Institute of Education

UCL

Doctorate in Professional Educational, Child and Adolescent Psychology

Programme Director: Professor Vivian Hill

Institute of Education, University of London

Doctorate in Professional Educational Child and Adolescent Psychology

Thesis:

'Eliciting the voices of children and young people diagnosed with ADHD, who have experienced exclusion and been placed in a Pupil Referral Unit, to understand their experiences and perceptions of ADHD diagnosis and intervention processes'

Nisha Rupa Parekh

Declaration

I, Nisha Parekh, hereby declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own.

Word count (exclusive of acknowledgements, abstract, impact statement, contents page, and appendices and list of references): 38,932

Acknowledgements

Firstly, I would like to thank my research supervisors, Professor Vivian Hill, and Dr Laura Crane for all of the many things that they have taught me, and for their outstanding and most patient academic support and pastoral care, throughout this research study which took place through the challenges of the pandemic and beyond.

Thank you so much to my son, Arjun, for his patience and for bringing sunshine throughout the challenging years of the doctorate. He has given me first-hand experience, through motherhood, of what it is to promote and respect the views of children and was an inspiration in my formulating of this study.

I give my greatest thanks for the valuable and insightful contributions from the children and young people who took part in this study, who have shown such resilience in the face of adversity, during the most vulnerable period of their lives and have used all their strength to try to make sense of their lives and move forward with that understanding.

Abstract

Significant international increase over the past 30 years in the number of children and young people diagnosed with ADHD as a behavioural disorder and consequently prescribed medication for ADHD has raised concern amongst EPs. Despite government guidelines stating children and families should first receive psychological intervention before medication, the prescription rates continue to increase. Existing literature places the value of the ADHD diagnosis into question. Furthermore, diagnosis rates are disproportionately higher amongst children who have experienced school failure. Reviews of existing practice indicate a lack of robust measures amongst EPs to support children during ADHD assessment and in developing effective interventions.

Legislative guidelines recommend that children's voices are listened to and incorporated into school intervention and care plans. This research aimed to give a voice to ADHD diagnosed children and young people who had experienced exclusion and placement into Pupil Referral Units. Suggestions of how their views and experiences may be embedded into EP practice are proposed in order to enhance the quality of the EP role in ADHD diagnosis and intervention processes.

Semi-structured interviews employing dynamic interactive tools were carried out with 15 children and young people.

The findings illustrated the importance of the EP working therapeutically and promoting awareness of impacting context on a child or young person's behavioural presentation, during ADHD diagnosis and intervention processes. Prominent themes included: a lack of supportive relationships from key adults, needing to be understood and

how their personal situations affected them. Additionally, references to improved psychosocial functioning and a reduction in ADHD related challenges as a result of being understood by key adults were made. Inadequate resources for psychological containment and isolation and exclusion appeared to have facilitated adverse functioning and upkeep of ADHD behaviour. Suggestions for EP practice are proposed, as a ‘Six-Step’ model.

Impact Statement

This research study investigated the experiences of a group of children and young people in ADHD diagnosis and intervention processes. All the children and young people in the study sample had experienced school failure, eventual permanent exclusion and placement into an alternative provision Pupil Referral Unit.

It is the first qualitative study that has considered the working role of EPs in ADHD assessment and intervention processes, and the first to my knowledge to focus on the views and experiences of ADHD amongst children and young people who have been excluded and placed in Pupil Referral Units. It therefore sought to fill a gap in the current evidence base that is of key importance to the role of the EP.

This research is essential in addressing the disproportionate numbers of ADHD diagnoses amongst children and young people who have experienced permanent school exclusion.

The study found that the partaking children and young people experienced a lack of emotional containment and inclusion from both key adults and the systems within their bio-ecological context. Children and young people's responses demonstrated a strong understanding of contextual factors adversely impacting them. They also appeared to have integrated their diagnosis into their understanding of themselves, in order to make sense of the social narrative provided to them by key adults in their environment. Children and young people's lived experiences consisted of the receipt of their ADHD diagnoses alongside experiences of isolation and exclusion, with little more, if any, support to facilitate their progress. Awareness of the need and desire to be understood by key adults, and to

be provided with self-support tools in order to be able to improve their own psycho-social functioning was found throughout the children and young people's narrative.

The study also highlights the necessity of EPs informing the understandings of key adults in the child's environment, by developing social narratives pertaining to children and young people's behaviour and offering guidance on the use and impact of legislative guidance at the macrosystem level on contemporary practice.

The implications of the findings for the role of the EP in ADHD assessment and intervention processes are succinctly proposed. The vital role of the EP in mediating processes that impact children and young people who challenge the boundaries of the education system and are at risk of receiving behavioural diagnoses is highlighted. Suggestions arising from the findings of the study included the role of the EP in:

- Providing psycho-education regarding ADHD and context through multi-agency collaboration;
- promoting children and young people's communication through providing therapeutic support for them to develop metacognitive strategies
- Working therapeutically with children and young people, including the provision of interventions for psychosocial development, as alternatives to pharmaceutical intervention;
- Promoting understandings of the impact of isolation and exclusion on vulnerable children and young people and the conceptualisation of the use of legislative guidance.

Contents

Chapter 1: Introduction 12
1.1 Study design and aim 12
1.2 Pertinent legislation 14
1.3 Year One research study 14
1.4 The child within a bio-ecological system 16
Figure 1. Bronfenbrenner's bio-ecological model 17
1.5 ADHD and bio-ecological factors: current awareness related to this study 18
1.5.1 Context of this research 21
1.6 Moving beyond the year one research study 22
1.7 Personal and professional interest 22
1.8 UNCRC and children and young people's participation 24
1.9 ADHD Definition, diagnosis and prevalence 26
1.10 Current models of ADHD 32
1.11 The medical model of ADHD 32
1.12 The bio-psychosocial model of ADHD 33
1.14 Impact of having ADHD-related behaviour on children 37
Chapter 2: Literature review 39
2.1 Children's views and experiences of ADHD diagnosis and intervention 40
2.2 Application of the EP's role in the current context 54
Figure 2: Lundy's model of participation 57
2.3 Children's rights and interactive approaches 61
2.4 Aims and Rationale 63
Chapter 3: Methodology 65
3.1.1 Epistemological stance 65
3.1.2 Reflexivity 68
3.2 Context 69
3.3 Participants 71
Table 1. Participant characteristics 72
3.4 Materials 74
3.5 Pupil tasks 75
3.6 Procedure 78
3.7 Data analysis 79

Table 2 **Error! Bookmark not defined.**
Table 3 **Error! Bookmark not defined.**
3.8 Ethical considerations 83
3.8.1 Data protection and anonymity 85
3.10 Participant care 85
Chapter 4: Results 88
Figure 3: The six pre-identified deductive themes 89
Deductive theme 1: What ADHD looks like to me 89
Inductive sub-theme 1.1: I'm hyperactive and can't stay focused 90
Inductive sub-theme 1.2: It is difficult to control my anger 91
Deductive theme 2: My school experience 93
Inductive sub-theme 2.1: I was separated from everyone else 93
Inductive sub-theme 2.2: They didn't want me in school 95
Inductive sub-theme 2.3: They didn't trust me in school 96
Inductive sub-theme 2.4: Coping with the challenges of my school environment 97
Deductive theme 3: What I need 99
Inductive sub-theme 3.1: I need to be helped by adults 99
Inductive sub-theme 3.2: Adults need to give me ways to help myself 104
Deductive theme 4: How my ADHD behaviour is understood 106
Inductive sub-theme 4.1: Others see a difference, I don't 107
Inductive sub-theme 4.2: My ADHD behaviour is not a problem 108
Inductive sub-theme 4.3: My ADHD shows depending on the situation 109
Deductive subtheme 5: ADHD and medication 110
Inductive sub-theme 5.1: Maybe I need it, maybe I don't 110
Inductive sub-theme 5.2: Negative effects 111
Deductive theme 6: Managing my context 113
Inductive sub-theme 6: Your home life affects you 113
Chapter 5: Discussion 118
5.1 What ADHD looks like to me 119
5.2 My school experience 122
5.3 What I need 128
5.4 How my behaviour is understood 132
5.5 My experience of medication 134

5.6 Managing my context 135
5.7 Summary 139
5.8 Implications for Educational Psychologists 140
5.8.1 Application of the findings to the EP's role 141
5.8.2 Further details of the tools incorporated into the Six-Step model 144
Figure 4: The Six-Step model 146
5.9 Strengths and Limitations 148
5.10 Key outcomes and future research directions 151
5.11 Conclusion 152
References 155
Appendices 170
Appendix A: Child Interview Schedule 170
Appendix B: The ideal-self activity instructions and example drawing 172
Figure 5: Drawings completed by a young person during an 'ideal/non-ideal' self PCP activity. 173
Appendix C: Instructions for Drawing the Ideal School technique and example drawing 174
Figure 6. An 'ideal/non-ideal school' drawing completed by a young person during a PCP activity. 176
Appendix D: SENDCo information sheet and consent form 177
Appendix E: Parent information sheet and consent form 181
Appendix F: Child Information Sheet and consent form 185
Appendix G: Doctoral Student Ethics Application Form 187
Appendix H: Interactive Factors Framework 206
Appendix I: The Hand Model of the Brain 208

Key abbreviations:

ADHD: Attention Deficit Hyperactivity Disorder

EP: Educational Psychologist

PRU: Pupil Referral Unit

SEND: Special Educational Needs and Disabilities

SENDCo: Special Educational Needs and Disabilities Co-ordinator

LA: Local Authority

UK: United Kingdom

U.S: United States

DECP: Division of Educational and Child Psychology

DfE: Department for Education

NICE: National Institute of Clinical Excellence

Research context:

This thesis research is to be submitted as part of the Doctorate in Educational, Child and Adolescent Psychology at the UCL Institute of Education. The research tutors are Professor Vivian Hill and Dr Laura Crane.

During Year One of the Doctorate, I conducted a small-scale research study to explore how children with ADHD make sense of their diagnosis. That research provided a foundation for the current research presented in this report.

Chapter 1: Introduction

1.1 Study design and aim

The overall aim of this study was to elicit the voices of children and young people who have a diagnosis of ADHD and who have experienced exclusion and placement into a Pupil Referral Unit (PRU). As this is a professional doctorate thesis children and young people's elicited views were drawn upon to evolve ways of working with this population for Educational Psychologists (EPs) that are in line with the United Nations Convention of the Rights of the Child (UNCRC) (United Nations, 1991, 2005, 2009). My specific focus is in the area of Attention Deficit Hyperactivity Disorder (ADHD) assessment and intervention, to promote optimal wellbeing for the children and young people involved in such processes. Importantly, the approach used in this study focuses on the elicitation of children and young people's views and experiences of this topic.

The initial plan for this research study was to include three separate participant groups consisting of parents, teachers and children and young people, as detailed in the ethics application form (see Appendix G). I collected the data from all three participant groups, however there was too much data to analyse within the time frames necessary for submitting the viva and in addition the data analysis process had begun at the start of the pandemic under strict lockdown and other very challenging circumstances such as complete lack of access to any childcare or support. I then decided to focus solely on the voices of the children and young people as during the formulation of this study the most important aim was to give a voice to a particular group of children and young people.

