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ECEY6006

Supporting Children with Additional Learning Needs

Cover sheet

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AI Cover Sheet

Section 1: Webinar Script

Reference list: Poster and Script

AI Acknowledgement

I acknowledge the use of Grammarly (<https://www.grammarly.com/>) on multiple occasions throughout the assignment to check my work using the prompts:

1. Check the text for readability, grammar, and syntax.

I acknowledge the use of Microsoft Copilot (<https://copilot.microsoft.com/>) on multiple dates throughout the assignment, using prompts such as:

1. Find and summarise academic journal articles dated within the past 10 years on ADHD identification, diagnosis, barriers, impacts on children, parents and practitioners, and ALPs. I need reliable articles with working links; no placeholders or broken links.
2. Reduce the following to around 2000 words, do not add/change wording, do not change tone/meaning, do not add any new concepts/ideas, do not add/remove any citations. Just remove unnecessary filler words.

I acknowledge the use of Canva (<https://www.canva.com/templates>), using prompts in the search bar such as:

1. Academic poster layout.

I confirm that I have not presented any AI generated text as my own work. I confirm I have copies of my drafts, notes and other resources I used before, and after the use of AI tools which I may be asked to provide as evidence.

Section 1: Webinar Script – 13 minutes, allowing 2 minutes for an additional 2 questions.

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most commonly identified neurodevelopmental (ND) conditions in childhood, yet its identification, diagnosis and support remain complex and shaped by multiple interacting factors. Clinical frameworks such as the DSM-5 and ICD-11 define ADHD through behavioural criteria and functional impairment (Musullulu, 2025; Peterson et al., 2024), but research shows identification is interpretive, context-dependent, and reliant on multi-informant evidence rather than biological tests (Posner et al., 2020). Alongside these clinical perspectives, the social model of disability challenges deficit-based interpretations by arguing that many difficulties arise not solely from the child's neurology but from environments that fail to accommodate diverse attentional, sensory and emotional needs (Kelly, 2018). This highlights the importance of understanding ADHD not only as a clinical condition but also as an interaction between the child and the systems around them.

Within Wales, these issues sit within a rights-based policy landscape shaped by the Additional Learning Needs and Educational Tribunal (Wales) Act 2018 and the ALN Code (Welsh Government (WG), 2021). Central to this framework is Additional Learning Provision (ALP), defined as support that is additional to or different from what is ordinarily available to learners of the same age in mainstream settings. ALP must be targeted, evidence-based and designed to reduce barriers to learning, ensuring that children with identified ALN receive timely and appropriate support. This policy context is intended to create a consistent, equitable system of support, but in practice, systemic pressures often limit its effectiveness.

Evidence suggests that long waiting lists, inconsistent practitioner knowledge and the under-recognition of emotional dysregulation continue to limit early identification and access to ALP (Nation.Cymru, 2025; Faraone et al., 2018; Moore et al., 2017). These challenges highlight the need to understand how ADHD is identified, how diagnosis is shaped by systemic pressures and how these processes impact children, parents and practitioners.

The NHS (2024) describes ADHD as a condition where the child's brain works differently from that of children of the same age. Children may have trouble

concentrating, sitting still, controlling impulses and managing high energy levels. Most diagnosed children show symptoms across both inattentive and hyperactive-impulsive domains, although some present predominantly in one. The NHS (2024) also highlights that identifying ADHD in girls is more challenging, as girls more commonly display quieter inattentive symptoms that are easily overlooked. This contributes to later identification and underdiagnosis among girls.

Musullulu (2025) states that ADHD identification is based on behavioural criteria and depends on observed behaviour rather than biological tests. They emphasise the need for a multi-method, multi-informant process involving parents, teachers and clinicians, as children may behave differently across home, school and clinical environments. Peterson et al. (2024) similarly argue that no single tool is accurate enough alone and that clinicians must consider developmental norms, environmental demands and the child's broader cognitive profile. This highlights the importance of triangulating information across settings.

However, Musullulu (2025) warns that identification is subjective, as rating scales are vulnerable to informant bias. Teachers, parents and clinicians may interpret the same behaviours differently depending on expectations, stress levels or cultural beliefs. Crocker et al. (2025) add that commonly used tools have poor specificity, increasing the risk of false positives and diagnostic inflation. These issues reinforce the need for careful clinical judgement.

