relevance of screening thresholds. This instability risked undermining confidence in locally developed models, particularly in areas where EYFSP data were central to early identification. More broadly, this highlights the vulnerability of local innovations to national policy shifts and the importance of alignment between policy development and service implementation to avoid disruption.

In Area C, the adapted identification approach prompted discussions regarding potential over-identification. Expanded EYFSP criteria designed to account for masking in girls increased the number of pupils referred for assessment; however, a smaller proportion ultimately received an autism diagnosis. While this approach surfaced children whose needs may otherwise have been overlooked, it also placed additional demands on already overstretched diagnostic services. This dynamic resonates with Foulkes' (2024) prevalence inflation hypothesis, which cautions that efforts to broaden awareness - though well-intentioned - may inadvertently pathologize normative behaviour. In Area C, the expanded criteria successfully identified previously overlooked presentations were implemented under significant time constraints that limited full adherence to the screening protocol for all girls identified via EYFSP data. As a result, outcomes need to be interpreted in light of reduced implementation fidelity, highlighting the challenges of evaluating effectiveness in real-world service settings. It is possible that fuller implementation of the intended process would have resulted in a higher proportion of assessed pupils receiving a diagnosis. These findings illustrate how

differences in local priorities and implementation constraints can shape identification outcomes.

Taken together, the evaluation demonstrates the need to balance early identification with diagnostic accuracy and service sustainability. A strengths-based, needs-led approach, as articulated in follow-up interviews across the three areas, may offer a way forward, by prioritising timely support while avoiding over-reliance on diagnosis as the sole gateway for intervention.

Several limitations should be considered when interpreting these findings. First, the three models were developed within specific local contexts and were shaped by differences in geography, population characteristics, service configurations, workforce expertise, and available resources. Alongside this, there was also variation between the models in terms of target populations, referral processes, and assessment pathways. While this variation provides valuable insights into different approaches to cross-sector working and early identification, it may limit the transferability of specific components to other local contexts, regions and healthcare systems. Second, qualitative findings were derived primarily from professionals involved in the implementation of the models and may therefore be influenced by their experiences. Parent, carer, and young person perspectives were not included, limiting understanding of how these approaches affected experiences of accessing support, navigating assessment pathways, and meeting the needs of children and families. Finally, the evaluation focused primarily on implementation processes, stakeholder experiences, and descriptive service data. Consequently, conclusions cannot be drawn regarding the effectiveness, diagnostic accuracy, cost-effectiveness, or longer-term sustainability of the models. Future research should examine these issues and explore the experiences of children and families across diverse service contexts.

Overall, the evaluation underscores the importance of multi-stakeholder collaboration, the value of embedding professional learning within schools, and the risks associated with reliance on single assessment frameworks that are vulnerable to policy change. Future research should explore how locally tailored early identification models can be scaled while maintaining diagnostic rigour, equitable access, and responsiveness to evolving educational policy.

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Declaration

Competing interest No conflicts of interest to declare.

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