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Neurodiversity and the integration of bidirectional competence between medical and educational professionals in SEND identification

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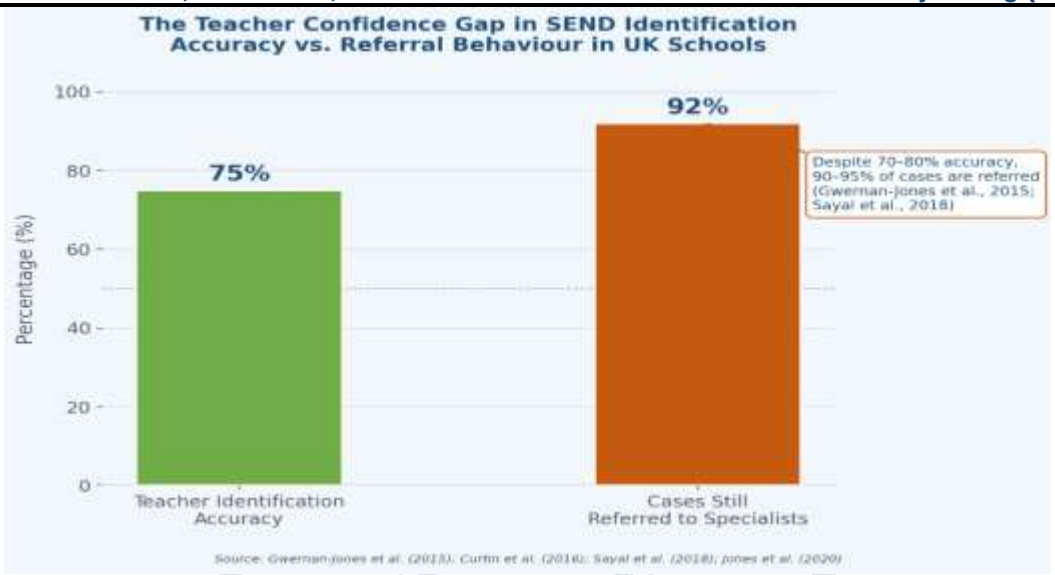
Abstract

Medical science provides the most weighty and final diagnosis for the identification of children with special educational needs and disabilities (SEND), and the rationale for this is not far-fetched—it is essentially because medical science by the nature of its organised study of the human body has assumed the towering feat of being the most competent field to diagnose symptoms, patterns, observations, and trends as they relate to the human body's system function. Today in the United Kingdom (UK), the identification of neurodiverse learners with SEND is a terrain that comes with challenges that have majorly culminated in the high rate of SEND referrals by teachers, as most teachers despite their best efforts do not have the training or professional confidence to take alternative routes, even when they feel there is a valid reason to. Drawing on the latest findings from the neurodiversity and education literature, this study seeks to bridge the gap between the assessment processes engaged by medical practitioners, and the instructional/educational methodology of teachers to better empower teachers and more meaningfully engage medical practitioners in the identification process. This paper identifies misidentification, delayed referrals, and gaps in early intervention as some of the most urgent concerns to be addressed, and proposes a framework that integrates fundamental medical and educational skills in a synergistic relationship that not only improves the competence of responsiveness, but preserves the sanctity of the educational setting, fosters better and faster diagnostic outcomes, and addresses complementary expertise gaps of both domains.

Keywords: Clinical pedagogy, medical-educational collaboration, neurodiversity, SEND identification, teacher empowerment.

INTRODUCTION

Although there are persisting challenges, however, over the last decade, the UK's educational system has experienced tremendous wins for children with Special Educational Needs and Disabilities (SEND), including significant legal reforms that have done more to increase their protection, as reflected in the Children and Families Act (2014). The diverse neurological conditions of children in UK schools range from autism spectrum conditions and attention deficit hyperactivity disorder (ADHD) to dyslexia and dyspraxia, among other neurological profiles (Hendrickx, 2020; British Psychological Society, 2022; Department for Education, 2023). However, in addition to these neurological challenges, there are administrative issues such as delays in assessing specialist evaluation (leading to years of imposed incompatibility and educational misalignment), lopsidedness in the geographical spread of the SEND service, and the generally low-level of teacher confidence in carrying out assessments (Fletcher-Campbell et al., 2016).