Furthermore, Posner et al. (2020) argue that because ADHD lacks a biological marker, it is best understood as a clinical construct. Large-scale research shows consistent patterns in how children with ADHD process information, manage attention and regulate emotions, with meta-analytic and population-level studies identifying reliable differences in executive functioning and self-regulation (Rubia, 2018; Pievsky and McGrath, 2018; Bernanke et al., 2022). Posner et al. (2020) emphasise that DSM-5 criteria reflect decades of refinement, underpinned by robust longitudinal and meta-analytic research demonstrating the stability and validity of ADHD as a diagnostic construct (Faraone et al., 2021; Cortese et al., 2020). Together, this evidence supports the validity of ADHD as a diagnostic category, even in the absence of biological testing.

In contrast, Kelly (2018) argues that ADHD criteria are culturally shaped and influenced by educational expectations and social norms. They suggest that what is labelled as 'symptomatic' may reflect children's responses to rigid schooling structures or societal intolerance of developmental variability, cautioning against broadening diagnostic categories without robust evidence. This perspective highlights the importance of considering environmental fit, suggesting that some behaviours labelled as ADHD may emerge from contextual pressures rather than underlying pathology.

As of September 2024, 20,770 children in Wales were waiting for an ADHD or autism assessment (Nation.Cymru, 2025). NHS projections warn this could rise to between 41,000 and 61,000 by 2027 (Autism Eye, 2025). These figures highlight the scale of demand and systemic pressures shaping the diagnostic landscape. Long waiting lists delay access to support and increase the likelihood that children's behaviours are misinterpreted.

The diagnostic process typically begins with a referral to ND services (NHS, 2024). Assessment involves a clinical interview gathering developmental, medical and psychosocial history. Behavioural rating scales such as Conners and Vanderbilt are commonly used (Musullulu, 2025). Continuous performance tests (CPTs) are sometimes used, but Musullulu (2025) notes they show low diagnostic specificity and cannot reliably distinguish ADHD from ASD, anxiety or trauma. This reinforces the need for comprehensive assessment.

Additionally, Wolraich et al. (2019) argue that structured clinical interviews significantly improve reliability and help clinicians rule out alternative explanations. Interviews allow exploration of developmental history, environmental triggers, family dynamics and co-occurring difficulties. They also help clarify inconsistencies between parent and teacher reports, which are common. This is highlighted by Peterson et al. (2024), who found that parent and teacher reports frequently disagree, reinforcing the importance of multiple perspectives. They conclude that ADHD identification is ultimately a clinical decision supported by tools, not a test-based diagnosis.

However, Cortese and Coghill (2018) argue that diagnostic reliability depends heavily on the quality of assessment. Addressing claims of overdiagnosis, Cortese et

al. (2026) contend that evidence overwhelmingly supports underdiagnosis, particularly where services are overstrained. This aligns with concerns about long waiting lists.

Mulraney et al. (2022) found that screening tools demonstrate good overall accuracy but rarely achieve adequate sensitivity and specificity simultaneously. Cree et al. (2023) also found that parent-reported diagnoses are highly reliable and that impairment can be present even when symptom patterns are less clear-cut. This highlights the need to prioritise functional impairment within diagnostic decision-making.

ADHD has wide-ranging implications for the child. French et al. (2024) argue that ADHD is linked to multi-domain impairments affecting mental health, physical health, education and social outcomes. McDougal et al. (2022) emphasise children's lived experiences, describing frustration, inconsistent academic performance and strained peer relationships. Maslow's (1943) hierarchy of needs reinforces this, as the frustration, inconsistent performance and strained peer relationships reported by McDougal et al. (2022) can compromise children's sense of belonging and emotional security, needs that must be met for learning and wellbeing to develop.

Furthermore, Faraone et al. (2018) stress that emotional dysregulation is a core part of ADHD and is commonly under-recognised by practitioners, despite being one of the most impairing features. However, emotional dysregulation is not included in DSM-5 criteria (Adler et al., 2018), creating a mismatch between clinical reality and diagnostic frameworks.

The impacts of an ADHD diagnosis can be profound for parents. Holland, Pell and Kids (2019) highlight that the diagnostic process is a major stress point, with many parents reporting guilt, emotional strain and self-blame. Bronfenbrenner's (1979) Ecological Systems Theory helps explain why this experience is so intense: parents are navigating multiple interacting systems, and pressures at home, school, services and society can compound one another. Difficulties within the microsystem and mesosystem, such as behavioural challenges, strained routines or judgmental school communication, can heighten parental stress. System-level barriers in the exosystem, including long waiting lists and inconsistent professional responses, add further strain, while macrosystem factors such as stigma shape how others interpret

the child's behaviour. Broomhead (2019) found that parents of children with ADHD experience particularly high levels of stigma because the condition is invisible and often attributed to poor parenting. Together, these interacting systems show that parental stress is not simply an individual emotional response but a reflection of wider systemic pressures.