No other study was identified, to my knowledge that had concentrated on the views of children and young people from such a background with regards to ADHD

diagnosis and intervention processes and it was hoped that first and foremost, this study may give a voice to a group of ADHD diagnosed pupils who had experienced school failure and exclusion. Secondly, it was considered that exploring the findings may provide an opportunity to understand implications on EPs' practice, in order to improve the experiences of these children and young people. Strategies were employed that facilitated children and young people to engage through a transactional and dynamic process, which promotes a more meaningful experience, whilst enhancing the quality of the study findings (Simpson et al., 2021). Specifically, methods employing Personal Construct Psychology (PCP) were used to facilitate an interactive, dynamic interview process, where I simultaneously took the roles of both an EP and a researcher. As a Trainee EP, I am responsible for promoting and safeguarding children's wellbeing. Challenging negative self-perception is vital, thus a static interview process (i.e., if I had not responded to children's interactions during the research process and disaggregated the two roles of EP and researcher) would have been ethically inappropriate. The chosen interactive dynamic interview style fitted well with my dual role as researcher and EP. The dual role also enabled me as a practitioner to build relationships with both the school and the children through therapeutic work commissioned by the school in my role as TEP, whilst enabling a sensitive and supportive response during the PCP based tasks in my role as researcher.

In summary, in this thesis the elicited views of this group of children and young people are explored, and the implications of these findings for the work of EPs are discussed. Ways of working for EPs during ADHD assessment and intervention processes are suggested in order to embed the elicited views of children and young people into educational psychology practice. Using approaches that are an outcome of practitioner

research, the aim of interactively promoting children and young people's voices and engagement and applying this process to practice is more likely to be achieved (Dunsmuir et al., 2009).

1.2 Pertinent legislation

There are various legal and legislative influences pertaining to the voice of the child in decision-making that affects them (Shier, 2019). Current legislation, as stipulated by the UNCRC (Blanchfield, 2013; McGoldrick, 1991) and guidelines pertinent to Attention Deficit Hyperactivity Disorder (ADHD) (NICE, 2018) state the importance of supporting children in sharing their views, and taking those views into account, during the decision-making processes of diagnosis and intervention for ADHD-related behaviour. Furthermore, professionals involved in this process must be conscious that children's opinions will alter as they mature, so revisiting their opinions over time is necessary (Bloom et al., 2020; Lundy et al., 2011). For the EP, children's views (as per the UNCRC stipulation) are of central importance and are interpreted as part of a contextual understanding of the child's development over time, using Bronfenbrenner's bioecological systems model (Ryan, 2001).

1.3 Year One research study

Considering the current legislation and its application to my work as a trainee EP, my research study undertaken in year one of my programme aimed to gain an understanding of children's experiences and understandings of having a diagnosis of ADHD, and then sought to compare those experiences with those of parents and teachers. Five school-aged children from one London Local Authority (LA) primary school, three of

their parents and three of their teachers were interviewed. Thematic analysis (Braun & Clarke, 2021) was used to analyse these data. The themes that were identified from these data highlighted how children most often viewed ADHD as a difficulty with anger and, at times, self-regulation, and self-control. During the assessment and diagnostic processes, children had not had their diagnosis explained to them by professionals, nor were they told how ADHD related to them specifically. Those children who received an explanation of ADHD from an adult appeared to have formulated more positive views of what their diagnosis meant to them. For example, one child who had received an explanation about their ADHD diagnosis from a parent said: *"I think having ADHD is a good thing, because I look at other people and they are bored but I am excited about everything."* The same child also demonstrated comparatively better agency and feelings of competency; for example, he shared positive experiences of the impact of meditation on his experience of ADHD:

> *"I wasn't really able to control it [anger, resulting from ADHD] … but now that I went to learn meditation, now I can really focus on what not to do, what to do… it just automatically reminds me… I can do more like they taught me to breathe if I don't feel alright… I feel like I don't need to be afraid I'm about to do something bad…"*

The children who had not had their diagnosis explained to them, or felt that they did not know how it applied to them, presented with a poorly integrated sense of self, implying generally weaker psychosocial functioning. It also appeared that these children used the diagnosis as an underlying explanatory reason when their behaviour was viewed as unwanted.

In summary, the findings of my year one study suggested that in practice, the utilization of children's views for both decision making in ADHD assessment methods (to

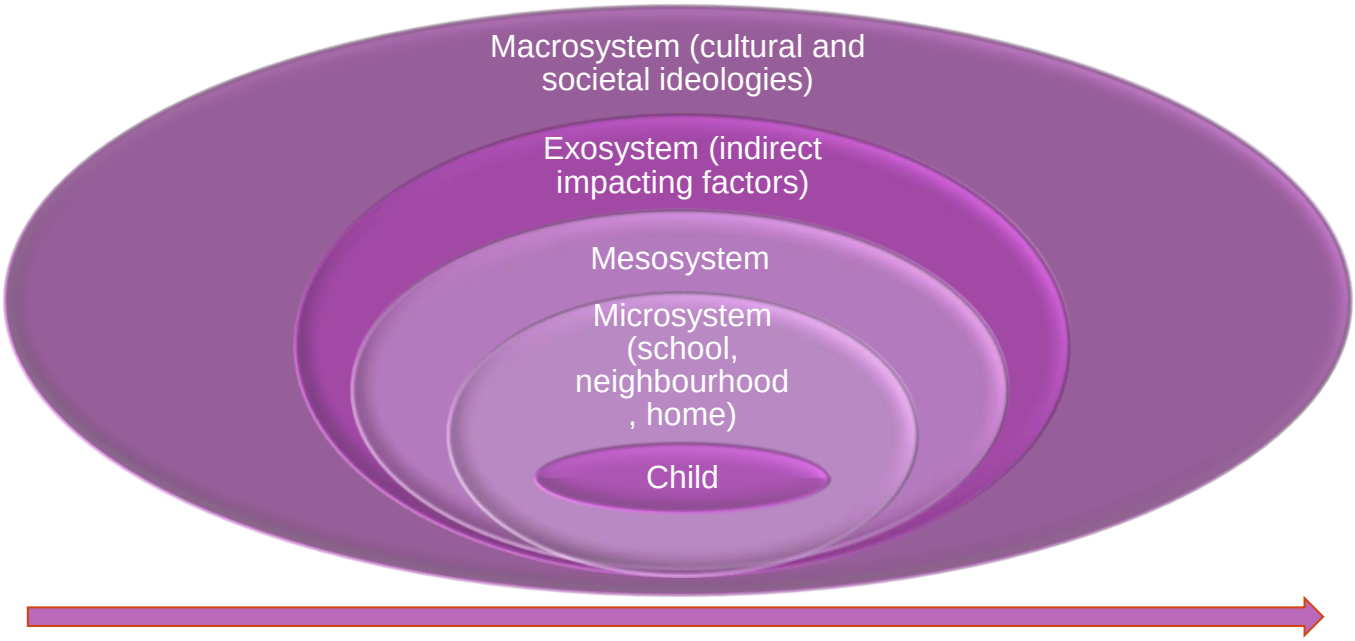
ensure that such a diagnosis is even relevant) and in intervention processes for ADHD-type behaviour (to ensure children are provided with appropriate care) by EPs, may aid children and young people's psychosocial development.

1.4 The child within a bio-ecological system

EPs rigorously consider a child's bio-ecological system, taken from Bronfenbrenner's bio-ecological model (Bronfenbrenner & Ceci, 1994; Tudge et al., 2016) when interpreting children's views and presentation. The bioecological model explains the complex developmental transformations, across time, of a child or young person as part of interdependent, interacting systems. The bio-ecological model refers to four areas: Process, Person, Context and Time. 'Processes' refer to interactions between the child or young person and objects or people. 'Person' refers to the individual differences of the child or young person such as their ability to manage stress, their cognitive capabilities and their physical individualities. 'Context' describes the environment as composed of different systems, the microsystem, mesosystem, exosystem and macrosystem. The child's immediate environment or microsystem includes their home, school and neighbourhood. Mesosystems refer to interactions between different microsystems, for example, the nature of the relationship between the family and the teachers in the child's school. The exosystem indirectly impacts the child as it includes the employment context of the child's parents, social services and health care and government agencies. The macrosystem refers to the ideologies and attitudes of the culture in which the child or young person is developing. 'Time' refers to the chronosystem. The chronosystem is composed of developmental changes across time, as a result of interactions with and between the other systems, such as traumatic events or changing school (Tudge et al., 2017).

The model serves as a framework for EP practice and also as a platform for this current study. It is important to acknowledge that this study is not employing the theory of the model in full but applying it as a conceptual framework that can be applied to consider the views and experiences of a group of children and young people with an ADHD diagnosis who have exclusion and placement into a PRU.

Figure 1. Bronfenbrenner's bio-ecological model



Note. Development takes place across time through reciprocal interactions between the child or young person and the interdependent systems and the factors within them.

The medical model of ADHD, whereby ADHD is seen as a neurodevelopmental disorder caused by biological differences in the brain (see Barr et al. (2021), for an overview) is viewed by EPs as limiting as it does not account for the impact of a child's environmental context on their development. Bronfenbrenner's bio-ecological model counteracts the risk of socially constructed reasons why a child's behaviour does not

match social expectations and protects children from the culture of behavioural disorders (Timimi, 2004). Considering this perspective, application of Bronfenbrenner's bio-ecological systemic framework emphasises family, peer and community socialisation practices, and their continuous interdependent interactions, thus highlighting the discussed aetiological factors contributory to the development, upkeep, or exacerbation of the characteristics of ADHD. Lawrence et al., 2021 and Sjöberg & Dahlbeck (2018) argue how the ADHD label can be detrimental to both children and their families' ability to understand their difficulties by limiting their perspectives, and therefore their progress, to a specific label.

1.5 ADHD and bio-ecological factors: current awareness related to this study

It has been asserted that the role of EPs in highlighting the impact of children and young people's developmental context during ADHD assessment and intervention processes is often missing (Hill & Turner, 2016). Various studies highlight the importance of understanding contextual factors that are often associated with children and young people receiving an ADHD diagnosis. For example, children from socio-economically disadvantaged backgrounds demonstrate poorer psychosocial development and are consequently more likely to present with social, emotional and behavioural difficulties and associated mental health diagnoses (Hodgkinson et al., 2017; Noonan et al., 2018). Other studies have highlighted the uneven distribution of diagnoses of ADHD across populations, with disproportionately high numbers amongst children from disadvantaged backgrounds (Miller et al., 2018). Children and young people who are from socio-economically disadvantaged backgrounds are found to have a greater risk of potentially traumatic events that occur in childhood, termed 'Adverse Childhood Experiences' (ACEs) (Walsh et al.,

2019). Relationships have been consistently found between ACEs, early childhood exclusion (Zeng et al., 2019) and adverse neuropsychological development (Novak, 2022; Spinazzola et al., 2021; Van der Kolk, 2017) which includes deficits in executive functioning that are proposed to underlie ADHD (Kofler et al., 2019). Additionally, a widely discussed relationship has been found between ADHD diagnosis and involvement with youth intervention services and criminal justice systems (Barra et al., 2020; Choi et al., 2019; Karlén et al., 2020; Testa et al., 2022; Young & Cocallis, 2021) and exclusion from school (O'Regan, 2010). In turn, it has been proposed that adversity causes neuropsychological deficits during child development (Brown et al., 2017; Van der Kolk, 2015) that are associated with needing support to access the school curriculum (Jackson et al., 2021) involvement with police during early adolescence (Jackson et al., 2022) insufficient access to adequate food in later life (Testa & Jackson, 2020) and ADHD diagnosis (Brown et al., 2017; Young & Cocallis, 2021).