In carrying out their assessments, medical practitioners usually use multiple assessment methods and protocols which incorporate different sources of neurodevelopmental insights, documented patterns, and also recorded data, which then become the basis for their neurological and developmental evaluation (Rutherford et al., 2021a; Rutherford, Johnston, & Forsyth, 2021b). Usually a historical analysis of prenatal, perinatal, and postnatal findings is first done, followed by an assessment of motor and language development, the level of cognition, and an assessment of the social and emotional progress of the child (Rutherford et al., 2021a; Rutherford, Johnston, & Forsyth, 2021b; Tesfay, Sebsibe & Tesfaye, 2021). However, these medical professionals, despite their expertise, lack the requisite pedagogical paradigm. And being that they usually conduct their evaluations outside of the educational settings where these problems manifest, a child's awareness of going through overt medical processes related to educational competence has the potential of adversely impacting on the state of mind of the child in addition to tampering with the the ecological generalisability of the observations (Huws & Jones, 2015; Rogers et al., 2016).

As for teachers, their expertise involves an extensive line of professional training and skills that are just as much applied daily in the classroom, spanning time data, curriculum differentiation, robust formative assessment measures, and identifying the learner's zone of proximal development. Others include behaviour management techniques, social-emotional learning development, cooperative and inclusive learning, and skills in multi-sensory instruction and metacognition strategy (Tesfay, Sebsibe & Tesfaye, 2021). However the professional confidence that teachers have in pedagogy, they lack in both diagnostic training and diagnostic confidence— even when the evidence show that due to teachers' extended longitudinal exposure to the pupils, their assessments have been 70% to 80% accurate but they still refer 90% to 95% of cases due to lack of professional confidence and widespread insecurity (Gwernan-Jones et al., 2015; Curtin et al., 2016; Sayal et al., 2018; Jones et al., 2020).

This paper therefore proposes a unique exchange approach that is both bi-directional and complementary, such that medical practitioners and professional educators can reciprocally teach each other skillsets peculiar to each domain as they relate to addressing neurodiversity, disabilities, and special education needs. This will help teachers gain vital clinical reasoning competencies, relevant risk-assessment measures, and essential diagnostic principles that can imbue them with the requisite professional confidence in their own independent assessments in identification cases that are more straightforward and do not require complex evaluations. In like manner, relevant medical practitioners can also be taught methods of pedagogical observation, vital classroom management techniques for seamless integration, and naturalist evaluation measures that will help boost ecological validity, enhance case differentiation, and curtail instances of institutional violence often associated with clinical assessments.

2. LITERATURE REVIEW

2.1 Theoretical Framework

Three theoretical frameworks in the literature are relied on to underpin the discussions in this paper. The first is Milton's *double empathy problem theory* (2012), the second is Wenger's *communities of practice theory* (1998), and the third is Akkerman and Bakker's *boundary crossing theory* (2011).

2.1.1 Double empathy problem theory

This theory challenges the traditional framing by clinicians that social interaction and communication difficulties experienced by autistic persons are individual deficits that are inherently unidirectional (Milton, 2012). The unidirectional claim is based on the view that the said deficits reside in the individual (Milton, 2012). However, the double empathy problem (DEP) theory posits that breakdown in communication and interactional difficulties are due to neurological differences in persons, and so when such persons try to interact, the neurological differences pose a challenge to communication (Milton, 2012). Thus, unidirectional clinicians and educators are at risk of misinterpreting neurodivergent behaviour (Milton, 2012; Crompton et al., 2020). This is because differences in communication influenced by neurotypical misalignments are bound to cause comprehension difficulties, and so what appear to

assessors as deficiencies in communication and social-emotional development, may actually be a reflection of assessors' limitations in comprehending neurodivergent communication (Crompton et al., 2020).

This theory shows the relevance of naturalistic approaches and justifies the insistence on ecological validity, especially for medical practitioners undertaking evaluations for educational purposes (Mitchell et al., 2021). This enables contextual learning of communication patterns in neurodiverse pupil populations and the incorporation of training in managing neurodiversity (Crompton et al., 2020; Mitchell et al., 2021). This will ultimately reduce artificiality, curb misidentification, curtail the excessive appeal to pathology, and prevent controversial experiences during clinical assessments (Crompton et al., 2020; Mitchell et al., 2021).

2.1.2 Communities of practice theory

This theory posits that communal repertoires of routines, tools, resources, and discussions are developed through sustained mutual learning engagements (Wenger 1998). Thus, strong communities are developed by internal coherence stemming from shared professional knowledge, research, and ideals that crystallise into uniformity of language, concepts, and culture, and could therefore lead to high levels of internal cohesion so that members become professionally reluctant to external influence and are selective of cross-boundary knowledge and ideals (Wenger-Trayner & Wenger-Trayner, 2015). Therefore, the success of a bi-directional relationship between educators and medical practitioners in respect to SEND identification, will be dependent on creating a sub-field for overlapping membership between the educational and medical communities, which would then allow for mutually developed boundary practices, and the convergence of shared knowledge, methods, and expertise.

