

ECEY6006

Supporting children with Additional Learning Needs

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I have not used any AI in this assignment

Presentation script

Introduction

According to the Welsh Government (2024) there are currently 52,152 children in maintained schools in Wales who have an Additional Learning Need [hereafter ALN] and state that 2,550 of these children have been diagnosed with Attention Deficit Hyperactivity Disorder [hereafter ADHD]. In the same vein, Greenway and Edwards Rees (2020) state that around 7.2% of children worldwide have ADHD. However, according to the Welsh Parliament (2024) and research from the Senedd many more children are waiting to be diagnosed and point out that in December 2023 16,812 children were waiting for an ADHD assessment and state research suggests that undiagnosed cases are not officially tracked meaning the actual number of children with ADHD may be significantly higher. This poster will critically evaluate how ADHD is identified and diagnosed and analyse the barriers that children with ADHD experience. The poster will explore an appropriate support strategy focusing on how targeted interventions can reduce barriers and promote positive learning outcomes for children with this learning need.

Identification and diagnosis

According to Eiland and Gildon (2024) ADHD is characterised by ongoing patterns of inattention, hyperactivity and impulsivity that can interfere with a child's development and learning including daily functioning. The authors suggest that ADHD is an additional learning need that can significantly impact a learner's concentration and ability to regulate behaviour and point out that these challenges may affect academic progress, social interactions and engagement in learning if not appropriately identified and supported. Greenway and Edwards Rees (2020) would agree and states ADHD is a condition that affects how the brain develops especially in areas that control attention and behaviour. The authors state that this involves ongoing problems with paying attention or being overly active and impulsive and suggest to be diagnosed children must show several symptoms before age 12 for at least six months and in more than one place such as school or home. In the same vein, the National Health Service [hereafter NHS], (2025) suggest ADHD symptoms usually begin before the age of 12 and mostly affect attention, activity levels and impulse control. They state some common signs to look out for include being easily

distracted, struggling to listen or follow instructions, forgetting everyday tasks, having high energy levels, fidgeting, restlessness, talking excessively and interrupting others or finding it hard to wait their turn. They state that most children with ADHD show a combination of inattentive and hyperactive impulsive symptoms, however point out that some children may show mainly one type.

According to the NHS (2025) advice and support page, parents or carers can speak to a GP or the school's additional learning needs Co-Ordinator [hereafter ALNCO] to request an ADHD assessment. They suggest an ADHD assessment is carried out by specialists such as a paediatrician or child psychiatrist and state the assessment usually involves discussing the child's symptoms, development and family life as well as completing questionnaires and gathering information from school staff. In the same vein, according to Hall *et al.* (2019) the National Institute for Health and Care Excellence guidelines for ADHD state that diagnosis usually relies on clinical observation and reports from parents, teachers and the child and point out that these reports can sometimes be missing or conflicting, causing delays or uncertainty in diagnosis. However, Berkhout *et al.* (2022) argue that clinical observation can cause the Hawthorne effect and make ADHD harder to diagnose because children may behave differently when they know they are being watched. The authors point out that a child who is usually distracted, impulsive or hyperactive may seem calmer and more focused during an assessment or observation. This can make their symptoms appear less severe and may lead to an ADHD diagnosis being missed.

The Welsh Government (2018) states that identifying and supporting a child with an ALN as early as possible is key and suggests early intervention is often more effective and can reduce the need for more costly support later. They point out that early interventions can improve outcomes and ensure children's needs are met promptly. According to Greenway and Edwards Rees (2020) teachers and teaching assistants are important in spotting ADHD because they observe children in the classroom and suggest their understanding and attitudes matter during assessment. However, the authors point out that a lack of knowledge can make it harder to recognise symptoms and negative attitudes can affect how children with ADHD are treated and supported. This is consistent with ADHD UK (2017) whose statistics show that 19% of teachers feel uninformed on ADHD with as many as 78% admitting

to not recognising some of the main characteristics such as difficulty with social interaction as a symptom of ADHD.