Brown et al. (2017) conducted an analysis of ACEs among 76,227 children diagnosed with ADHD. The results suggested that the presence of one or more ACEs increases the chance of a child's parent reporting an ADHD diagnosis and that a higher number of ACEs is associated with an increase in ADHD severity. Brown et al. (2017) asserted that augmented efforts to identify ACEs among children who have a diagnosis, or may be referred for assessment, should be a key component of efforts to improve ADHD assessment methods and intervention processes. Furthermore, the process of ACE identification might ensure that care is sensitive and responsive to the needs of children and families who have experienced trauma. The Attention Deficit Disorder Information and Support Service (ADDISS), in 2006, found that 11% of ADHD diagnosed children and

young people had experienced permanent exclusion from school. This is notably higher than the permanent exclusion rate of 0.10% reported from the general population at a similar time (Department for Children, Schools and Families, 2009). Pupil Premium is a category of funding provided to schools for economically disadvantaged children. It has been argued that Pupil Premium is a reliable indicator as a measure for socio-economic disadvantage and that when identifying children and young people who are at risk of low achievement, using parental education or occupation is only marginally more reliable than Pupil Premium eligibility (Ilie et al., 2017). It has been identified that children who receive Pupil Premium are four times more likely to be permanently excluded (Stanforth & Rose, 2020). The Timpson Review (Graham et al., 2019) highlighted that 78% of pupils who had experienced permanent exclusion were children and young people who had been categorised as ‘in need’, in receipt of Pupil Premium or had a previously identified special educational need (Graham et al., 2019). Novak (2022) found that children with more indicators of neuropsychological deficits (including ADHD) and a higher number of ACEs were more likely to experience school exclusion than children with less.

Related to the above statistics, it has been noted that teachers report poor emotional relationships, weak co-operation, and greater conflict in their interactions with pupils diagnosed with ADHD compared with other children. Consequently, rejection of diagnosed children from teachers presented as a risk factor for poor academic progress in addition to peer exclusion, victimisation and rejection, leading to low self-esteem and loneliness (Berchiatti et al., 2021; Ewe, 2019; Ewe & Aspelin, 2021).

In turn, ADHD-related aspects of children’s behaviour, across home and school settings, likely provoke negative parenting responses, stabilising a poor sense of self (Sonuga-

Barke & Harold, 2018). A developmental cascade of this nature may contribute to the perpetuation and upkeep of ADHD-related behaviours, likely increasing the risk of exclusion. Furthermore, it has been found that negative educational trajectories surrounding expectations and aspirations held by children and their parents from socio-economically disadvantaged backgrounds appear to have already been established in the family narrative (Poon, 2020). It is likely that these factors are compounded by children and young people's understandings of antisocial behaviour and behavioural problems at school. Notably, children and young people with ADHD and other social, emotional and behavioural difficulties have been identified as individuals whose views are least heard in research literature (Starbuck et al., 2020).

1.5.1 Context of this research

As reflected in the reviewed studies, the majority of children attending PRUs are likely to have experienced some adversities within their contexts. The Children's Commissioner's 2017 framework provides a definition of a vulnerable child or young person (Bright, 2017) according to whether or not listed difficulties including exclusion from school, having SEND or being at risk of neglect can be identified in their contexts.

In light of this, I wanted to give a voice to a group of children and young people who had experienced exclusion, had been placed in Pupil Referral Units and who had received a diagnosis of ADHD. For this reason, the children and young people partaking in this study met these criteria and were attending one of two pupil referral units where the number of children in receipt of Pupil Premium was identified by Ofsted as well above the national average.

1.6 Moving beyond the year one research study

In light of current research and in order to expand on the findings of my year one study the current study was designed to integrate the roles of both researcher and EP to elicit and interactively explore the views and experiences of a sample of ADHD diagnosed children and young people who had also experienced exclusion and placement into a PRU. In a culture that promotes behavioural disorders, EPs can play an optimal role in enabling children and young people and their families to shift their narrative beyond the constraints of their diagnosis, which arguably dismisses social, cultural and systemic problems (Brady, 2014; Brown et al., 2017; Timimi & Leo, 2009).

1.7 Personal and professional interest

Prior to joining the educational psychology doctoral training programme, I worked for several years as a primary school teacher. The majority of the children in the schools that I worked had experienced different types of disadvantage within their ecosystems and as a teacher, I was very aware of the contextual factors impacting their behaviour. Very often I found that children who presented with behavioural difficulties that adversely impacted their psychosocial development, well-being and learning were provided with an ADHD diagnosis, sometimes offered medication and little more. Children shared how they were experiencing discomfort from the medication, including feeling ‘like a zombie’ and feeling ‘stuck in my body’. These children would often experience temporary exclusion and at times, permanent exclusion. I found this very disheartening to observe and I was unable to see how the outcomes benefitted diagnosed children and their families, psychologically or otherwise. As a trainee EP I went on to understand the processes surrounding this

outcome and gained active experience in enabling better outcomes. The training I received as an EP and my research of the evidence base, supported my beliefs and experiences.

A study in the field of educational and child psychology that is pertinent to this research by Hill and Turner (2016) explored the views of 136 EPs representing 70 LAs, regarding their professional experiences in assessment, diagnosis and intervention processes for ADHD. With regards to the involvement of EPs in ADHD processes, 60% of EPs stated that they were ‘never’, or ‘rarely’ included in diagnostic processes, while 25.9% reported that they were only ‘sometimes’ included. Forty eight percent of EPs described experiencing diagnostic processes where contextual and systemic factors were ‘never’ or ‘rarely’ considered during diagnosis processes while 37.5% felt these were ‘sometimes’ considered. Nineteen percent of EPs stated that they ‘never’ or ‘rarely’ felt confident to challenge a diagnosis of ADHD that they disagreed with, while 34.6% of EPs ‘sometimes’ challenged a diagnosis. Forty two percent of respondents indicated that they would ‘often’ or ‘always’ feel confident to express a different view of a child’s diagnosis. Eighty three percent of EPs believed that it was appropriate for EPs to be included in diagnosis processes for ADHD. It was also found that just 21% of EPs worked in services with a standardised protocol for ADHD assessment processes. Just 10% of EPs knew of local records containing details of ADHD diagnoses and 12% worked in LAs where no records of ADHD diagnoses were kept.

With regards to how families and their children were supported during ADHD processes, 56% of EPs shared that in their professional experience families were ‘rarely’ or ‘never’ offered psychological interventions before being offered medication. Just 17% of EPs indicated that psychological interventions were ‘sometimes’ offered. Fifty-one per cent

of EPs stated that children were ‘rarely’ or ‘never’ involved in decisions about the treatment they received, 13% stated that this ‘sometimes’ happened and just 3% of respondents stated that this was ‘often’ or ‘always’ the case.

The inadequate involvement of EPs in diagnostic and intervention processes for children and young people presenting with ADHD-related behaviour as highlighted in Hill and Turner’s study further fuelled my curiosity in formulating ways to empower EPs to safeguard children and young people in ADHD processes. My curiosity led to the formulation of this current practitioner research study (Menter et al., 2011).

1.8 UNCRC and children and young people’s participation

After publication of the Children and Families Act (2014) and the associated SEND Code of Practice (Department for Education and Department for Health, 2015), the voice of the child received renewed importance within educational psychology in England; highlighting the need for the child to be at the centre of processes of assessment for SEND.

The UNCRC stipulates the point of reference for children’s rights. The UNCRC agreement has been internationally undertaken by most nations and has been endorsed in the United Kingdom (UK). It necessitates the provision of access to an education that promotes all children to reach their optimum potential. Children with SEND are at risk of experiencing significantly greater challenges in achieving their potential. Accordingly, Article 23 of the UNCRC outlines that children with SEND have identical rights and entitlements to all children: of living a fulfilling life in conditions that promote wellbeing, independence and the opportunity to be a full member of society (Hill et al., 2016). Article 12 of the UNCRC asserts that during the process of adults making decisions about a child,

the child has the right to express their opinion and that this opinion must be considered. It is essential that all children are provided with these rights. Further, adults must provide for and support the process of eliciting children's views, experiences and hopes, to incorporate these into the centre of plans for their future.

A child's capability to form a view is in addition to being influenced by their developmental stage, also shaped by the information with which they are provided; as well as their 'experiences, environment, social and cultural expectations, and levels of support' (United Nations, 2009, para. 29). Lundy et al. (2011) assert that Article 12 should be considered through Article 13, which stipulates the right of children to seek, receive, and convey information. Furthermore, it is stated that children must have the right to information, as that information is the 'precondition' of children's formulated decisions (United Nations, 2009, para. 25). Shier (2019) and Thomas (2011) assert that this right has been widely overlooked in every area of children's lives. Hill et al. (2016) further highlight that for professionals working with children with SEND, achieving provision of this right presents a challenge.

There is sparse literature on children and young people's views and experiences of ADHD related practice in the UK and none pertaining specifically to the views of diagnosed children and young people who have experienced exclusion and placement into a PRU. No studies were found that explored the provision of appropriate information about ADHD for children by EPs, nor were studies found on the elicitation of the voice of the child and its application to ADHD diagnosis and intervention processes by EPs. The aforementioned UNCRC and other legislative particularities relating to children and young

people's participation provide a context through which existing literature on the views and experiences of children with an ADHD diagnosis may be critiqued.

1.9 ADHD Definition, diagnosis and prevalence

ADHD is classed as a neurodevelopmental disorder and referred to as the most common neurobehavioural condition of childhood (Sayal et al., 2018). There are two diagnostic classification systems utilised in the UK that feature ADHD. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) characterises ADHD according to a list of behavioural symptoms.

The DSM-5 criteria collectively list 18 behavioural descriptors that are categorized into two groups of nine. One group pertains to a category of inattention type behavioural descriptors and the other group to behavioural descriptors of both impulsivity (three descriptors) and hyperactivity (six descriptors).

The behavioural descriptors refer to difficulties including complying with instructions, completing assigned tasks, remaining seated for sustained periods, and regulating behaviour in accordance with environmental input.

Depending on which behavioural descriptors are recognised in a child or young person's presentation, three types of ADHD profiles are listed: Impulsive/hyperactive type, inattentive type, and combined type ADHD (Murphy et al., 2002). Children or young people whose presentation meets at least six out of nine of the diagnostic criteria in the inattentive group are diagnosed with inattentive type ADHD. Those whose presentation meets at least six out of nine hyperactive-impulsive behavioural descriptors are diagnosed with impulsive/hyperactive type ADHD.

Children and young people who meet the criteria across all three categories are diagnosed with ‘combined type’ ADHD. The child’s behavioural presentation must be consistent across two or more settings, must have begun before the age of 12 years and must have persisted for at least six months.

The children and young people partaking in this study, and seemingly in many other studies in the ADHD literature base appear to have a profile that is consistent with combined or impulsive/hyperactive type ADHD as opposed to the inattentive type. It is likely that this is because children and young people who display impulsive and hyperactive behaviour pose comparatively more difficulties for both themselves and those around them (Mayes et al., 2019, 2020).

Various correlates have been proposed in studies asserting associations between the ADHD types and differences in gender, comorbidities, prevalence and gender (Freitag et al., 2012; Mayes et al., 2020; Merrell et al., 2017; Murphy et al., 2002; Sayal et al., 2018). For example, Weiss et al. (2003) reviewed 143 cases of children with inattentive type ADHD and 133 cases of combined type ADHD. When compared to children with hyperactive and impulsive symptoms, the children with inattentive type ADHD were more likely to be girls, with more comorbid internalising disorders such as anxiety (Biederman et al., 2002) speech and language difficulties and learning difficulties. Their social behaviour was viewed as less impaired and they were less likely to receive psychostimulant medication as an intervention.

ADHD is also listed in the International Classification of Mental and Behavioural Disorders 11th revision (ICD-11, World Health Organisation, 2018) It is referred to in the ICD-11 as ‘Hyperkinetic Disorder’. This term is used widely in Europe and in European

clinical guidelines. It is defined as persistent and severely impaired psychosocial functioning that manifests early in childhood. Additionally, it involves a combination of "overactive, poorly modulated behaviour, marked inattention, lack of consistent task involvement, and pervasiveness". This behavioural presentation needs to be seen across situations and to persist over time, with an onset before the age of seven years.