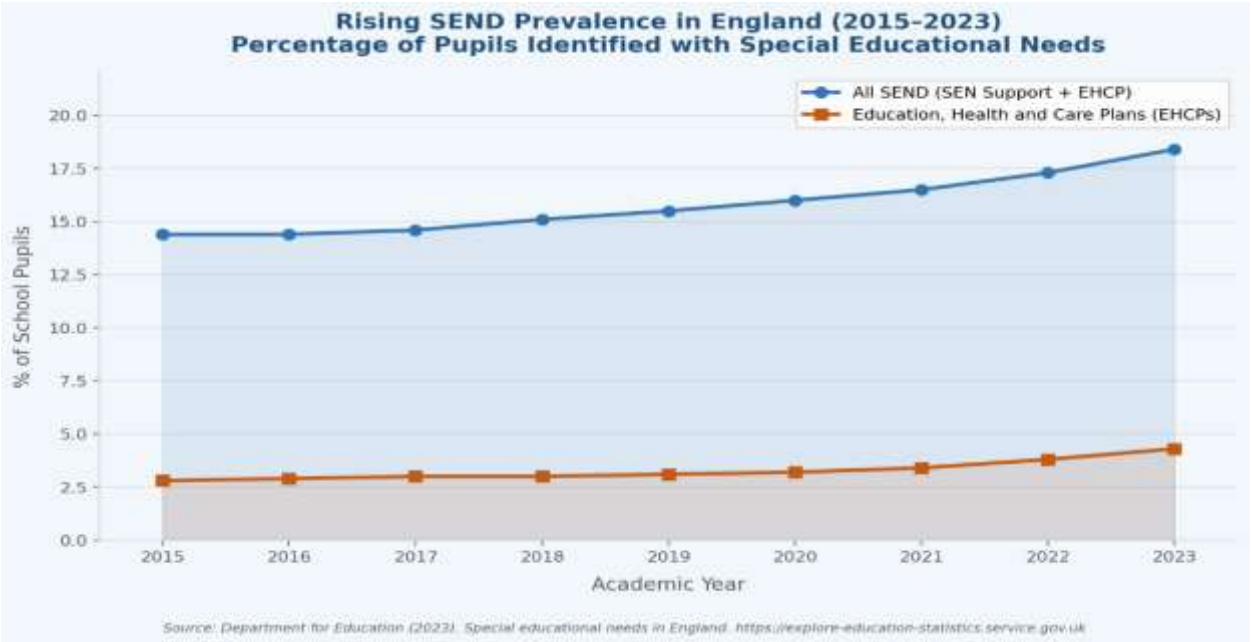
2.1.3 Boundary crossing theory

This theory provides a postulation that is apposite for effective relations across different domains of knowledge, activities, and professional practices, canvassing that where individuals try to navigate between systems and domains they will be confronting some of their own perspectives which could lead to productive specialisation is something new (Akkerman & Bakker, 2011). However, it also exposes them to a feeling of identity conflict, discomfort, and even potential resistance (Akkerman & Bruining, 2016). This is why Akkerman & Bakker (2011) have postulated the need to adopt four elements that are important in the acclimatisation process, i.e., *identification* (recognising that there is difference), *coordination* (developing mutual routines), reflection (integrating different disciplinary views that broaden perspectives), and *transformation* (in this instance mutually creating a hybrid of new practices from both disciplines). Boundary crossing both fields will include adopting boundary bridging objects things like jointly developed methods and documentation systems, and shared protocols for evaluations, with which professionals in both domains can agreeably work in a hybrid context.

