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Script

Welcome everyone and thank you for joining today's webinar as we come together to explore effective ways to support children with a wide range of Additional Learning Needs. My name is hannah headon and in my poster I aim to explore attention deficit hyperactivity disorder (ADHD).

Introduction:

This poster aims to explore attention deficit hyperactivity disorder (ADHD) as an additional learning need (ALN). The additional learning needs and education tribunal (Wales) act, (2018) states that an additional learning need (ALN) is a learning disability or challenge that indicates a child or young person requires more support to learn compared to others of the same age. The Welsh government ALN code, (2021) also state that medical needs are the most established predictors of a child being identified with ALN. ADHD is defined as a developmental disorder which involves differences in brain development and functioning (CDC, 2025). National institute of mental health (NIMH), (2024) explain that it affects attention regulation, executive functioning, behavioural regulation and activity levels. ADHD symptoms in young children are characterised into three domains. These are inattentions, hyperactivity and impulsivity (American Psychiatric association, 2013).

Identification and diagnosis of ADHD:

CDC, (2024) explains that diagnosing a child that is showing symptoms of ADHD is a process that takes several steps. However, there isn't a single test to diagnose. NHS, (2025) adds that if a child is showing symptoms throughout school settings, then teachers usually make a referral to the settings additional learning needs coordinator (ALNCo) who will then discuss support strategies throughout the classroom environment. World health organisation (WHO), (2019) imply that it is important to ask for help from mental health professionals in order to determine the correct diagnosis. Furthermore, according to American psychiatric association, (2013), ADHD is defined and diagnosed using standardised frameworks, primarily the diagnostic and statistical manual of mental disorders (DSM-S) and the international classification of diseases (ICD-11). Research shows that when ADHD is not recognised in early childhood, children are more likely to experience academic underachievement, social difficulties, emotional dysregulation, and later mental health problems, including anxiety and depression (Hinshaw and Arnold, 2014). Early recognition also helps distinguish ADHD from typical developmental behaviours, ensuring that children receive appropriate support rather than being mislabelled as disruptive or inattentive (Thapar and Cooper, 2016). Public health bodies emphasise that identifying symptoms early allows families and educators to implement evidence-based strategies that improve functioning at home and school,

reducing behavioural escalation and improving relationships (CDC, 2025; NIMH, 2024). Furthermore, early identification supports access to structured assessment pathways and targeted interventions, such as parent-training programmes and classroom adaptations which are shown to significantly improve outcomes when implemented during the preschool and early primary years (Barkley, 2015).

Barriers

A key medical barrier of ADHD, when viewed through the medical model of disability, is the assumption that the child's difficulties stem just from underlying neurological impairments particularly in cognitive processing and organization skills.

Sonuga-Barke (2005) argues that these neurocognitive differences which affect attention, behavioural regulation, and active memory processing create functional limitations that directly restrict a child's ability to participate in structured learning environments. However, this is critiqued by Timimi and Taylor (2004), who questions biomedical interpretations and argues that defining ADHD primarily as a neurological deficit can neglect the social and interpersonal contexts shaping behaviour. Similarly, Moncrieff and Timimi (2013) suggest that the medical model labels normal variations in childhood behaviour as disorders and places excessive emphasis on neurobiological causes. On the other hand, Faraone et al. (2015) argues that findings from neuroimaging and genetic research substantiate ADHD as a recognised neurodevelopmental disorder.

A significant social barrier of ADHD, when viewed through the medical model of disability, is the way medical labelling shapes how children are perceived and treated in social and educational environments. While researchers argue that diagnosis reduces stigma by validating children's difficulties, others contend that the medical model *creates* social barriers by framing behaviour as disordered. For example, Biesta (2014) argues that the medical framing of ADHD promotes limiting assumptions about capability, which may influence teachers' attitudes and increase the risk of exclusion. This position directly challenges researchers such as Radez, *et al* (2021), who argues that dismissing medical perspectives may minimise the genuine challenges experienced by many children and limit access to early support. Similarly, Conrad and Bergley (2014) questions the prevalence of biomedical explanations for restricting broader understandings of children's behaviour, while Visser, Peter and Luman (2024) argues that diagnosis can support families by offering clarity and facilitating access to resources. These contrasting perspectives illustrate how, even within a medical-model, social responses to the diagnosis such as stigma, lowered expectations, and exclusion become barriers themselves, shaping children's participation more than the symptoms alone.