Around 5-7% of children globally are estimated to have received ADHD diagnoses across the last three decades (Polanczyk et al., 2014). Polanczyk et al. (2014) conducted a systematic review and meta-analysis of ADHD prevalence estimates over the last 30 years. Prevalence rates were not found to vary according to time. However, it was suggested that increasing rates of diagnosis and intervention for ADHD may reflect methodological differences between studies identifying prevalence (Sayal et al., 2018). They may also result from wider awareness of ADHD, increased treatment availability and change in clinical practices. For example, across countries, those using DSM (as opposed to ICD-11) classification systems have been found to have higher prevalence rates, although this may be explained by the varying cultural subjectivity of diagnosis and variance in diagnostic approaches. For example, rates of diagnosis of ADHD remain twice as high among White children compared to Black and Hispanic children (Bax et al., 2019; Shi et al., 2021). Additionally, UK prevalence rates are found to be consistently higher amongst boys (Cybulski et al., 2021; Sayal et al., 2018). It is argued in a recent critique of gender differences pertaining to ADHD (Fraticelli et al., 2022) that ADHD related impairment is consistently underestimated as female behaviour is less externalising and problematic and therefore less likely to provoke any type of intervention.

Gershon (2002) conducted a meta-analysis of studies pertaining to gender differences in ADHD diagnosis. It demonstrated a significant difference in ratings of ADHD symptoms by teachers between genders, with teachers rating boys as more impaired, particularly in the hyperactivity category. Further studies have confirmed these findings (Rucklidge, 2008; Ullebø et al., 2012) with the studies suggesting that amongst diagnosed children, boys are more likely than girls to be referred for diagnosis and intervention processes, likely due to the ADHD symptom ratings of teachers. A study by Isaksson et al., (2020) comparing ratings by teachers and parents of ADHD symptoms in 137 children with a diagnosis of ADHD showed that teacher ratings of girls were significantly lower than parental ratings in all three ADHD behavioural categories. This difference was not found with ratings of boys. Biederman et al. (2002) assessed 140 boys and 140 girls for subtypes of ADHD and found that girls presented as more inattentive than boys, demonstrating less behavioural difficulties in and outside of school. Boys with ADHD were more likely than girls to receive medication and psychotherapeutic intervention. Biederman et al. argued that girls with an ADHD diagnosis present differently as they are less likely to demonstrate disruptive behaviour whilst at the same time at the same risk of experiencing adverse ADHD outcomes as boys. They concluded that this placed girls with ADHD at risk of being overlooked in referral for ADHD assessment and intervention. In line with such studies, it appears that studies pertaining to exploring the impact of ADHD (which were particularly prevalent around 20 years ago) tend to focus mostly on children and young people who present with hyperactive or combined types of ADHD, likely due to such presentations being more disruptive both in school and at home (Kendall, 2016; Russell et al., 2014). Those students who are diagnosed with inattentive type ADHD do appear to have been

comparatively overlooked in the literature however various studies assert that inattentive type ADHD is a distinct disorder that places children and young people at higher risk of poor academic outcomes (Merrell et al., 2017; Milich et al., 2001). In this study, no pre-existing criteria for ADHD type was used for recruiting participants, however all of the partaking children and young people appeared to have been diagnosed with either combined type or hyperactive-impulsive type ADHD suggesting that the related symptoms had manifested in their behaviour and lead to diagnosis and exclusion. For this reason, the focus in this study is predominantly on studies pertaining to children who have been diagnosed as hyperactive and impulsive.

A lack of evidence to suggest an increase in the number of children in the population who meet criteria for ADHD when standardized diagnostic procedures are followed has been noted (Polanczyk et al., 2014). A strong overlap has also been found in those individuals meeting diagnostic criteria listed in both the DSM and ICD classification systems (First et al., 2021). However, in the UK specifically, ADHD prevalence is reported as 1-2% for the ICD-11 classification and 3-9% under the DSM-IV classification (NICE, 2018). Discrepancy in rates has been attributed to less rigid DSM symptom criteria, which require symptoms to present before the age of 12 years, as opposed to 7 years. In addition, ICD-11 requires symptoms to be present in all three behavioural categories (First et al., 2021). Less than half of children who would meet the criteria for ADHD have received diagnosis or treatment (Sayal et al., 2018). Merten et al. (2017) assert that professionals diagnosing ADHD may not rigorously adhere to diagnostic criteria, rather forming a clinical judgment that is shaped by heuristics and cultural and individual subjectivity.

In both classifications, no differential baseline for definitive comparisons between typically developing and pathological behaviour is included. It is argued that the extent of inattention, hyperactivity and impulsivity in an individual's behaviour exists on a continuum within the general population, making it difficult to define whether a person with ADHD is qualitatively different in comparison to others (Timimi, 2014). Further, it has been suggested that a lack of consistent biological evidence (Sjöberg & Dahlbeck, 2018; Timimi & Leo, 2009) reduces diagnostic tools for ADHD to a measure of non-quantified behavioural symptoms (Hill & Turner, 2016).

In the UK ADHD is usually diagnosed by a medical professional. Recommended assessment practice consists of a multi-disciplinary assessment (BPS, 2000; NICE, 2018) that assesses the child's functioning across their life history and considers parental views, the views of the child themselves, as well as the views of the child's teacher and other relevant professionals working with the child, including EPs. Rating scales such as the Conner's rating scale (Conners, 2008; Conners, Sitarenios, Parker, & Epstein, 1998), are commonly used in the assessment process (Sharkey & Fitzgerald, 2007). Conner's rating scale is used to gain multi-informant ratings of a child's behaviour across settings via rating forms for children as well as their parents and teachers (Conners, 2008). Timimi (2014) argues that for ADHD diagnostic procedures, paediatric primary care providers' reliance on parent and teacher rating scales that list behavioural presentations means that they do not consider contextual underpinnings to the behaviour. Timimi and Leo (2009) assert further that explaining a child's behavioural presentation through ADHD challenges our ability to understand other potential factors underlying ADHD-type behaviour, such as poor nutrition

and sleep, witnessing domestic violence or being bullied (Bob & Konicarova, 2018; Calder et al., 2020; Davidson & McEwen, 2012; Gubi et al., 2019).

1.10 Current models of ADHD

Controversy exists in the literature surrounding the aetiology of ADHD and corresponding intervention practices. Causes continue to be unproven and contentious (Conrad, 2017; Wright, 2012). The three dominant models are the medical model (Sayal et al., 2018b), the bio-psychosocial model (Hill & Turner, 2016) and the socio-cultural model (Timimi, 2014; Timimi & Leo, 2009), each of which are briefly discussed in turn.

1.11 The medical model of ADHD

The medical model, which continues to be the most dominant model for considering ADHD (Hill & Turner, 2016), describes ADHD as a neurodevelopmental disorder for which pharmacological intervention using psychostimulants such as methylphenidate is recommended despite this being associated with adverse outcomes (Storebø et al., 2018). Irrespective of the acknowledgement of adverse side effects, use is viewed as effective (Carucci et al., 2021). Since the 1990s, a 700% increase in prescription rates has been estimated (Bachmann et al., 2017).

In the context of the medical model, various studies propose a deficit of the neurotransmitter dopamine in specific areas of circuitry (Lai et al., 2018) in the prefrontal lobes of the brain (Cupertino et al., 2019). Proposed deficits in neuropsychological functioning in the prefrontal lobes, which are the areas of the brain responsible for executive functioning, are thought to be important for altering self-regulatory behaviour. Executive functioning is a term that encompasses different meta-cognitive domains of

mental control processes that enable self-control. Indeed, researchers have attempted to explain ADHD as a condition characterized by difficulties in executive functioning, whereby symptoms reflect poor self-regulatory control (Kofler et al., 2019).

Existing studies surrounding the aetiology, development and course of ADHD have not, to date, demonstrated a consistent link between the condition and a neurological or biological atypicality (Timimi, 2014). However, the medical model supports the use of psycho-stimulant medication as an intervention for ADHD-related behaviour. Significant international increase over the past 30 years in the number of children and young people with ADHD prescribed psycho-stimulant drugs such as methylphenidate and atomoxetine has raised concern amongst EPs (Hill & Turner, 2016; Travell & Visser, 2006). The use of stimulant medication for children and young people has been associated with various listed side effects such as insomnia, reductions in growth rate, possible long-term adverse neurological changes and cardiac complications (Graham et al., 2011). Medication as treatment undermines government guidelines (NICE, 2008, 2013, 2018) that list psychological approaches such as behaviour-based parent training as first-line.

1.12 The bio-psychosocial model of ADHD

Studies relating to the bio-psychosocial model, which encompasses aspects of both the medical and the socio-cultural models, discuss a high level of ADHD heritability (Grimm et al., 2020). This is believed to interact with environmental factors. Specifically, there are suggestions of associations with inadequate parenting practices, with an emphasis on poor mental health in parents giving rise to atypical behaviour (Smit et al., 2021). In addition to increased levels of negative and ineffective parenting, associations have been reported between ADHD and difficult family functioning, challenging parent-

child relationships, negative parental perspectives of their child's behaviour (Climie & Mitchell, 2017), increased parenting stress, and parental psychopathology; all of which predict poor social and academic outcomes (Biondic et al., 2019). Accordingly, it has been proposed that socialisation practices in the family context are contributory to the development or upkeep of ADHD symptoms either through gene–environment interplay, environmental influences, or epigenetic change (Schuch et al., 2015). Epigenetic change refers to changes in whether a specific gene is active or inactive, as a result of the environmental feedback that an individual receives (Hamza et al., 2019).

It has been argued that studies of heritability overestimate the genetic origins of ADHD. Te Meerman et al. (2017) dispute claims of heritability, having questioned the methodological approaches of familial, twin and adoption studies used for calculating heritability coefficients, which can be as high as 0.77 (Banerjee et al., 2007; Froehlich et al., 2011). For example, Meerman et al. (2017) argue that higher co-occurrences of ADHD between monozygotic (identical) twins in comparison to dizygotic (non-identical) twins are most probably mediated by environmental influences as monozygotic twins being more likely to share greater phenotypic and psychological similarities thus provoking more similar treatment than those that are dizygotic. Furthermore, it was also noted by Te Meerman et al. (2017) that the studies depended on observational tools to assess parent-child behaviour and interaction, which are prone to rater-bias. In contrast, studies that employ genetic analysis testing procedures demonstrate that associated genes were found to occur approximately 10% more often in diagnosed individuals (Franke et al., 2009). Meerman et al. (2017) assert that this finding does not explain or predict a genetic basis for ADHD behaviour and believe that the finding should be shared amongst educational

professionals to prevent the consideration of an ADHD diagnosis as an explanatory within-child genetic abnormality.

In view of this, children who have been exposed to psychosocial stressors such as abuse, institutionalisation or neglect show adverse changes in brain functioning due to morphological reductions in the pre-frontal, parietal, and temporal areas of the cortex (Farah, 2017; Harms & Pollak, 2020; Kelly et al., 2013). Pertinently, such cortical abnormalities are linked to an increase in ADHD symptom behaviour (McLaughlin et al., 2014). McLaughlin et al. (2014) propose that reductions in the size of the cortex caused by early life adversity are a neurodevelopmental pathway to the manifestation of ADHD in later life. Brown et al. (2017) suggest that behaviours of children who have undergone complex trauma are consistent with ADHD DSM-5 symptoms. Complex trauma related behaviours include poor self-regulation, impulsivity, inattention, opposition, distant and detached demeanour, difficulties with learning and cognition, hyper-vigilance and guardedness (Briggs-Gowan et al., 2010; Brown et al., 2017; Spinazzola et al., 2018, 2021).

It is suggested that the bio-psychosocial model presents a compelling representation of ADHD as it supports a multi-modal approach to intervention that combines medical, psychosocial, and educational dimensions (Horton-Salway & Davies, 2018; Salamanca, 2014).