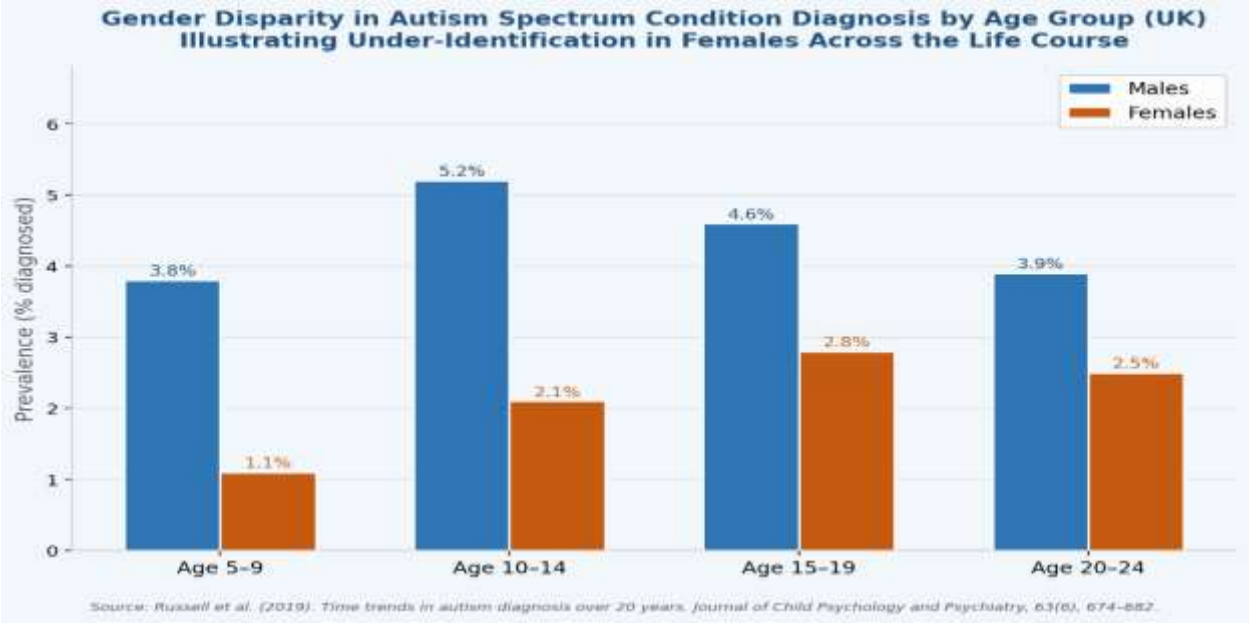
2.2. Review of the Literature

2.2.1 Neurodiversity and systemic weaknesses in SEND identification

Accepting neurodiversity as an existing reality is one way to reframe how developmental and cognitive differences are viewed and interpreted, particularly creating a new awareness that interpersonal neurological variations are natural at different stages of human existence and for different reasons and should therefore not be superficially dismissed as a reflection or symptom of inherent deficits (Singer, 2017; Walker, 2021). In relation to the education system in England, there is a need to inculcate this value system whilst in the same vein trying to ensure schools effectively carry out their obligation to ensure a graduated but early response to identifying additional educational needs (Department for Education [DfE] & Department of Health, 2015).



We have seen co-existing realities of both extremes such as delays in identification versus overidentification, and inconsistencies in the referral assessment process versus rapid escalations through referrals—indicating the need for balance (Ofsted, 2020; DfE, 2023). However, the reality shows that the system shows serious disparities in its handling of neurodiversity. For instance there is significant disparity between the number of girls diagnosed with autism even when they show similar symptoms with boys (Russell et al., 2019).



In an earlier report on ADHD, diagnostic rates were shown to vary with referral limits and interpretation differing from setting to setting (Moore et al., 2017). Thus, not having consistent tracking measures, teachers may misconstrue differences in executive and developmental function for differences in the child's level of motivation or attitudinal discipline (Moore et al., 2017). Reading difficulties have also been wrongly associated with poor academic attainment linked to individual deficits (Snowling & Hulme, 2021). These systemic irregularities in SEND identification have since 2019 been recognised to lead to wrong labelling, protracted delays, and inappropriate escalation (Ofsted, 2020)

2.2.2 Teachers' confidence gap in identification assessment

Teacher training programmes do not provide the requisite neurodevelopmental training to professionally arm teachers with the sense of adequacy and applicative competence for identification purposes despite being at the centre of the identification process (Hodkinson, 2020; Nash & Norwich, 2021). Therefore we have seen different instances of over 70% accuracy in identification, yet over 90% of the cases were still referred before administering even the minutest of applicable pathways for fear of parental backlash, diagnostic uncertainty, and professional disapproval (Gwernan-Jones et al., 2015; Crane et al., 2018). With funding considerations, tensions around parent school relationships, and the risk for legal battles, teachers become more inclined to manage their exposure to unpalatable impacts on their careers (Done et al., 2021; Pearson & Mitchell, 2020). Interestingly, medical examinations hold a superior sway over educational observations, even when teachers may be contextually better positioned, while the adverse impacts of the two extremes of false positives (i.e., parental backlash) or false negatives (i.e., protracted delays) further escalate referrals (Graham & Jahnukainen, 2021; Jones et al., 2020; Sayal et al., 2018; Runswick-Cole, 2016). Teachers are also unwilling to take any risks and so there is a strong entrenched culture of risk aversion.