Practitioner awareness is essential for supporting learners with ADHD, as early recognition and informed responses directly influence access to appropriate support. International frameworks such as the UNESCO Salamanca Statement (1994) and the UNCRPD (United Nations, 2006) position inclusive education as a rights-based obligation, requiring practitioners to identify barriers and adapt environments so that all learners can participate meaningfully. In Wales, these principles underpin the ALN Act (WG, 2018) and ALN Code (WG, 2021), which place clear duties on practitioners to recognise emerging needs, collaborate with families and provide timely, person-centred support. This policy context makes practitioner knowledge, confidence and understanding central to ensuring that children with ADHD receive equitable and effective provision.

However, research shows practitioners often feel underprepared. Moore et al. (2017) found that teachers feel undertrained and emotionally strained. Ward et al. (2021; 2022) note that training improves knowledge but does not always translate into practice. While Greenway and Edwards (2020) found that TAs had higher ADHD knowledge and more positive attitudes than teachers, yet both groups reported insufficient training.

Children with ADHD experience intertwined systemic and practice-based barriers. A major systemic barrier is prolonged waiting times for assessment (Nation.Cymru, 2025; Autism Eye, 2025). Delayed assessment increases the likelihood that behaviours are framed as deliberate non-compliance rather than ND difficulties (Cortese and Coghill, 2018; Peterson et al., 2024), leading to punitive responses and missed intervention windows (French et al., 2024; Mulraney et al., 2022).

A second barrier is the under-recognition of emotional dysregulation, despite strong evidence that it is central to ADHD (Faraone et al., 2018; Shaw et al., 2014). In practice, practitioners may focus narrowly on attention and hyperactivity, leading emotional responses to be interpreted as intentional or oppositional (Moore, Russell

and Ford, 2017; Greenway and Edwards, 2020). This misinterpretation can result in children being corrected rather than supported, reinforcing cycles of frustration and escalating behaviour. The impact extends beyond moment-to-moment interactions: when emotional needs are overlooked, children experience reduced psychological safety and weaker peer relationships, undermining their sense of belonging and security, both of which are foundational for learning and engagement (Maslow, 1943; McDougal et al., 2022).

Under the ALN Code (Wales), ALP refers to support that is additional to or different from what is ordinarily available in mainstream classrooms (Welsh Government, 2021). A structured Executive Function (EF) Skills Group represents an example of targeted ALP appropriate for learners with ADHD, as it directly addresses core functional impairments (Adler et al., 2017; Faraone, 2018; French, 2024).

Research consistently shows that ADHD is linked to deficits in working memory, planning, emotional dysregulation and sustained attention, which contribute to poorer educational outcomes (French et al., 2024). Small-group Executive Function (EF) provision directly targets these areas through structured teaching of planning, sequencing, organisation, self-monitoring and emotional regulation. This aligns with McDougal et al. (2022), who found that children with ADHD experience persistent difficulties with concentration, attention and emotional frustration in learning environments.

An EF Skills Group supports these needs through activities such as breaking tasks into manageable steps, practising planning and sequencing, developing organisation strategies, using timers and routines, teaching self-monitoring, rehearsing problem-solving and providing structured opportunities to apply skills. As an ALP, it offers targeted, scaffolded support within a safe environment, though limitations include withdrawal from class and the need for skilled facilitation to ensure generalisation.

Overall, the evidence shows that ADHD identification is shaped by the interaction of clinical criteria, practitioner understanding and wider systemic pressures. Long waiting lists, inconsistent awareness and the under-recognition of emotional dysregulation continue to delay support and contribute to uneven experiences for children and families. Within this landscape, educational settings play a central role

in reducing barriers to learning through responsive, needs-led support. ALP and targeted interventions such as EF Skills Groups form part of this wider approach, but their effectiveness depends on informed practitioners and environments that adapt to children's cognitive, emotional and regulatory needs. Taken together, the research highlights the need for coordinated assessment, timely intervention and flexible systems that recognise the complexity of ADHD.

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