Barriers

According to the Welsh Government (2021) ALN Code for Wales, all practitioners supporting learners should take part in ongoing professional learning and point out that while practitioners are responsible for their own development, schools are also expected to provide support, training, resources and guidance to help staff develop their knowledge and skills in ALN. However, despite this statement from the Welsh Government (2021), the National Association of Headteachers (2020) reports that the situation facing schools supporting children with special educational needs is extremely challenging. School budgets are under significant pressure, while cuts to health and social care services have made it even harder to provide the support vulnerable pupils need. As a result, many schools are struggling to meet these needs effectively. In the same vein, Greenway and Edwards Rees (2020) study showed that teaching assistants in the early years reported challenges surrounding ADHD that included negative emotional effects, lack of support, limited training and knowledge and negative attitudes toward ADHD within schools and point out that better support, training and understanding of ADHD in the classroom needs to be more accessible for all staff. This is consistent with the data obtained by ADHD UK (2017) statistics that show 63% of teachers in the UK have not received adequate training or support on how to work with children with ADHD and claim that 49% of teachers think that children in school who suffer with ADHD are often left out or isolated by those around them because of their condition. Akdag (2023) suggests that ADHD related behaviours can negatively affect peer relationships in school as children may display disruptive or controlling behaviours and suggests this can lead to rejection from peers and exclusion from group activities. Armstrong *et al.* (2017) also argue that children with disabilities often experience peer prejudice which increases loneliness, anxiety and can affect self-esteem. They further suggest that many UK schools do not sufficiently promote positive attitudes towards disability and that teachers may need more resources to better support inclusion and acceptance.

This perspective links to Zaks (2024) who explains that the medical model of disability which has been dominant since the 1800s views disability as a problem within the individual that should be treated, cured or made to appear normal. The author claims that this way of thinking has led to harmful outcomes including stigma, segregation and reduced opportunities for disabled children and points out that it continues to reinforce negative ideas that disabled individuals are inferior or a burden on society. In the same vein, according to Toro *et al.* (2020) the medical model sees disability as being caused by a problem in the body or mind and suggests it focuses on the disability as a health issue that needs medical care or treatment. Similarly, Guevara (2021) argues that the medical model often frames disability as a personal tragedy presenting it as an unfortunate condition that happens to individuals. The author claims this can reinforce negative stereotypes by portraying people with disabilities as damaged or in need of being fixed, encouraging pity rather than understanding.

In response, the social model emerged. According to Toro *et al.* (2020) the social model views disability as being caused not by a child's condition but by barriers within society such as discrimination, exclusion and a lack of support. The authors suggest it makes a clear distinction between impairment which is a biological condition and disability which is a disadvantage created by social factors. From this perspective, the challenges faced by children with ADHD are not only due to their symptoms, but also to how schools respond to their needs. This highlights the importance of creating inclusive school environments where barriers are reduced, and understanding and acceptance are actively promoted so that all children feel supported and included. However, Hogan (2019) argues that both models have limitations. The author claims the medical model focuses too much on clinical definitions and can ignore the children's real life experiences and adds the social model highlights social barriers and injustice however, can overlook the physical and emotional effects. The author suggests this comparison shows that disability is influenced by both a person's condition and the society around them and points out that neither model fully explains the complexity of disability on its own.