The implications of these include escalation of referrals, specialist services requiring minimal assessments, professional growth is stunted as progressive skills are not allowed to grow (Curtin et al., 2016; Goodall, 2020). Interestingly, parallel research in medical education demonstrates how structured clinical reasoning training and explicit risk-assessment protocols reduce defensive practice among junior clinicians (Falender & Shafranske, 2021; Van Cleave & Leslie, 2018). When medical trainees receive systematic instruction in differential diagnosis, learn standardised frameworks for judging when further assessment is warranted versus sufficient data exist for action, and understand the relative risks of various decision pathways, their clinical confidence increases whilst inappropriate testing decreases (Mamede et al., 2020). This suggests that similar training could benefit educators, providing explicit frameworks for judging when observations warrant specialist referral versus when teachers possess sufficient evidence for independent decision-making.

2.2.3 Medical practitioners and the ecological validation challenge

While the challenge with teachers is their limited professional confidence, medical practitioners face the challenge of limitations in contextual understanding in carrying out their clinical assessments, particularly due to the fact the children are usually presented in clinical settings (Rogers et., 2016; Solomon et al., 2018). Added to this is the little observational time that they have to make their diagnosis compared to the significant longitudinal advantage teachers have and the fact that teachers observe in a more natural setting with the right degree of social, emotional, and academic complexity that creates the space for the manifestation of the challenges these individual learners have (Rimstad et al, 2019; Langley et al., 2020). Reports show that there are recurring disparities between teacher

ratings and the assessments of clinicians, with the results showing that difficulties identified with teachers are frequently unreflected in the notes of clinicians (Rimestad et al., 2019; Langley et al., 2020; Hull et al., 2020). The major accounting factor for this would not seem to be the error of the teachers but because clinicians carry out their assessments in more relaxed and less complex social environments. As a result, the children being examined are there only for a short period which doesn't trigger the level of load or engagement they face in school where they need to sustain attention in the midst of distracting activities and the significantly longer range of school hours that requires navigation socially (Rimestad et al., 2019; Langley et al., 2020; Hull et al., 2020).

The likelihood of deficit questions is high, and for many children this could become frustrating and annoying, leading to distress and sometimes violent reactions (Huws & Jones, 2015; Pellicano et al., 2018; Botha et al., 2022). The increasing cases of gaps in ecological validation or generalisability has escalated the calls for medical practitioners to conduct their assessments within educational settings (McConachie et al., 2015; Saggers et al., 2016). In addition, concerns about some of the children showing severe distress also raise ethical considerations and the need to adopt more educationally aligned environments that are normalised and allow the children demonstrate the issues while feeling safe in a school environment they are familiar with. However, these calls would mean that clinicians need to also develop relevant pedagogical skills and paradigms that can help them fit in more seamlessly when they perform their assessments in the school settings.

METHODOLOGY

Using conceptual-analytical research, the study adooted an interpretive and integrative review of the literature with an inclination towards showing the intersections between two fields: i.e., clinical neurodevelopmental assessment and special educational needs pedagogy. The study provides a new paradigm and framework to effectively converge in mutually supportive ways the roles of medical science and professional educatirs in meeting the demands of special educational needs and disabilities.

The review was conducted drawing on seminal works, and also from publications made between 2015 and 2023 and available in the following peer-reviewed databases: ERIC, PsycINFO, and Google Scholar. Key search terms included combining the following words *neurodiversity*, *SEND identification*, *teacher assessment confidence*, *clinical pedagogy*, *ecological validity*, *bidirectional learning*, *interprofessional education*, and *neurodevelopmental assessment*. Selected studies were streamlined based on relevance to the United Kingdom, publication quality and show or methodological rigour, and potential to contribute to insights on the place of effective synergy between medical professionals and educators in tackling challenges in SEND education.

