

AI Statement

I acknowledge the use of Google Scholar (Available at: <https://scholar.google.co.uk/>) for the purpose of research for Module 16 – Supporting Children with Additional Learning Needs (ECEY6006).

I acknowledge the use of COPILOT to locate current sources (including e-books, journal articles, and webpages), dated between 2015 and 2025 for the purpose of research for Module 16 – Supporting Children with Additional Learning Needs (ECEY6006). I also acknowledge the use of COPILOT to help design my poster and generate some some of the images included on the poster.

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 in evidence.

Prompts:

- What is Autism?
- What is the prevalence of Autism in 2026?
- What impact does Autism have for children lives
- How is autism identified and diagnosed in Wales
- What does legislation and guidance say about additional learning needs in Wales.
- How do we monitor emerging or identified additional learning needs
- Are there barriers to identification and diagnosis
- Medical and Social Model of disability
- Implications of non-inclusive environments on social interaction for autistic learners in early years settings
- What is intensive Interaction?
- How can practitioners use intensive interaction to support learners

Module: ECEY6006

- Part 1 - Webinar Poster delivered on Teams 13.05.2026 @ 18.30pm (74minutes)
- Part 2- Webinar Poster Script, Pages 3-9
- **References** – Pages 10-15

Part 2 – Webinar Script.

Main Introduction: Thank you, for my presentation, I will be discussing autism spectrum disorder also known as ASD. This is an area I am passionate about having worked with children with ASD since 2012. I will give a brief overview of ASD, looking at the identification and diagnosis process, barriers children with ASD have in relation to social interaction, and one strategy to support learners with ASD.

Presentation: Thank you, for the warm introduction Acklima, I will just share my screen. Please can you all confirm that you can see it before I begin? Thankyou everyone! I would like to start by saying what an opportunity it is to be invited present at this informative webinar. As mentioned previously, my presentation today will explore autism spectrum disorder otherwise known as ASD within the context of Wales and early years.

Autism Spectrum Disorder is defined by National Health Service (2024) and National Autistic Society (2026) as a lifelong neurodevelopmental condition that affects social communication, interaction, sensory processing, and patterns of behaviour. The World Health Organisation estimated in 2021 around 1 in 127 people are autistic, although more recent reporting suggests it is much higher (World Health Organisation, 2025).

Autism influences how children engage, communicate, learn, and experience their environment meaning that developing a clear understanding of ASD supports early identification and responsive provision. Autism is a diverse condition, and presentations vary widely between individuals (Whittington Health NHS Trust, n.d.). Wing (1988) first described autism as a continuum of characteristics rather than a single category emphasizing autism traits vary across all areas of development. Wing (2005) later argued that autism is best understood as a spectrum of neurodevelopmental variations rather than a collection of deficits. This is reflected in the multidimensional visual model as shown in Figure 1. (Parker, 2025) at the top of the page, which highlights variation across sensory processing, communication, emotional regulation, perception, and executive functioning. Identifying autism in this way reinforces that responses must be tailored to each child's individual profile of strengths and needs (Happe and Frith, 2020). I will now move onto identification and diagnosis.

Identification and Diagnosis

For this section I have demonstrated a graduated response flow chart used within Newport. This visual illustrates how emerging needs are identified and how practitioners respond through graduated evidence-based support. Identification of autism begins with recognising developmental differences, often first noticed by parents, health visitors, early years practitioners and GPs. Wing (1988) describes autism as differences across social interaction, communication, imagination and behaviour, while NICE CG128 (2021) outlines early features such as differences in communication, interaction, play, routines and sensory processing. These characteristics often emerge in infancy, making early years professionals key in recognising developmental variation.

In Wales, the Healthy Child Wales Programme provides routine health visitor checks from birth to four, monitoring communication, social interaction, play and emotional development (Welsh Government, 2022). Developmental screening tools such as the Schedule of Growing Skills (SOGS) assessments help identify developmental patterns that may indicate emerging autistic characteristics (GL Assessment, 2024). Early years practitioners also contribute to identification through Early Years Development and Assessment Framework (2025) using Early Years Profiles to measure developmental progress and can highlight areas of concerns. However, while these practitioners play an important role in early recognition, they are not clinicians trained to make diagnostic interpretations (Antalek *et al.* 2025) highlighting an early tension between policy expectations for early identification and the limits of practitioner expertise.