1.13 The socio-cultural model of ADHD

Hill and Turner (2016) and Timimi and Leo (2009) argue that the lack of consensus and subjectivity of the diagnosis process, which is based on culturally chosen symptoms, as opposed to scientific foundations, frames ADHD as a socially developed

construct. In the context of the socio-cultural model, Timimi and Leo (2009) assert that evidence for the medical model is not consolidated. Conrad (2017) and Timimi (2014) argue that although psycho-stimulant medication for ADHD has been shown to lead to a reduction in ADHD symptoms (Mechler et al., 2021), this is only in the short-term. A review by Mechler et al. (2021) highlighted that long-term use of psycho-stimulant medication for ADHD is questionable and asserted the importance of clinical guideline recommendations that individuals with ADHD must be periodically assessed and a period in which medication is not taken must be incorporated into their care plans. Benefits were determined through reported improvement in ADHD symptoms, and academic and psychosocial functioning, and an absence of difficulty with tolerance to medication or adverse effects. ADHD symptom criteria refer to behavioural frequency without the use of a non-quantitative baseline using wording such as ‘excessive’ (Hill & Turner, 2016). Multi-modal treatment that is without a pharmacological component is endorsed by this model. In this context, medication is viewed as an ethically contentious way to control, manage, or alter the autonomous social behaviour of children, impinging on their human rights (Conrad, 2017; Timimi, 2014). Various critics of the socio-cultural model have argued that there is a wealth of neuro-scientific evidence that ADHD is a legitimate diagnosis (e.g., illustrated through neuroimaging studies of the brain) and that rejecting the bio-psychosocial perspective may hinder the development of provision for children with a diagnosis (Horton-Salway & Davies, 2018; Salamanca, 2014). Rose (2005) highlights how biological determination of a condition refutes the importance of human agency, leading to an ill-founded sense of poor competency and diminished expectation of self.

1.14 Impact of having ADHD-related behaviour on children

Having an ADHD diagnosis has been associated with poor life outcomes (Schiavone et al., 2019). Various aspects of quality of life have been proposed as being adversely affected in children and adults with ADHD (Cherkasova et al., 2021; Thorell et al., 2019), particularly emotional well-being, social and emotional competence, and parent-child relationships (Araujo et al., 2017; Hapsari et al., 2020; Peasgood et al., 2021). Literature suggests that school-aged children with ADHD experience numerous academic and educational difficulties (DuPaul & Langberg, 2015; Lawrence et al., 2021). In comparison to children without an ADHD diagnosis, children with an ADHD diagnosis are more likely to utilise school SEND resources and present with behavioural problems that lead to exclusion (Fleming et al., 2017).

From a review of existing literature, associations between ADHD diagnoses and poor school grades, and poor reading and mathematics standardized test scores have been highlighted (Arnold et al., 2020; Visser et al., 2020). Various studies propose executive functioning challenges as the cause of underachievement (Kofler et al., 2019; Roselló et al., 2020). However, other studies have compared children with an ADHD diagnosis to non-diagnosed children and differences were not found between the groups in relation to executive functioning or explicitly trained number calculation skills (Antonini et al., 2016; Tamm et al., 2021). Merrell et al. (2017) found that within a sample of 46,369 children from English primary schools, ADHD symptom severity, particularly in the area of inattention, was negatively associated at age five years with attainment in reading and mathematics when assessed again at age 11 years.

Lawrence et al. (2021) compared the academic performance of 327 Australian children and young people aged between four and 17 years, over eight years, with 3916 children and young people without a psychiatric diagnosis. In year three, ADHD diagnosed children were one year behind in both reading and numeracy skills and nine months behind in writing skills, in comparison to their non-diagnosed peers. The performance of diagnosed children when they were in year nine of school indicated that their performance was two and a half years behind in reading skills, 3 years behind in numeracy skills and four and a half years behind in writing skills.

Some studies argue that the adverse impacts of ADHD on quality of life have been found to continue into adolescence (Sayal et al., 2015). Erskine et al. (2016) and Owens et al. (2017) found that in adolescence, individuals with ADHD diagnoses experience problems with accessing and completing higher education, driving, employment and relationships. Relationships are foundational for mental health and well-being and children with ADHD diagnoses have been found to experience various difficulties with family relationships, family functioning (Peasgood et al., 2021; Smit et al., 2021) and relationships with peers (Mikami et al., 2017).

Chapter 2: Literature review

Firstly, this chapter seeks to illustrate the importance of eliciting the voice of children and young people with a profile consistent with ADHD type behaviour. Secondly, the chapter reviews literature including current guidance that informs an understanding of the role of EPs in supporting children and young people with a profile consistent with ADHD. In order to formulate these two parts, a literature review was conducted in order to examine the findings of other authors. A database search was conducted using University College London authentication and this was completed between June 2020 and December 2021. A second literature review search of the same kind using chronological parameters of the years 2018 to 2022 was conducted following the thesis viva to search once more for relevant literature in the last five years. The main databases that were accessed were Sage publications, SpringerLink, Wiley online library, Psychnet, Cambridge University Press, Taylor & Francis, Elsevier, PubMed Central, PsychINFO and British Education Index Children Development and Adolescent Studies.

Specific key words were used, without chronological parameters and included “children’s/young people’s views ADHD”, “pupil voice”, “ADHD”, “diagnosed children’s beliefs”, “Educational Psychologists ADHD” and DECP/DfE/NICE guidance ADHD”.

For the part of the literature search pertaining to studies that elicited and explored children and young people’s views, there was found to be less research (in comparison to previous years) available in the last five years prior to the viva and the assigned corrections.

After the reviewed studies, the findings are conceptualised in order to provide and justify a rationale for this study.

2.1 Children's views and experiences of ADHD diagnosis and intervention

Studies have been conducted that have elicited ADHD diagnosed children and young people's views with regards to their experiences of having a diagnosis and of receiving intervention. Such studies are reviewed in the current section. No studies were found that matched the current study whereby the selected participant sample were specifically children and young people from socio-economically disadvantaged backgrounds, or who had experienced school exclusion to an alternative setting. The authors of various studies refer to the importance of incorporating children and young people's views into ADHD evaluation and intervention processes.

Kendall et al. (2003) conducted one of the first studies to elicit diagnosed young people's views. Specifically, the views of 39 children from a range of socio-economic backgrounds, aged six to 17 years, were gained using semi-structured in-depth interviews and analysed using constant comparative analysis. Children were asked about their experiences of having a diagnosis of ADHD. Descriptions included being different to others, strange and having problems with anger, fighting and learning. Kendall et al. found that authority figures, including parents and health professionals, facilitated several children to explain their ADHD related behaviour as an illness with a name. Children also appeared to view themselves as being a disappointment to others, in that they presented with awareness of a discrepancy between their own behaviour and the social expectations of adults. Kendall et al. (2003) argued that as a result the children lived with a constant state of dissonance, between what they felt was a correct way to be and their actual behaviour as they tried to function with the various challenges they were experiencing. Later, Gallichan and Curle, (2008) conducted a study with 12 young people aged 10 years

11 months to 17 years using semi-structured interviews. The data were analysed using grounded theory to produce an over-arching model. Interestingly, the authors asserted that the model formulated from their data proposed a mutual relationship between children and young people and their social context and that the concept of ADHD was that it caused a hindrance to the reciprocal relationship between children and their social context. The authors suggested that diagnosed children and young people were inherently different to everyone else yet trying to force themselves to fit into their contexts. They proposed further that this proposed interruption to the reciprocal relationship between child and social context caused children and young people to experience a loss of control and low self-esteem. This finding of self-esteem being adversely impacted in such children is also reflected in other studies (Padilla-Petry et al., 2018; Wiener et al., 2012).

The negative self-concept identified by Kendall et al. (2003) was also identified as a subtheme in my year one research study. For example, one child shared distress about his belief that others viewed him as ‘scary’ and when asked to draw ‘a person with ADHD’, he drew someone throwing a chair and table across the classroom. These findings have also been evident in a range of other research studies. Similarly, in the study by Gallichan and Curle (2008), the authors reported that one child expressed being taken over by ADHD as if being taken over by a monster and another felt that being perceived as strange had caused him to begin misbehaving. Considering these findings, the authors highlighted the strong impact of the social context on children with a diagnosis. They asserted that challenges might evolve from others’ views rather than the child themselves, due to a lack of correspondence between the child’s needs and the environment. The authors suggested that adults with influence and power over children’s lives can facilitate feelings of

competence and agency if they accept and value their individual differences. Associations between anger and ADHD were only made by male participants, but given that there were only two female participants, it is difficult to formulate comparisons between genders. In contrast, a context in which adults responded in a more positive way to a child's difficulties was also highlighted in Gallichan and Curle's study. Specifically, one child in the study stated 'I sort of trained myself 'cause I thought it's cheating, you can't cheat yourself' (p.356). Another child demonstrated feelings of agency, mentioning: 'What I'm trying to do is control myself… I'm getting this thing for like, working with others, stay with others, and, get used to 'em (p.356).' Similarly, in my Year One study, a child who had received positive explanations of ADHD found that learning meditation alleviated his experience of ADHD and enabled him to develop agency.

A more recent study in the UK by Brady (2014) highlighted that children with ADHD utilised the medical model to explain their behaviour in social contexts when they felt it necessary. Brady (2014) conducted interviews with seven children diagnosed with ADHD aged between six and 15 years about their experiences and beliefs of ADHD. Brady asserted that children's sustained control over their own lives through neither accepting nor rejecting the medical model of ADHD, suggesting children may perceive advantages and disadvantages to having a diagnosis. Flack (2018) conducted a UK based study where nine boys aged 11-15 were interviewed about their experiences of ADHD using semi-structured interviews and noted similar findings where children drew on their diagnosis to explain their behaviour in different situations. In this study, the young people appeared to conceptualise ADHD as both attributable to individual difference in personality traits and to having a medical disorder, which meant that they often felt that their behaviour was beyond

their control. Flack also assessed the support available for pupils with ADHD in school. Interestingly, the young people shared that they withheld their views of what may support them in school, from school staff. Tools that would facilitate children and young people to share their views that may be used by both EPs and school staff were proposed and included PCP based tools developed from the Ideal Self (Moran, 2001) used in this study. A similar finding to the study by Brady (2014), of children using their diagnosis to explain aspects of their behaviour, was also highlighted by Singh (2011). In Singh's VOICES ('Voices on Identity, Childhood, Ethics and Stimulants: children join the debate') project, interviews were conducted with 151 children aged nine to 14 years from the U.S. and UK. Children were in one of three groups: (1) with a diagnosis of ADHD; (2) with a diagnosis of ADHD and on prescription medication for ADHD; or (3) without any psychiatric diagnosis. Note that some children from the UK sample, included to supplement participant numbers, were suspected of having ADHD by teachers so may not have met criteria for an official diagnosis. Children in the study took part in hour-long semi-structured interviews, which included questions, a drawing task, pictures, a sorting task and a sentence completion task. The different components of the interview were drawn upon to prompt and steer children's communication in different areas. Singh (2011) highlighted two constructions of ADHD amongst the children. The 'performance niche' (p.892) focused on ADHD as negatively impacting on academic performance and achievement. The 'conduct niche' (p.892) represented a view of ADHD as a behavioural disorder that manifests as aggression and anger. Some children were identified as holding views in both niches. Differences between children from different countries were also noted. Children from the U.S. were less likely to disclose their diagnosis and were more often identified as holding a

‘performance niche’ construction. In contrast, children in the UK more typically held a ‘conduct niche’ (p.892), which was often described by children as a consequence of ADHD and therefore beyond their own control. Most importantly, Singh identified that the children did not personally believe that their unwanted behaviour was beyond their own control, however they were aware that adults did. Accordingly, children explained using their diagnosis as a tool for excusing poor behaviour, relieving them of accountability.