4. DISCUSSION: THE MEDICAL AND EDUCATIONAL BIDIRECTIONAL EXCHANGE FRAMEWORK

The proposd bidirectional framework provides a unique sub-field that connects medical science and the field of education in an active partnership to curtail the reported excesses of identification and contextual validity failures in managing SEND cases. It provides a structured competency exchage that not only has the potential to cut down costs and expenditure, but will enhance the seamlessness of the SEND identificatin process, reduce waiting times, and save the children from frustrations that stem from avoidable situations. The school system will become inherently more capacitated to handle SEND referrals, pushing only complex, sensitive, and clinical treatment cases to medical.practitioners. The overlapping membership shared by the relevant medical and educational professionals in this new sub-field in SEND identification, will have mutually developed boundary practices, and the convergence of shared knowledge, methods, and expertise that set the standards and uniformity of language between these two domains, thus sealing the shared competency and spelling out points of specialisation.

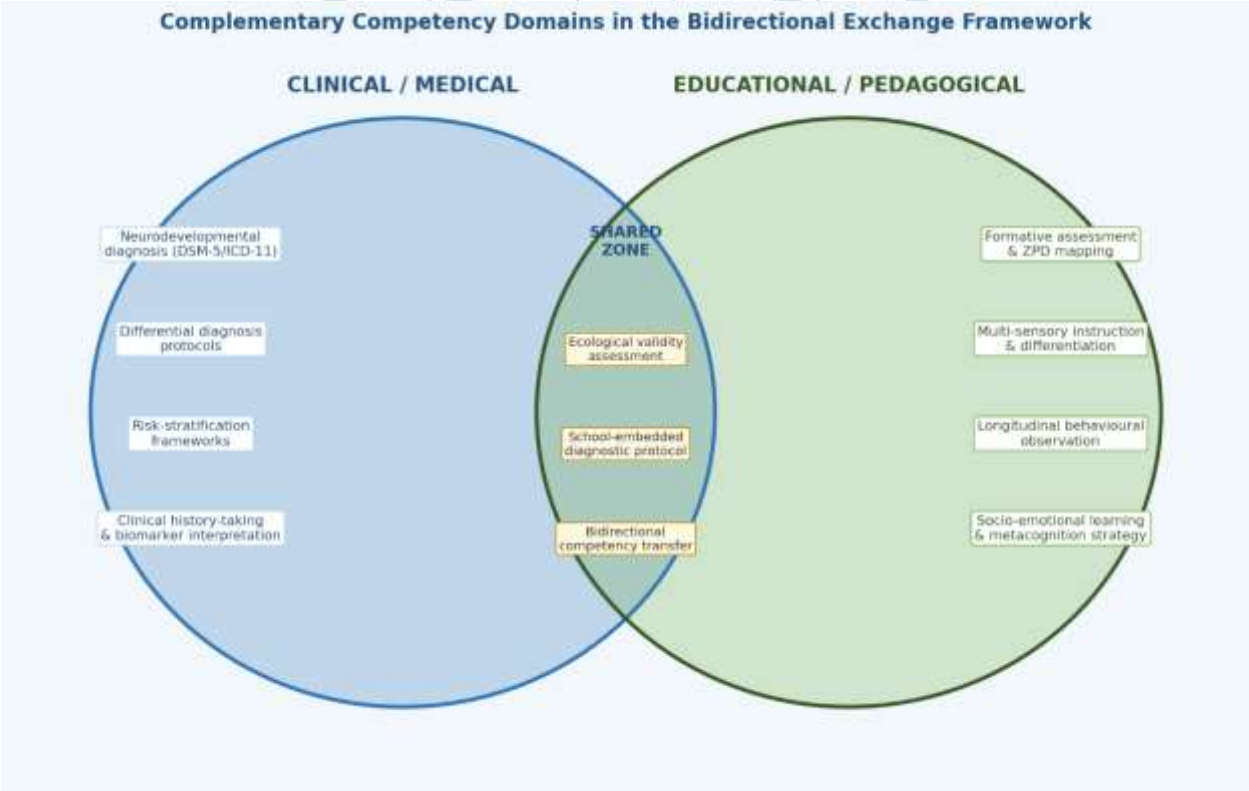
These streams of shared competence and specialisation within the same sub-field will be further strengthened by collaborative practice opportunities where professionals use their newly acquired skills in real assessment settings. However, as already noted boundary crossing theory, there are four main principles that should guide this process, *identification* (recognising that there is difference between these converging fields), *coordination* (developing mutual routines), *reflection* (integrating different disciplinary views that broaden perspectives), and *transformation* (in this instance mutually creating a hybrid of new practices from both disciplines). Furthermore, the bidirectional framework itself will work only where there is reciprocity (mutual learning instead of one-sided knowledge transfer), competency focus (developing practical skills over theoretical knowledge), context-embeddedness (simulating learning in practice settings), and child-centredness (all learning aimed at improving assessment quality and reducing trauma). An important factor that will engender child-centeredness is incorporating a paradigmatic shift from seeing neurological differences from the strict lens of pathology and accommodating neurodiversity as a more encompassing worldview without undermining the need for special care where proven to be necessary

