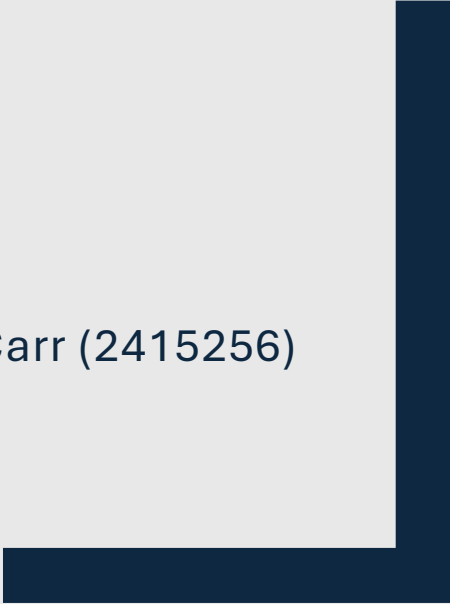




Supporting Children with Additional Learning Needs

ECEY6006

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Contents:

AI Statement:	2
Script:	3
References:	10

Recorded presentation link:

[Recap: ECEY6006 Supporting Children with Additional Learning Needs. 16 May | Meeting | Microsoft Teams](#)

AI Statement:

I acknowledge the use of ChatGPT (<https://chat.openai.com/>) and Canva AI (<https://www.canva.com/>) on May 2026 to support the development of this assessment.

ChatGPT was used to:

- support proofreading, grammar, sentence clarity and academic flow;
- support the organisation of poster headings and presentation sections;

Canva AI was used to:

- Generate visual designs based on text and wording created by myself.

I used prompts including:

1. Generate images and speech bubbles using this text. All wording included within the images was my own.

I confirm that I have not presented AI-generated text as my own work.

I confirm that I have retained copies of my drafts, notes and supporting materials before and after the use of AI tools, which I may be asked to provide as evidence.

Chair:

Good Morning everyone and welcome to today's Webinar Supporting Children with Additional Learning Needs Individual presentations ECEY6006.

Today we will each be presenting on different areas relating to additional learning needs and inclusive practice within education and childcare settings.

Natasha will begin by presenting on Tourette Syndrome, followed by my presentation on Foetal Alcohol Spectrum Disorder, Emma will then conclude with her presentation on Down Syndrome.

After each presentation we will open the floor to a couple of question

Just some basic housekeeping, please can you ensure mircophones are muted when someone is presenting. Can I confirm you are all happy to share your screens during your presentation.

Just to confirm, this session is being recorded for assessment purposes.

If everyone is ready, I will now hand over to Natasha to begin.

Thank you Natasha. Let me share my screen now.

During this presentation, I will critically discuss what FASD is, the challenges surrounding identification and diagnosis, barriers within education and childcare settings, and support strategies which may help children with FASD feel more understood and included.

What is FASD?

FASD is a lifelong neurodevelopmental condition caused by prenatal alcohol exposure.

Research by Mukherjee, Hollins and Turk (2006) explains that FASD may affect memory, executive functioning, emotional regulation, sensory processing and adaptive behaviour.

Cunningham (2012) suggests FASD is often described as a “hidden disability” because, **although** some children may present with **distinctive** facial features associated with FASD, these are not always present despite significant neurological differences.

According to Lees *et al.* (2020) prenatal alcohol exposure can significantly affect psychological, behavioural and neurodevelopmental outcomes **throughout childhood**. Tenenbaum *et al.* (2020) further found children within adopted and fostered populations are disproportionately represented within FASD diagnoses due to increased exposure to prenatal adversity, trauma and incomplete early histories.

Moving across to the “Identification and Diagnosis” section of my poster.

FASD can be difficult to identify and diagnose.

Breuer, Greenmyer and Wilson, (2024) explain there is **currently** no single biomarker or medical test available.

Instead, Hoyme *et al.*, (2016) explains, diagnosis relies upon **multidisciplinary assessment, developmental history, cognitive functioning, behavioural presentation, physical characteristics and evidence of prenatal alcohol exposure.**

Both, the **Department of Health and Social Care, (2021)** policy and **Hoyme, Shah and Abdul-Rahman, (2026)** research, describe FASD as medically, behaviourally and systemically complex, which may contribute to delayed identification, diagnosis and variation across services.

Millians (2015) further argues educational environments may struggle to meet the complex and individualised needs of children with FASD.

Importantly, Hoyme *et al.* (2016) explain that many children with FASD experience significant neurological impairment without presenting with the more commonly recognised facial characteristics associated with prenatal alcohol exposure, such as a smooth **philtrum**, thin upper lip and smaller eye openings. This increases the risk of misunderstanding, **missed diagnosis** and delayed support.

Davey and Smee (2024) suggest stigma and under-reporting may restrict identification, while Curran (2020) found additional needs are often missed due to limited practitioner knowledge.

Consequently, many children may remain misunderstood within educational systems. (Mukherjee, Hollins and Turk, 2006; National Organisation FASD, 2020; Adoption UK, 2023).

This may be particularly significant for adopted and fostered children, as Tenenbaum *et al.* (2020) found many experience **delayed diagnosis** due to incomplete, unavailable or undisclosed **prenatal histories.**

The speech bubble within this section highlights an important ethical tension identified throughout my research. **Although birth parents** have rights to **confidentiality**, children also have rights to appropriate educational support and early intervention. This

reflects Article 3 of the **UN Convention on the Rights of the Child**, which states children's best interests should remain **a primary consideration (UNICEF UK, no date)**.

This raises important ethical questions surrounding confidentiality and children's rights.

Moving onto Barrier 1: Memory Processing and Behaviour Misunderstanding.