Strategies

Action for Children (2026) state children with ADHD need individualised support and suggest strategies used at school should also be used at home to help with consistency. They state that parents and practitioners must keep instructions clear, explain daily plans and practise social situations and suggest the use of visual aids and timetables can help them stay organised and help avoid any triggers for the children. The NHS (2025) supports these approaches and offers strategies online to help children manage ADHD symptoms. They recommend breaking tasks into shorter more manageable chunks with regular breaks. They also highlight the importance of physical activity, explaining that it helps children channel their energy and improve focus. In the same vein, Chan and Jang (2021) claim research shows that appropriate exercise can help reduce ADHD symptoms. The authors argue that short bursts of activity and regular exercise support physical and mental health and suggest combining exercise with usual treatments can increase overall benefits especially for impulsivity and hyperactivity. They point out that exercise can be especially helpful and can improve blood flow to the brain, boost attention and strengthen self control. Child Mind Institute (2026) would agree and claims half an hour of exercise a day can make a positive difference and decrease the severity of symptoms for children. The Welsh Government (2019) provides guidance for practitioners and offers practical ideas on how to incorporate structured physical activity into the daily school lives of these children. However, Sun and Yu (2022) found that although physical exercise can improve attention and cognitive skills in children with ADHD. The authors point out that it may be less effective in reducing hyperactivity, social difficulties and aggressive behaviour. Ogundale and Ayyash (2023) agree that research shows combining behavioural therapy and exercise with stimulant medication can improve attention and reduce impulsive behaviour. They also suggest that this approach can improve antisocial and challenging behaviours. The authors highlight that, while medication plays an important role in managing core ADHD symptoms, it is most effective when combined with behavioural and physical activity interventions rather than being used alone.

Conclusion

This poster has shown the importance of early identification and support through collaboration between parents, schools and healthcare professionals, as early intervention can improve outcomes. However, barriers such as limited staff training, stigma and social exclusion can affect access to support and participation in school life. The discussion of the medical and social models highlights the need to reduce barriers within education rather than view ADHD only as an individual problem. Finally, the poster explored support strategies such as behavioural interventions, physical activity and medication, showing that a combined approach is often most effective in managing symptoms and supporting wellbeing and learning.

Questions

Why is ADHD more common in boys than girls?

Answer

According to research by Skogli *et al.* (2018) ADHD is diagnosed more often in boys than girls, with studies showing boys are referred for assessment and treatment more frequently. The authors suggest this is because girls often show different symptoms. They claim boys are more likely to display hyperactive, impulsive and disruptive behaviour which is easier for teachers and parents to notice and state girls more commonly show inattentive symptoms and internalising difficulties such as anxiety, making ADHD less obvious and leading to underdiagnosis. In the same vein, the ADHD Centre (2022) claim ADHD in women and girls often appears as internal struggles such as overwhelm, forgetfulness, poor focus and low motivation rather than obvious hyperactivity. It can also involve strong emotions like anxiety, shame, guilt and emotional outbursts along with conditions such as depression or anxiety. In practice, I can easily think of boys in my setting who I believe may be struggling with ADHD, but it is much harder to identify girls who may be experiencing the same difficulties. This suggests that practitioners often associate ADHD more with boys, which can lead to girls' symptoms being overlooked or less easily recognised.

Question

Because of the waiting lists for diagnosis for ADHD, can children be assessed and diagnosed privately?

Answer

ADHD UK (2025) say yes, children can be diagnosed privately for ADHD. They point out that because NHS waiting lists are often long many families opt for private assessments despite the cost. They suggest that a private diagnosis is equivalent to an NHS one and is usually recognised by schools. However, claim it does not automatically give access to NHS treatment or prescriptions and suggest only some GPs may choose to support it. According to Young et al. (2021), people who struggle to access diagnosis and support are often directed to, or seek out, local support groups. However, many of these charities are overwhelmed by demand and may not always have the resources or expertise to meet everyone's needs. As a result, those who can afford it may choose to move away from NHS services and seek private healthcare instead, with assessments costing around £695 (Private ADHD and Autism, 2025).

The Welsh Government (2025) has acknowledged the rising demand for mental health and ADHD services and states that it is investing £688 million to recruit more staff and strengthen NHS provision, with the aim of reducing waiting lists and improving access to care.

In practice, this means supporting many children with suspected ADHD who are still awaiting assessment. In my setting, we are aware of these children and provide support strategies as effectively as possible while they wait for a diagnosis.

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