Both medical and social barriers shape how children with ADHD experience daily life. Medically, difficulties with attention, inhibition, and working memory can make learning, routines, and emotional regulation harder, limiting participation (Faraone et al., 2015). Critics argue that focusing only on these biological factors oversimplifies

children's behaviour and risks unnecessary diagnosis (Timimi, 2017). Socially, stigma, negative labelling, and lowered expectations can further restrict children's opportunities and affect their confidence. Harwood and Allan (2014) highlight how diagnostic labels can influence teacher perceptions in unhelpful ways, while Coghill (2016) argues that diagnosis can also reduce stigma by validating children's needs. Overall, children are impacted not just by ADHD symptoms but by how adults and systems interpret and respond to those symptoms.

Strategies

One effective strategy to support a child with ADHD is Behavioural Parent-Training (BPT), an evidence-based intervention that helps caregivers implement consistent routines, positive reinforcement, and structured behaviour-management techniques. BPT directly addresses both the medical barrier (executive-function difficulties) and the *social barrier* (negative responses to behaviour) by equipping adults to scaffold attention, self-regulation, and emotional control. Meta-analyses show that BPT improves child behaviour, parent-child relationships, and functional outcomes (Brown et al., 2025). However, researchers disagree on its effectiveness and theoretical grounding. For example, Evans et al. (2018) argue that BPT is one of the most robustly supported non-pharmacological interventions and should be prioritised before medication, whereas Hodgson, Hutchinson and Denson. (2012) contest this position, suggesting that parental reporting bias may inflate effect sizes and that improvements are not always transferable across settings. In contrast, Musich (2026) defend BPT as a core component of multimodal treatment, arguing that critiques underestimate the importance of environmental modification in reducing impairment.

There is evidence that Behavioural Parent-Training (BPT) is effective in supporting children with ADHD, but some researchers disagree on the strength and interpretation of this evidence. Large-scale reviews show that BPT improves child behaviour, parent-child relationships, and emotional regulation, making it one of the most consistently supported non-pharmacological interventions (Chronis-Tuscano et al., 2004). However, some researchers argue that these benefits may be overstated. For example, Lambez et al. (2020) claims that many positive outcomes rely heavily on parent-reported measures, which may inflate effect sizes. In contrast, Daley et al. (2017) explain that even when using blinded assessments, BPT still demonstrates meaningful improvements, suggesting that criticisms underestimate its practical value. More recently, Brown et al. (2025) argues that BPT is most effective when adapted to family context and delivered with high fidelity, challenging earlier claims that its effects are inconsistent.

Conclusion

ADHD is a neurodevelopmental condition identified through behavioural assessment using frameworks such as the DSM-5 and ICD-11, which require symptoms to be persistent, developmentally inappropriate, and present across settings. Children with

ADHD experience both medical barriers, such as executive-function difficulties that affect attention and self-regulation, and social barriers, including stigma, negative labelling, and reduced participation when behaviour is interpreted solely through a biomedical lens. One effective support strategy is Behavioural Parent-Training (BPT), which helps caregivers use consistent routines and positive reinforcement to reduce impairment and improve functioning. Although researchers debate the strength of BPT's effects, it remains a widely recommended intervention that addresses both the child's neurocognitive needs and the social responses that can limit their inclusion.

Thank you all for joining today's webinar, I hope you're leaving with a clearer, more confident understanding of our chosen ALN areas and how we can better support every child moving forward. We now know potential barriers linked with our needs and how best to support them with our strategies mentioned.

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