Further work by Singh et al. (2010) involved interviewing 16 children with ADHD in the UK, aged between 9 and 14 years, to explore their experiences of taking psychostimulant medication. Singh et al. found that the children viewed medication as necessary, describing their own behaviour without medication as socially destructive and a hindrance to others. Moreover, children believed that they were perceived negatively with a general poor reputation. Interestingly, the authors found that children did not believe that their problematic behaviour was due solely to having ADHD or not being under medication. The authors emphasised that the children demonstrated high levels of agency over their own behaviour and appeared to understand that medication and their diagnosis could not be used as an excuse for their behaviour. The findings supported Brady’s (2014) findings of children neither accepting nor rejecting the medical model of ADHD. These findings do, however, contrast with the views of the children who were specifically from the UK in the Singh (2011) study discussed above. These children had described ADHD as a problem with anger and aggression. However, Singh (2011) asserted that the children from the UK group were from a UK state school culture of ‘aggression’ (p.893), which likely worsened children’s ADHD symptom behaviour and encouraged them to use ADHD as a tool to absolve responsibility for their own behaviour, as a way of adapting to a context where

aggressive and conflicting interactions are common and unavoidable. Furthermore, considering that children may use their diagnosis in different ways and for different purposes, Singh et al. (2010) also found that older children described a desire to discontinue taking medication, despite stating its usefulness, in the near future. It may be possible that as older children have more sophisticated cognitive tools for managing their lives and an increasingly clearer self-identity, the positive outcomes of the use of medication as explained by the children as reducing their disruptive behaviour and facilitating their friendships might be viewed as a less useful tool as they progress into adolescence.

Singh (2011) suggests that there is a need for the acknowledgement of the impact of context on children's behaviour, such as the 'aggressive' (as described throughout the study) culture in the UK state school system, alongside support interventions to develop moral behaviour. Singh emphasises that for many diagnosed children the ability to self-regulate is both a cognitive skill and a moral behaviour. Singh asserts further that a child's cognitive and behavioural capabilities and accordingly their moral potential are inextricably linked with relational expectations. In turn, these expectations can motivate behavioural self-control. The author noted that children reported making decisions to fight when they felt morally obliged, and also reported mobilizing their diagnosis of ADHD to avoid fighting in conflict situations. Children shared views that, at times, some teachers fuelled poor perceptions of individuals with ADHD through asking other children to keep away from them and attributing poor behaviour to ADHD. Similarly, Gallichan and Curle (2008) found that children reported becoming angry as a result of other's perceptions of them.

In another earlier study, which focused on the experiences of diagnosed secondary-aged children who were taking medication, Travell and Visser (2006) interviewed 17 children aged 11 to 16 years in the UK about their views of ADHD. The children had been taking ADHD medication for between one and six years, with 14 taking medication for a minimum of two years. The authors' conclusions appear to overlap with those made in the Singh (2011) study. For example, they concluded that although children identified that short-term improvements in ADHD symptoms resulted from using ADHD medication, longer term psychological effects might offset any benefits. The authors also emphasised how the child's voice should be considered during assessment processes that may lead to ADHD diagnosis, alongside a wide range of factors underlying behaviour, such as social or cultural factors. Another important finding from this study was that during the diagnostic process, children received limited explanation of the assessment and their diagnosis and were directly placed on medication. The children reported feeling little autonomy to question this decision, being told that the medication would 'calm them down' (p.212). Many children felt, in accordance with other studies (Honkasilta et al., 2016; Ringer, 2020; Singh, 2011), that this may reduce the burden of their behaviour on others. Some children described their own behaviour as leading them to self-perceive as 'stupid' or 'naughty' (p.207). The authors asserted that, firstly, these thoughts appear to have been formed from the influences of adults' perceived social understandings of behaviour and of ADHD. Secondly, it appeared that a diagnosis and prescribed medication were a response to caregivers' challenges with behaviour at home and/or at school, and not definitive evidence that the child themselves had a disorder. Children's reported difficulties appeared to reflect their individual personality traits as opposed to ADHD symptoms. Such difficulties

included becoming angry quickly and disruptive to others. More than half of the 17 participating children agreed with their ADHD diagnosis, two disagreed, and the rest were unsure. Children appeared to demonstrate feelings of both concern and relief, as they reported that although medication had improved their schoolwork and reduced their ADHD symptoms, they were worried about having to take medication, and raised concerns that there were abnormal in comparison to others. This led to young people feeling simultaneously relieved and worried. Relief was associated with improvements in behaviour and schoolwork, but worry was shared about taking medication, being ‘different’ (p.207) from others and having something ‘wrong’ (p.211) with them. These views resonated with those of the children in my Year One study, who reported feeling ‘different’ and feeling as though they had something intrinsically wrong with them. Comparatively, in a very recent study (Carr-Fanning & McGuckin, 2022) explored the views of ADHD diagnosed parents and their ADHD diagnosed children. They asserted that children’s views reflected reduced negative feelings of being different because they had a parent who was also diagnosed.

As an implication of the Travell and Visser (2006) study, the authors asserted that the voice of the child should be fully considered and that children should be provided with adequate information about ADHD diagnosis and intervention in addition to the opportunity to make an informed choice about whether they wish to take medication. Relatedly, the children in the study shared wishes that school staff would be more understanding of ADHD, that their needs would be better accounted for, and that the intervention that they receive might be more appropriate to their needs. However, all the children in the sample were from the same LA in the UK, limiting the transferability of the findings.

In a more recent study, the voices of 10 young people in Spain between the ages of 11 and 18 who had experienced difficulties in school and consequently received an ADHD diagnosis were elicited (Padilla-Petry et al., 2018). Nine out of 10 of the young people had received their diagnosis after their teachers had complained about their behaviour at school and suggested they undergo an ADHD assessment. Semi-structured interviews were used and the authors found that for eight out of 10 participants, their diagnosis had been internalised as a brain based problem that is the underlying cause of problematic behaviours which disturb their ability to make academic progress and integrate socially. The authors found that at the same time, situations within their school context that may possibly trigger ADHD symptom behaviour including the type of learning tasks or challenges with accessing learning were not questioned by the young people and instead the symptoms were attributed to the diagnosis as an internal deficit within themselves. The young people in the study were accessing different forms of intervention, including medication and self-control strategies through psychotherapy and appeared to view these methods as ways to cope with the social and academic requirements of their school context. The authors asserted that the young people who were taking stimulant medication for ADHD described it as a negative experience that they were obliged to maintain at the request of parents or professionals and also to be able to fit in at school. One young person talked about becoming calmer to a point where he no longer felt like himself from taking the medication and suggested that perhaps his parents should instead take a medication to calm themselves down. The findings also suggested that following teacher requests for an ADHD assessment, a confirmed diagnosis and prescribed medication, the responsibility of both the school and parents towards each young person was supposed to

have been achieved. Alterations to the classroom environment or the provision of pupil-specific differentiated learning tasks was not offered.

In a study by Wiener et al., (2012) the views of 86 ADHD diagnosed children aged nine to 14 years were explored. The children were found to view their own behaviours that were seen as more problematic to others as beyond their own control and something to be ashamed of. At the same time, the children viewed their other, less problematic ADHD related behaviours as less pronounced than their parents and teachers. The authors explained this as positive illusory bias (Wiener et al., 2012).

In other studies that have elicited children' and young people's views on their experiences of ADHD, some children and young people reported that medication was beneficial in areas related to school success. Children and young people reported that medication lessened, but did not take away, ADHD symptoms completely (Honkasilta et al., 2016; Kendall et al., 2003). However, they also reported negative physiological and psychological side effects of psycho-stimulant medication for ADHD (Charach et al., 2014; Rashid et al., 2018; Walker-Noack et al., 2013). Across studies, children reported that ADHD medication made them feel a loss of agency. For example they described that on medication they were not themselves, that they had lost self-control and were instead being controlled by medication (Rashid et al., 2018). Similarly, in my Year One study, when asked about medication, one participant reported feeling as if they were 'stuck in their own body' and 'being like a zombie' while another threatened that they would 'throw them (the tablets) on the floor' if their mother asked them to take them (p.39). A second child reported wanting to 'vomit' to get the tablets out 'because they make me feel sick' (p.39).

Studies suggest that at secondary school age (11-16 years), children and their parents tend to openly question the need for medication, worry about side effects and perhaps choose to discontinue their medication, often expressing concerns about over-medication (Brinkman et al., 2012; Bussing et al., 2012; Ferrin et al., 2012; Singh et al., 2010). From these studies, it appears that older children are more receptive to the advantages and disadvantages of medication and have developed a more sophisticated awareness of how ADHD relates to them. It is possible that entering secondary school age might increase their accessibility to different resources of information about ADHD, which they had not been provided earlier during their diagnosis processes. This might underlie their desire to discontinue taking medication as they become older. Primary age children are more reliant on information provided by adults, and this might underlie their contrasting views of medication being a necessary intervention. This highlights the importance of the UNCRC Articles 12 and 13 (Shier, 2019; Thomas, 2011), which stress the need to provide children with the right to seek, receive and convey information and to consider that information during diagnostic and intervention processes.

Arora and Mackey (2004) assert that improvements for a child should not be judged in relation to ADHD symptom reduction but instead by achieving an understanding of the child's self-perceptions and how they report their strengths and competencies. They strongly argue that children must be actively involved in ADHD diagnosis and intervention processes through sharing their voice, and that children have a lack of agency over decisions to take medication. In the context of children and young people's rights to seek, receive and convey information (Article 13, United Nations, 2009), children must receive accessible information about ADHD and medication before making an informed judgment

of whether medication may be useful or not. Furthermore, such a process may facilitate children to make decisions about what their individual needs may be, providing scope for professionals to suggest corresponding interventions.

Treating ADHD with psycho-stimulant medication has been shown to have positive short-term effects but it is widely argued that there is little convincing evidence to show long-term benefits in the fields of improved academic outcomes and sustained behavioural improvements (Bachmann et al., 2017; Charach et al., 2014; Travell & Visser, 2006). For example, Swanson et al. (2017) reported on the Multimodal Treatment Study that started as a randomised clinical trial of behavioural and pharmacological treatments of 579 children with ADHD aged seven to 10 years and transitioned into an observational long-term follow-up of 515 cases (between two to 16 years after baseline). Findings showed a significant decline in symptom severity in the groups who received stimulant medication, compared to those who did not, after 14 months. However, the most recent findings indicate that in the long-term, symptom-related benefits of medication may dissipate and do not continue to be significant.

Massuti et al. (2021) conducted a systematic review and meta-analysis of studies on the possible under or over-treatment of children and young people with ADHD medication. The authors discussed that in the U.S. children are commonly described as having received prescribed medication despite not meeting the criteria for ADHD; and US guidelines recommend pharmacotherapy as first-line guidelines. They noted that this approach to prescription has found to be less apparent in the UK, and this is also reflected in European guidelines which recommend therapeutic interventions as first-line for ADHD intervention prior to considering use of medication. Similarly, authors of other studies have

asserted that the more loose the diagnostic criteria, the more likely it may be that a child is prescribed medication (Sawyer et al., 2004). This assertion resonates with the discourse surrounding the subjectivity of diagnosis (Timimi & Leo, 2009). Studies of this nature fuel the controversy surrounding the role of medication and highlight the importance of the EP in eliciting and incorporating the child's voice to inform the conclusions being made about them (Hill & Turner, 2016). Sawyer et al. (2004) suggest that further clarity in legislative guidelines may improve diagnostic and intervention processes and state that additional research of these processes is needed. Massuti et al. (2021) argue that the dispute between supporters and opposers of medication should be addressed through further integration of evidence-based medical and parental education into public health policies.

Moore et al. (2019) conducted a review of four systematic reviews that included 138 studies, to evaluate the effects of non-pharmacological, school-based interventions for ADHD. The three identified interventions were categorised as either behavioural, neurofeedback or cognitive training. The authors explained that although some positive effects were found for behavioural and academic studies, the effectiveness and implementation of such interventions were heavily meditated by contextual factors that were the quality of teacher-child and child-peer relationships, the socially constructed attributions made about the cause of ADHD, and the social stigma surrounding ADHD.