The first major barrier explored is memory processing difficulties and behaviour misunderstanding. Lees *et al* (2020) highlights children with FASD commonly experience difficulties with working memory, executive functioning and emotional regulation.

However, **within** education and childcare settings, these **behaviours** are often viewed as "challenging behaviour" rather than **neurodevelopmental** need.

Many behaviour systems rely upon children processing information quickly and regulating emotions independently. **Lee Harvey-Heath (2021)**, argues children are often expected to process information neurotypically despite neurological differences affecting memory, communication and understanding.

Children may forget instructions almost **immediately** after hearing them, which may be **interpreted** as "not listening" rather than neurological difficulty.

The image on my poster contrasts what adults may see, **such as a child appearing "lazy" or "defiant"**, with the neurological difficulties that **may actually underlie** these responses.

This is a powerful reminder for practitioners to consider what may be happening neurologically rather than placing blame.

Similarly, the second image from **FASD Network (no date)** comparing "Jim" and "Mike" highlights how hidden **disabilities** may be judged differently depending on whether a

disability is recognised or formally **diagnosed**. Although both children display the same behaviour, the child with a recognised disability may be judged more negatively, while the other child's behaviour may be dismissed as a bad moment.

Reedman, Breen and Wu (2024) further found sensory overload frequently contributes to exclusionary educational experiences for children with FASD. Parents within my setting described children having a “slow to react brain,” where overwhelm and sensory regulation difficulties may be mistaken for anger or defiance.

Although FASD is medically recognised as a neurodevelopmental disorder, these experiences also link closely to the social model of disability. Blackburn, Carpenter and Egerton (2010), alongside Writer (2022), suggest **educational** barriers frequently emerge through limited practitioner understanding, rigid routines and inflexible behavioural expectations. However, children with FASD may remain excluded when behaviours are interpreted through disciplinary rather than neurodevelopmental **frameworks**. This conflicts with the UNESCO **Salamanca** Statement (1994), which promotes inclusive education systems that adapt to diverse learning needs rather than expecting children to fit **rigid** educational structures

The second barrier explored within my poster was **undisclosed prenatal histories** and the impact this may have upon **diagnosis, support and future outcomes for children with FASD**.

Tenenbaum *et al.* (2020) found many adopted and fostered children experience delayed **diagnosis** due to unavailable or incomplete **maternal** histories.

Prenatal alcohol exposure may remain **unidentified** when important early history is missing, increasing risks of misdiagnosis and delayed support.

Gibson *et al.* (2025) further argue barriers to care are often systemic, including stigma surrounding alcohol use during pregnancy, limited professional training and inconsistent diagnostic pathways.

Importantly, this may leave children misunderstood for years, increasing risks of exclusion and unmet educational needs. Children may receive punitive responses rather than appropriate neurodevelopmental support.

Research suggests repeated experiences of misunderstanding, failure and punishment may significantly affect emotional wellbeing, educational outcomes and future life opportunities (Mukherjee, Hollins and Turk, 2006; Cunningham, 2012; Adoption UK, 2023).

The speech bubble within this section reflects an important ethical and systemic issue identified throughout my research: the problem is not only the child's needs, but whether systems identify and respond early enough to provide appropriate support.

Within Wales, this is particularly significant when considering the ALN Code and Curriculum for Wales, both of which promote equity, inclusion and person-centred practice. However, recent Welsh Government research (2025) suggests some learners with additional needs continue to experience inconsistent inclusion due to variation in practitioner understanding, training and implementation across educational settings.

The final section of my poster explored support strategies linked directly to the barriers identified throughout my research.

Overall, the findings suggest children with FASD benefit more from relationship-based and **trauma-informed** approaches than **punitive** behaviour systems. Research by **Petrenko** (2015) highlights the importance of structured, predictable and **emotionally safe environments**, which closely aligns with Bath's (2008) trauma-informed framework **emphasising** safety, connection and emotional regulation.

Cunningham (2012) highlights that visual supports, structure and predictable routines can reduce cognitive overload for children with FASD. Within practice, strategies such as one-step instructions, visual prompts, calm transitions, sensory regulation, co-regulation, emotionally available adults and repetition without shame are often more effective than punitive responses, as they promote **emotional** safety, belonging and

engagement. This reflects Maslow's (1943) hierarchy of needs, which suggests children's emotional and **relational** needs should be met before higher levels of learning and **development** can occur.

Similarly, Vygotsky (1978) emphasised the importance of **supported** learning through **positive** adult interaction and guided co-regulation, reinforcing the role of trusted adults in helping children manage emotional and behavioural **difficulties**.

Importantly, these approaches reflect neurodiversity-informed **perspectives** which recognise behaviour as communication linked to processing **differences** rather than **deliberate** defiance. Bronfenbrenner's (1979) ecological theory further highlights how children develop **within** interconnected systems including home, school and wider services. This suggests support for children with FASD should remain consistent across environments to reduce anxiety, confusion and emotional dysregulation.

However, Neuhaus and Gödecke (2025) argue support strategies must remain **individualised** because one approach **will not** support every child equally.

To conclude, FASD remains a misunderstood and **under-identified** neurodevelopmental condition, particularly within adopted and fostered **populations**.

My research demonstrated that barriers are created not only through neurological differences, but also through stigma, misdiagnosis, missing **prenatal** histories and **inflexible educational systems**.

Many **difficulties** emerge when systems **fail to** respond to children's **needs early enough**.

However, children with FASD can thrive when practitioners adopt **trauma-informed**, **neurodiversity-informed** and **relationship-based approaches** which adapt environments to children, rather than expecting children **to adapt to rigid systems**.

Thank you for listening. I now welcome any questions.

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