In construing the componentts that will ground the workability of the bidirectional framework, let us look at the identified components that should found the relationship. While the boundary crossing pronciples will help facilitate the initial process, thus opening the forum for mutuality without which the process would not start. But betond this, the practice that must guide this new sub-field are rooted in the four values of *reciprocity, competency focus, context embeddedness, and child-centredness.* Reciprocity challenges traditional hierarchies, which often view medical knowledge as superior to educational expertise. The framework asserts that both clinicians and educators have valuable, complementary knowledge that is necessary for effective assessment in SEND and smooth-running of the system. While they are each superior in their areas of specialisation, they however need shared competency to make the system work better. Relying solely on one group isn't enough (Reeves et al., 2017; Whitehead, 2023). This equality of knowledge is crucial for genuine learning; if either group sees their interaction as one-sided, it can create defensive dynamics that hinder learning (D'Amour et al., 2005). In practical terms, reciprocity means each group spends equal time learning from the other. Joint problem-solving replaces expert consultation, and assessment becomes a collaborative effort that includes both clinical and educational expertise.

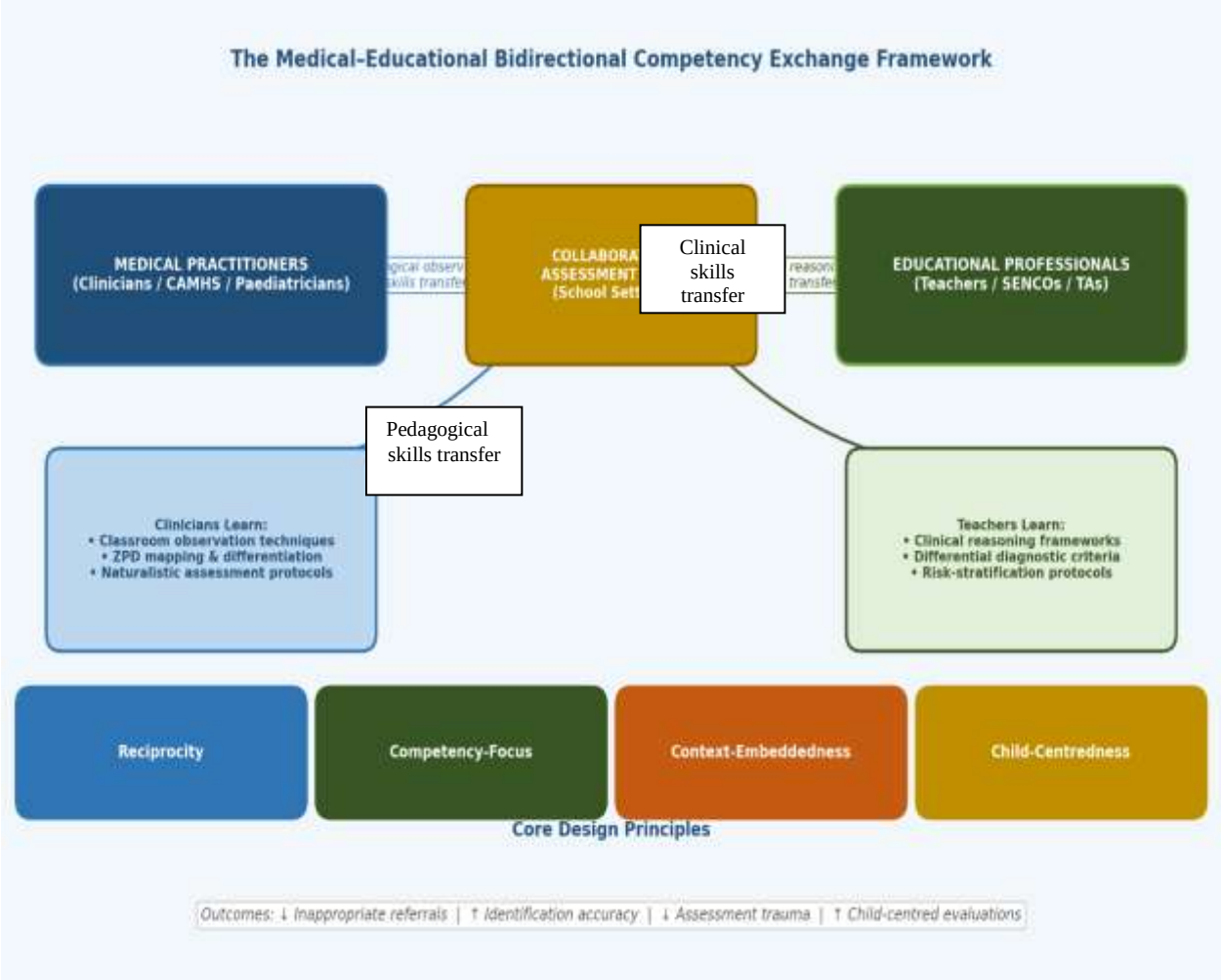
The competency-focus sets this framework apart from typical interprofessional education models, which tend to emphasize understanding roles and communication (Reeves et al., 2017). While those models can be helpful, they often leave professionals familiar with what others do, without the skills to actually do it. In contrast, this framework allows each group to develop practical competencies in the other's field. For example, teachers can learn clinical reasoning and risk assessment, while clinicians can learn to navigate classroom environments and carry out educational observations. This requires intense, practical learning, rather than just lecture-based information transfer (Falender & Shafranske, 2021; Kennedy, 2016).