In consideration of the reviewed literature it appears that in ADHD processes, the provision of information necessary for children's decision-making is lacking, as are the corresponding processes for the elicitation and consideration of children's views. The provision of information about ADHD for children appears to be a distinct limitation in some of the studies seeking children's views that are reviewed above (Honkasilta et al., 2016;

Kendall et al., 2003; Moldavsky & Sayal, 2013; Rashid et al., 2018; Travell & Visser, 2006). Whilst children in the aforementioned studies held views and were prompted to share them, it is unclear whether they were provided with the necessary information to formulate views that were useful enough to bring meaningful awareness and provide a foundation for positive change. In that light, if processes do not meet the requirements for children's rights, ill-fitting diagnosis and intervention processes will follow that place constraints on the development of children and young people's self-concept and agency. Furthermore, although it is widely recognised that the use of medication as an intervention is associated with improvements in behavioural control and academic performance (Rashid et al., 2018; Singh et al., 2010) there are guidelines for the decision making process as to whether medication should be prescribed or not.

These latest guidelines, on diagnosis and intervention processes for ADHD, were published by the National Institute for Health Care and Excellence (NICE) in 2018. The guidance will not be revisited until the year 2028 and states the importance of both including children in all treatment discussions and encouraging them to express their opinions, such as those surrounding treatment aims and outcomes. Additionally, it states that children above the age of five years, as well as young people, should only be offered medication if their ADHD symptoms are causing 'persistent and significant impairment' after the implementation and review of environmental modifications. In addition, it is emphasized that professionals involved in making decisions in intervention processes must be conscious that children's opinions will alter as they mature and therefore revisiting their opinions over time is necessary. The guidance does not, however, appear to include the importance of providing clear accessible information about ADHD to children during the

diagnosis process. This poses the question of whether the process of how children make decisions has truly been considered during the formulation of the guidance. Faltinsen et al. (2019) critically evaluated the NICE (2018) ADHD guidance on pharmacological treatments for individuals with ADHD. They argued that the NICE guidelines were formulated on the basis of systematic reviews that contained serious methodological limitations and that despite the document explaining the rationale behind decisions on whether to prescribe medication, the poor quality of the studies is not referred to and it can be assumed that patients and clinicians would not have the time to evaluate studies underlying the guidelines. They asserted that NICE made recommendations despite the evidence not being obtained from satisfactory studies and that individuals accessing this document should be made aware of this fact.

2.2 Application of the EP's role in the current context

A lack of robust and directly applicable research available was identified during the literature search for how EPs might support children and young people with a profile consistent with ADHD in the UK context. Existing government legislation and frameworks and advice applicable to the work of EPs were instead predominantly considered, in order to formulate the current section.

With regards to the discussion in this section, the aforementioned study in the field of educational and child psychology by Hill and Turner (2016) can be referred to again here, where the views of 136 EPs regarding their professional experiences in ADHD related processes were explored. Forty eight percent of EPs described experiencing diagnostic processes where contextual and systemic factors were 'never' or 'rarely'

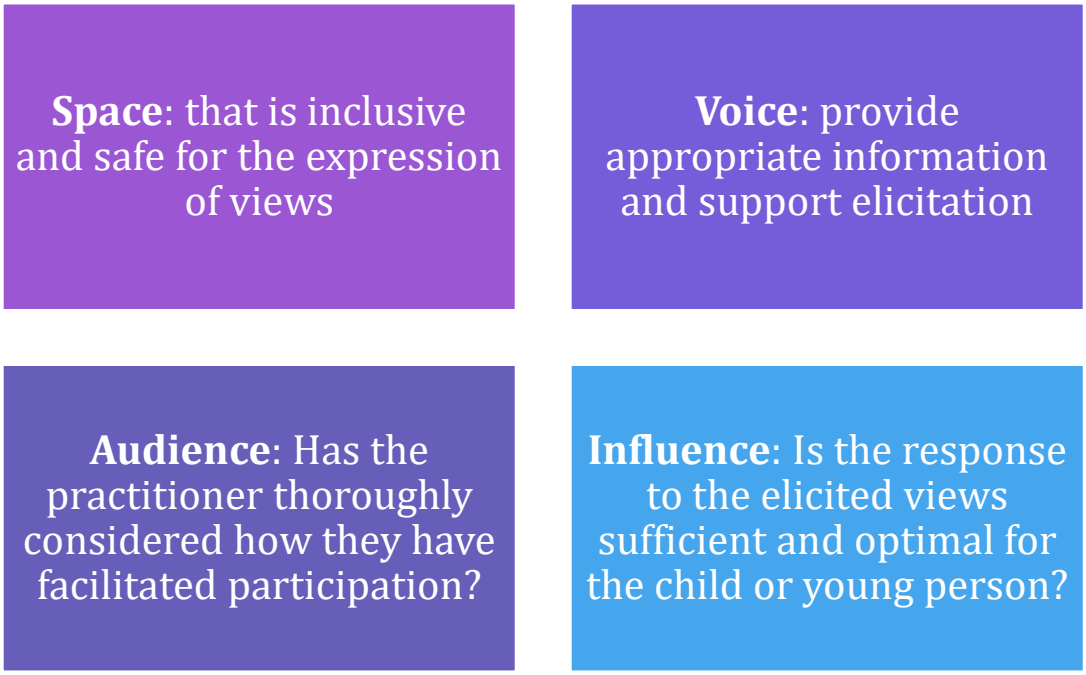
considered during diagnosis. Fifty-one per cent of EPs stated that children were ‘rarely’ or ‘never’ involved in decisions about the treatment they received.

Brady (2014) asserts that children are disempowered in sharing their voice by the narrative of their ADHD diagnosis, with their choices and perspectives construed as impulsive, lacking in focus and poor in attention. From internalising the diagnosis, a child’s sense of competency and agency may diminish. As one child from my Year One project stated: *“Sometimes people with ADHD can’t say, as much as they want to say, like it kind of jumbles up their words…”* This emphasizes the necessity for an EP to provide appropriate information that enables children and young people to establish in what ways, if any, information about ADHD may relate to them, and if so, to facilitate an understanding of why and how ADHD symptoms might relate to them. The ability to fulfil this requirement for children involved in these processes is a key responsibility for EPs under the Special Educational Needs and Disability Regulations (2014) and the Children’s Act (2004) (Hill et al., 2016). Hill and Turner (2016) assert that professionals can apply their professional knowledge and expertise to formulate creative techniques that promote an inclusive approach for children, whereby practice informs evidence. For an EP involved in the diagnostic or intervention processes of a child with ADHD, it might be useful to utilize a UNCRC-informed robust participatory framework. The framework may provide guidance on whether the child has fully participated, and whether planned intervention reflects the child’s views and context. An example of a framework that EPs might use in contemporary practice is Lundy’s Model of Participation (Lundy, 2007).

This model has been referred to by authors in informal DECP publications and in existing, recent educational psychology literature (Atkinson et al., 2019; Howells, 2021; Kay, 2019).

Lundy et al. (2011) argue that although the stipulations from the UNCRC refer to the minimum level of participation for children to be facilitated to share their voice and for their voice to be considered, it does not provide a tool that can facilitate practice. The Lundy Model of Participation (Kennan et al., 2019) expands on Article 12 and 13 of the UNCRC and proposes a more thorough process for practice whereby children must be provided with opportunities to express their opinions, be facilitated in the process of expression, and be listened to. Accordingly, Lundy's Model of Participation (see Figure 2) is comprised of four sections that provide guidance: a 'Space' that is inclusive and safe for children to express their views; 'Voice' whereby the professional must provide appropriate information to the child and support the elicitation of their views; 'Audience', which refers to the necessity of ensuring the person hearing the child's views holds appropriate responsibility to listen; and 'Influence', which emphasizes that the child's view should be considered and acted on, where possible and appropriate. Furthermore, the expressed views must be acted on in a way that is in the best interests of the child. If utilised by EPs as a participatory tool, adherence to each of the areas allows the EP to fully consider whether they have supported the child in participating. The model may be used by the EP themselves, and also used to train school staff as a technique to ensure that they are eliciting and applying pupils' voices in their settings. However, it is important to note that contextual factors such as the needs and life situation of the child and the organizational attitudes of the setting are not considered in this model (Herz & Haertel, 2016) and that it would be necessary for EPs to add these considerations themselves, using creative techniques during consultation, assessment and the development of their formulations when conducting casework.

Figure 2: Lundy's model of participation



It is important to consider the working context of the EP profession when considering how an EP might respond with methods to ensure that adequate and appropriate support is put into place when a child or young person's behaviour provokes concerns or the presence of ADHD symptoms are raised. My own professional application of working with children and young people in alternative provision settings is also drawn upon here. After the economic recession and subsequent financial cuts to English education budgets that were introduced in 2010, the number of LA EP teams implementing a partially or fully-traded model of service delivery began to increase (Lee & Woods, 2017). This means that schools and educational settings, rather than LAs, fund the services offered by EPs, making the working model of EPs more business-like and less traditional. This has shaped how EPs work as a profession and which skills they need to employ. EPs have found that they have been able to extend their service delivery beyond statutory work and work more creatively, for example through the provision of training and therapeutic work (Hardy et al., 2020).

EPs play a valuable and vital role as advocates for children and young people, and in particular those from vulnerable backgrounds, (Atkinson et al., 2011; Dunsmuir & Cobbald, 2016; Fallon et al., 2010; Hill & Turner, 2016). Their role as advocates also extends into the therapeutic approaches they apply in order to accurately support elicitation ‘Voice` and ‘Âudience’ (in Lundy’s model) and also in responding optimally to the views and experiences of children and young people through therapeutic intervention (‘Influence’ in Lundy’s model). As such, there is an ongoing conversation within the EP profession pertaining to the need to draw light on the role of the EP in working therapeutically through providing and promoting alternatives to pharmaceutical interventions in order to support the mental health and wellbeing of vulnerable and marginalised populations and in supporting key adults who care for such children and young people (Atkinson & Kenneally, 2021; Dunsmuir & Cobbald, 2016; Dunsmuir & Hardy, 2016; Hill, 2013). The EP is obliged to educate key adults about these processes as part of their role in informing professionals and caregivers to look beyond ADHD symptoms and behaviour and to look at underpinnings from an interactionist perspective. This process should be carried out with sensitivity and awareness of the need for discretion and professionalism towards such discussions, respecting the dignity of the parents and of the child or young person in the process (Dodd, 2009).

Many schools appear not to have fully understood the distinctive contribution of educational psychology services and the role of the EP as a mental health professional in providing support to children, young people, families and organisations. It is asserted that EPs have a responsibility in making schools, settings and organisations aware of the unique value they can bring through how they present and interact professionally (Fallon et

al., 2010). In order to optimise the traded model that EPs are working within, they are required to reflect on their own unique skills and competencies, professional identity and development. Through such reflection, EPs can better place the resources they have as individual professionals into effective action (Fallon et al., 2010).

Furthermore, alongside traded work, EPs have to consider competing work including statutory service demands; placing time restraints on what they can offer and the consideration of time allocation. During my work, I had considered such factors. The work I completed with children and young people was partly traded time however I also made full use of statutory work consultations, assessments, feedback and collaboration with schools and parents as a platform for putting consequent therapeutic intervention into place. Contact time was needed to build trusting relationships with both the settings and the children and young people, after which I focused increasingly on providing intervention. Intervention consisted of helping children and young people who had a profile consistent with ADHD to understand themselves and their experiences, to develop their awareness of their feelings and reactions to events, and to learn to self-regulate their emotions. I also delivered staff training in relevant areas, at times during consultations with smaller staff groups such as the senior management teams. I employed therapeutic strategies to provide co-regulation through acknowledging and validating children and young people's emotions. Through feeding back details around the attunement I provided to children and young people and their responses to key adults, the adults were supported in reflecting on their own interactions with young people and what had worked well and why. Such conversations were discussed in consultation and review meetings and referred to in consultation records. The PCP approaches used in this study were used as a platform for

the development of therapeutic conversations, facilitating self-awareness of behaviour, of the reasons for their responses to situations and how these responses could be mediated. In this way, the children and young people's unconscious beliefs were brought to their consciousness, facilitating self-awareness (Maxwell, 2006). My work was adjusted according to the different ages and cognitive abilities of the children and young people that I worked with, for example, with younger children my work was highly visual and incorporated methods such as cartoon strips to illustrate interactions between people.