When concerns are identified, Section 11 of the ALNET (Wales) Act (2018) requires settings to act by implementing additional learning provision (ALP) based on the child's needs and seek advice from support services. However, early identification relies on practitioners having time, capacity and developmental knowledge to observe children effectively (Children, Young people and Education Committee, 2024). These sector specific tools support building an overview of children's development, but the effectiveness of them depends, training and capacity to use them consistently however, workforces shortages across both health and early years mean families are not receiving consistent developmental reviews (Institute of Health

Visiting, 2025) and high staff turnover, recruitment difficulties and limited access to professional development in the early years sector reduce practitioners' ability to focus on learning, development and early identification (Ofsted, 2024).

For children under five once needs have been identified, referrals proceed directly to the Integrated Service for Children with Additional Needs (ISCAN), which brings together a multidisciplinary team to review the evidence including developmental history, structured observations and multi-setting information (ABUHB, n.d.; NICE, 2021). Where autism is suspected, ISCAN refers the child to the Neurodevelopmental service for diagnostic assessment using DSM-5 or ICD-11 criteria (American Psychiatric Association, 2013).

However, Wales sets a 26-week target for neurodevelopmental assessment, but Senedd research found that demand for diagnostic assessment exceeds capacity therefore 67% of children had waited over the expected 26 weeks with 45% of children waiting over a year and many services are reporting waits of two to three years (Hardy, 2024). This directly contradicts ALNET's needs-led intentions. The Autism Code of Practice similarly highlights that early identification depends on sufficient workforce capacity and coordinated multi-agency working (Welsh Government, 2021). As a result, early identification remains inconsistent across Wales, and some children's needs may go unrecognised, delaying access to early support and referrals to diagnostic pathways (British Medical Association, 2019).

The last step would be receiving an official autism spectrum disorder diagnosis. Under ALNET (2018), additional learning provision must be needs-led, and the assessment arrangements in non-maintained curriculum support this through continuous, observation, review and adaptation of provision (Welsh Government, 2022). This cycle enables practitioners build a holistic understanding of the child's profile and individual nature of autism. Some wider support services remain diagnosis led, meaning by receiving a diagnosis of autism they can access enhanced support and intervention from specialists. However, the extended waits for neurodevelopmental assessment prevent children from accessing support at the point their needs first emerge (Children, Young people and Education Committee, 2024) and could delay LA IDP processes where children may meet criteria for specialist provision, resulting

in children remaining in mainstream settings for longer while awaiting the diagnostic evidence required for some specialist pathways.

Barriers

I will now examine one of the key barriers autistic children have in early years settings; the way differences in social interactions are understood and responded to. The DSM-5 describes autism through differences in eye contact, reciprocal conversation and relationship building (American Psychiatric Association, 2013), reflecting a medical model view that positions autistic interactions and communication as deficits (Randa, 2023). When practitioners view children in this way they may stereotype children, hold lowered expectations or misinterpret autistic communication (Woods, 2021). For the child, this can limit peer relationships, reduce participation and undermine rights to inclusion and non-discrimination under the UNCRC (1989) and the Equality Act (2010).

In contrast, the social model of disability argues difficulties arise from environments, attitudes and social norms rather than a child's neurology (Disability Wales, 2024). This is supported by observational research showing autistic children interact far more with adults than peers, but importantly non-autistic children rarely initiated interaction with autistic children (Tsamitrou and Plumet, 2024). This demonstrates social interaction challenges are reciprocal, and Milton's (2012) double empathy problem emphasizes these reciprocal breakdowns arise from misunderstandings between autistic and non-autistic people not autistic deficits alone. However, as a result, autistic children often remain on the periphery of play, limiting opportunities to develop shared joint attention, turn taking and collaborative play skills (Wong *et al.* 2015). Beardon (2021) argues that neither the medical nor the social model captures the autistic experience, emphasising the need for approaches that recognise autistic communication as difference rather than disorder (Anderson-Chavarria, 2021).