Implementing bidirectional competency exchange presents several challenges, including logistical issues, professional resistance, power dynamics, and conceptual conflicts. Recognizing these barriers is essential for effective planning and avoiding implementation failures that could undermine the whole approach. Five challenge areas require particular focus: workload and resource limits, professional boundary concerns, power differences and hierarchies, quality assurance, and unintended side effects.

Both education and healthcare sectors face significant workload pressures that limit their ability to provide additional training and collaborative practice (National Education Union, 2021). Teachers are already overwhelmed with excessive demands. Adding clinical reasoning training and joint assessment responsibilities could worsen the situation (Hodkinson, 2020). Medical practitioners, especially in community pediatrics and CAMHS, juggle unsustainable caseloads, leaving little time for thorough school-based assessments (National Audit Office, 2019). Without structural changes—like designated time for training, adjusted workload demands, and more staffing—bidirectional learning risks becoming another unfeasible requirement that professionals agree to but cannot implement meaningfully.



Methodologically sound research that confirms effectiveness and identifies key factors remains crucial for evidence-based implementation. Randomized controlled trials comparing bidirectional training with unidirectional approaches or standard practices would provide strong evidence about its impact on referral appropriateness, identification accuracy, assessment quality, and child outcomes (Reeves et al., 2017). Professions maintain boundaries to protect their areas of expertise, ensure quality, and preserve professional identity. Bidirectional learning could challenge these boundaries, leading to resistance from those who view competency exchange as a threat (Graham & Jahnukainen, 2021). Teachers may resist taking on clinical skills if it seems to add responsibilities without corresponding authority or pay. Medical practitioners might object to teachers gaining diagnostic skills that could challenge their control over assessments (Whitehead, 2023).



5. CONCLUSION

Current methods for neurodevelopmental assessment in UK educational settings are hampered by strict professional boundaries that reduce both efficiency and quality. Teachers can make accurate observational assessments but often lack the confidence to act on them, leading to defensive over-referrals that overwhelm specialist services and delay necessary support. Medical practitioners perform thorough diagnostic evaluations but lack the teaching skills needed for meaningful assessments, resulting in technically accurate but contextually poor conclusions. This gap in expertise negatively impacts children, frustrates professionals, and wastes resources. The bidirectional competency exchange framework proposed here offers practical ways for medical practitioners and educators to build complementary skills. By teaching educators clinical reasoning and risk assessment, clinicians can boost their confidence to make appropriate independent judgments in straightforward cases. By teaching clinicians pedagogical observation and integration into natural settings, educators can improve the validity of assessments and lessen trauma related to evaluations. This reciprocal learning can lead to fewer inappropriate referrals, better identification accuracy, faster processes, and more child-centered evaluations.

Importantly, the framework challenges traditional hierarchies that have often placed educational knowledge below medical expertise. By promoting real reciprocity, where clinicians learn from teachers just as teachers learn from clinicians, the framework acknowledges educators as holders of valuable contextual knowledge vital for valid assessment. This isn't just about technical training; it represents a fundamental shift in power dynamics, recognizing that successful assessment requires integrating both types of knowledge rather than simply deferring to medical authority. Whether it is possible to achieve this balance within existing institutional frameworks remains uncertain, but striving for it offers a chance for better professional relationships and improved assessment practices.

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