Strategy for support:

An appropriate strategy to support autistic learners in the early years is Intensive Interaction, as it addresses the social-interaction barriers identified earlier. Intensive interaction is a person-centred, relational approach that values an ASD child's own communication style, through practitioners adjusting pace, language and response to facilitate mutual connection (Intensive Interaction Institute, 2026). This aligns with the

non-maintained curriculum emphasis on belonging and emotional security as foundations for learning (Welsh Government, 2022). By prioritizing communication in this way, the approach helps to mitigate the reciprocal breakdown in communication styles as described by Tsamitoru and Plumet, (2024), creating spaces for autistic children to be understood and valued. Intensive Interaction involves noticing the child's sounds, movements and expressions as communication and responding playfully through imitation and shared actions, creating moments of connection and mutual communication (Peterborough SEND Service, 2021).

Intensive interaction is flexible and can be used at any time in any environment, when the child is alert, relaxed and open to the interaction (Oxford Health NHS Foundation Trust, 2017). This reduces barriers to participation and ensures interaction opportunities are embedded naturally throughout the day without pressures or demands. Evidence shows Intensive Interaction develops early communication skills such as joint attention, turn-taking, eye gaze and intentional communication (Papadopoulos *et al.* 2023). These skills underpin autistic children's social inclusion and emotional wellbeing by strengthening connection, attunement and rapport (Suffolk County Council, n.d.), leading to increased engagement, reduced anxiety and greater access to play and learning.

However, reviews show that Intensive Interaction relies heavily on practitioner skill and consistency, which can be difficult in busy early years settings (Hutchinson and Bodicoat, 2014). More recent work shows many practitioners find the non-directive, relational stance unfamiliar or unnatural. Especially in task focused environments (Berridge and Hutchinson, 2021). If I can draw your attention Figure 2. It is a lovely illustration of connection and interaction at the child's level.

Conclusion:

To conclude, Welsh Legislation such as ALNET (2018), the Equality Act (2010) and the UNCRC (1989) provides strong foundations for ensuring that autistic children have equitable access to education and support. However, health and education systems continue to work in isolation, meaning early identification and receiving appropriate support is inconsistent. Strengthening collaboration, reducing reliance on diagnostic confirmation and creating environments that expect and support neurodiverse learners would ensure the adjustments autistic learners need are

embedded rather than added reactively. Meaning improving the lived experiences of autistic children in Wales. That is all from me today, I will now stop sharing my screen and hand back to Acklima.

Questions:

- 1. In your experience, what is the biggest barrier for autistic learners in early years settings?** In my experience, the biggest barrier is the adults understanding, attitudes and willingness to adapt their practice, which is often shaped by the ethos of the setting. When practitioners do not fully understand a child's communication style, interaction needs or how to use approaches such as Intensive interaction to support development, this can unintentionally hinder the child's access to participation. As a result, the environment becomes less responsive, and opportunities for meaningful engagement are reduced. When adults are confident, reflective and flexible, autistic learners can access learning and interaction much more effectively.
- 2. How can we monitor the effectiveness of intensive interaction?** The effectiveness of Intensive Interaction is monitored through careful observation with the focus is on tuning in to the child, understanding their communication style, and not expecting progress too quickly. Consistency and persistence are key, because Intensive Interaction works best when it feels relaxed, natural and led by the child. Dave Hewett (2018) has an intensive interaction handbook outlining stage such as encounter, early reactions and early responsiveness and Laurie (2017) describes a seven-point interaction scale, but practitioners still need good understanding of the approach to be able to monitor and record accurately. For me, it is more about the consistently in finding opportunities to engage in these meaningful interactions. The Intensive Interaction Institute (2026) also emphasises meaningful, enjoyable interactions promote social inclusion, emotional wellbeing and the foundations of communication through connection.
- 3. Whilst a child is waiting for a diagnosis what support can practitioners and family's access?** While it is frustrating the wait times for a diagnosis and this can mean challenging times for child ana practitioners. In Newport the Early Years Prevention Team and the Early Years Inclusion Team can offer support through teacher advisors and child development practitioners who are

trained in supporting children with emerging or identified additional learning needs. They work closely with settings and families to model strategies, upskill staff and build confidence. Families can also access support through family information service and flying start.

To Acklima - What support is available to help practitioner support children with sensory processing differences?

To Mary – What changes are needed to improve Trauma-informed care across Wales?

To Helen -Why is personalized support important for dyslexic learners?

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