When considering the literature reviewed in the first section of this chapter in addition to pertinent legislation, the following approaches might be utilised by EPs, when responding to concerns regarding children and young people whose profile is consistent with ADHD:

- Using consultation to address the necessity of awareness and consideration of key contextual factors and experiences that occur within a child or young person's development and influences their associated ecosystems impacting their neurological development and behaviour (Bronfenbrenner & Morris, 2007; Spinazzola et al., 2018, 2021);
- Promoting awareness from key adults of the child or young person's subconscious belief systems underpinning their behaviour, with regards to the social self, and their expectations of key adults and their educational setting (Dunsmuir & Cobbald, 2016);
- Promote awareness amongst key adults of the NICE ADHD guidelines (Faltinsen et al., 2019, NICE, 2018) and provide alternative non-pharmacological interventions.

- Train key adults in the social narrative surrounding ADHD, and highlighting the implications, limitations and impact of the use of medication with reference to the NICE (2018) guidelines;
- Conduct individual work with the child or young person to support their developing self-awareness
- Support key adults to elicit the child or young person's voice and update key adults as young people's views change over time and to use this to understand the underpinnings of the child or young person's behaviour (Kennan et al., 2019; Lundy, 2007);
- Key adults can be supported in reflecting on situations where they may enable the child or young people to understand their own behaviour (Dunsmuir & Hardy, 2016; MacKay et al., 2016a);
- Children and young people should receive regular therapeutic work to support them in developing age appropriate understandings of their profile of needs (Hill, 2013).

It appears that incorporating the voice of the child into ADHD processes alongside thorough consideration of their ecosystem to better understand the adaptive aspects of their behaviour, is essential in removing discrepancies between the child's views of what may support their progress and the socially constructed views of key adults in their environment.

2.3 Children's rights and interactive approaches

Over the last four decades, increasing interest in the elicitation and consideration of children's views as separate from adults is evident (James & Prout, 2003; Kennan et al., 2019; O'Kane, 2008; Waller & Bitou, 2011). This development is reflected in children's

rights as stipulated by the UNCRC being acknowledged in research (Cole-Albäck, 2019; Davis, 2019; Kindblom et al., 2020). The reviewed literature on children's views includes studies in which the majority have employed a methodology that is researcher-led. The current practitioner research study is designed to enable children and young people to interact as part of a dynamic interview process (as discussed in the methodology section of this thesis), and to embed children and young people's views into EP practice (as detailed in the discussion section).

Interactive activities employ communication tools that enhance children's abilities and competencies (Clark, 2010). Children's agendas are given primary importance through focusing on their life experiences and moving beyond the scope of conversation. Well-evidenced participatory tools include story-telling, mapping, games and drawings (O'Kane, 2008). Such tools allow children to communicate the complexities of their understanding in their own terms. Furthermore, the adult-child power imbalance is lessened, as the child has full control (Kennan et al., 2019; Simpson et al., 2021) It is argued that researcher-led activities that employ semi-structured, partly leading questions that may be interpreted as requiring correct or optimal responses place limitations on children's communication (Simpson et al., 2021).

In the current study, two PCP techniques are used as part of the interview process to enable the children and young people who took part to share their views in a meaningful way. Children and young people who have social, emotional and mental health needs may have challenges with engaging with abstract concepts, recalling and deliberating personal experiences, identification and expression of emotion and may need time to process information (Simpson et al., 2021). Personal construct techniques allow

children to express subconsciously held concepts (Moran, 2001) whilst simultaneously allowing the researcher to follow an ethical approach whereby the child or young person's dignity is respected and upheld (Cole-Albäck, 2019).

2.4 Aims and Rationale

There is complex discourse surrounding the existence of ADHD as a diagnosis. The contextual factors in a child or young person's ecosystem associated to ADHD, its related diagnostic and intervention methods, and the current legislative context contribute to this discourse.

In light of this, the aim of this study was to elicit the views of a group of children and young people who had been diagnosed with ADHD and who had experienced exclusion and placement into a Pupil Referral Unit (PRU), in order to understand their experiences and perceptions of ADHD diagnosis and intervention processes.

A sample meeting these criteria has not been identified in any of the studies in the reviewed literature. In one reviewed study by Singh (2011) some contextual background of children (specifically the school context of the children from the UK sample) was considered. Additional contextual factors were not presented.

White and Rae (2016) assert that children and young people with special educational needs and disabilities should be viewed as the experts in their own difficulties and therefore formulations of how they might be supported should be developed with them, by EPs. As a natural outcome of my findings, the children and young people's views of their own experiences and needs are considered and drawn upon in the discussion section, to inform current EP practice.

Chapter 3: Methodology

In this section of the thesis, I describe the research design, the epistemological stance, data collection and analysis processes, and ethical considerations.

The initial plan for this research study was to include three separate participant groups consisting of parents, teachers and children and young people, as detailed in the ethics application form (see Appendix G). I collected the data from all three participant groups, however there was too much data to analyse within the time frames necessary for submitting the thesis and in addition the data analysis process had begun at the start of the pandemic under strict lockdown and other very challenging personal circumstances, such as complete lack of access to any childcare or support. I then decided to focus solely on the voices of the children and young people as during the formulation of this study the most important aim was to give a voice to a particular group of children and young people.

3.1 Design

The design of this research was qualitative. Data were collected through the use of semi-structured interviews and participatory tools.

3.1.1 Epistemological stance

A critical realist approach to research makes the assumption that reality exists, however access to knowledge of that reality is heavily mediated by socio-cultural meanings. Both the participants' and the researcher's interpretative resources are meditating the understandings of that reality, meaning that direct access to a reality independent of human notion cannot be accessed (Bhaskar, 2020).

The voices of the children and the young people that are elicited during the data collection provide their version of reality, and the approach to analysis as part of this study

has provided an interpretation of that reality, that is mediated by the researcher's experiences and views of reality (Clarke et al., 2015).

Critical realists take the stance that social reality is composed of social structures, cultural systems and individuals that exist within them, and that mediation occurs between society and individuals. Society and culture are seen as having been formed by the activity of individuals and are continuously reinforced and particularised by the activity of individuals (Bhaskar & Hartwig, 2016).

This approach is highly compatible with the approach taken by EPs when considering the context of children and young people through the application of Bronfenbrenner's bio-ecological model (Bronfenbrenner & Morris, 2007), which was used as a basis for the development of the semi-structured interview questions and participatory techniques used in this study (Kvale, 2012). Consideration of the various systems impacting a child or young person's developmental trajectory and behavioural presentation across time, including adversity and socio-economic deprivation, is essential for EPs understandings and interventions (Slavin, 2019).

The critical realist stance takes the approach that people's words reflect their version of reality and what that reality means for them, and that their behaviour is in turn shaped by that meaning. Eliciting children and young people's views about ADHD diagnosis and intervention across time and in different contexts, as well as what the diagnosis means for them, enables an understanding of their lived experiences and the meaning that they have attached to their experiences. Furthermore, it demonstrates how these experiences shape their actions (Kvale, 2012). Although the semi-structured interview schedules for the current study were tailored to address the research questions,

the possibility of discovering and discussing new concepts that were identified from the data, was also an option for the researcher. The interview schedules for the current study were designed to probe the systems impacting on the child or young person with ADHD according to Bronfenbrenner's bio-ecological model (Bronfenbrenner & Morris, 2007). The questions were therefore initially designed to investigate:

- The outcomes of ADHD across time (chronosystem)
- Societal discourse of ADHD (macrosystem)
- Local services in place for ADHD related care (exosystem)
- The nature of relationships between the child's key people (mesosystem)
- Practices within family, school and classroom settings (microsystem).

A critical realist stance complimented the practitioner research approach and the aim of the thesis which was to conceptualise the views and experiences of children and young people with regards to their experiences of ADHD diagnosis and management processes.

Children and young people with disabilities, or who have experienced permanent exclusion from the mainstream school system are classed as vulnerable (Bright, 2017). This study was designed as emancipatory research, in that it would give a voice to children and young people who may be described as being from a vulnerable population (Kramer-Roy, 2015). The study was designed as practitioner research as I wanted to evolve ways of working for EPs that are in line with the UNCRC through the use of my skills as a trainee EP to support children and young people's well-being and self-concept during professional practice and the research process (Menter et al., 2011).

3.1.2 Reflexivity

The critical realist takes the belief that the possibility of discovering and discussing new concepts available to the researcher from the study data must involve the process of reflexivity; the researcher must recognise the impact of their own being on the formulation of new concepts. My personal and professional background may bias my interpretations whilst simultaneously bringing useful insight (Palaganas et al., 2017).

Prior to EP training, I worked as a primary school teacher in schools where children were often developing within contexts which would define them as vulnerable (Bright 2017). As such, I have been able to understand the impact, over time, of adversity and the impact of a child or young person's unmet needs leading to the medicalisation of their behaviour. I was then able, as a trainee EP working in schools (including alternative provisions teaching excluded pupils), to be part of the process of facilitating a psychologically informed view of children and young people that considers contextual factors. This enabled me to understand the vital role of the EP in diagnosis and intervention processes for behavioural disorders such as ADHD, particularly for children and young people who were likely to have experienced adversity in their contexts. Having explored and considered the literature, I view ADHD as a socially developed construct.

Additionally, my pre-existing involvement with settings may have caused the children and young people to view me as a person who is part of the setting culture, rather than an EP who was interested in understanding their views and experiences without judgement. This might also have affected the adult-child power imbalance as they may view me as an authority figure within the school staff team. This possibility was carefully considered and they were reminded throughout the process that they may end their

participation at any time during the research process, without giving reason. A ‘stop’ sign was also placed on the table, and its purpose explained, so that participants could point to it if they wanted to do so.

I also considered my abilities and their shaping my quality as a researcher, as an essential part of the research process (Dodgson, 2019). Having had varied fieldwork experience, with very positive feedback, as part of the EP training programme and previously as a primary school teacher in communicating with children and young people, I felt that my practitioner-researcher role was appropriate for my skill level. Furthermore, I had completed a year and a half of EP training in the same LA prior to the research process, which had facilitated my understandings of available services, common practices, the use of EPs by schools, intervention implementation and pupils at risk of school exclusion in that LA. Furthermore, the relationships that had been built with some of the children and young people over time through therapeutic work commissioned by the school in my role as TEP heightened my awareness of remaining vigilant to needing to provide sensitive and supportive responses during data collection.

3.2 Context

The participants were recruited from two different alternative provision settings, Setting A and Setting B, both situated in one London LA. The LA is population dense with the most recent census estimating just under 300,000 residents. The population is ethnically diverse with 30% of residents born outside of both the UK and the European Union. Of all residents, around a third were Black, Asian or other minority ethnic groups and a fifth were White, non-British residents. For a fifth of people, English was not their first language. Just

under 15% of people living in the LA had an illness or disability affecting their daily activities. The LA is ranked between 125-150 of the most deprived of 317 local authorities in the UK.

Setting A is a state special school for boys and girls aged from 11 to 16 years. The type of SEND provision is listed as Social, Emotional and Mental Health. Most of the pupils in this setting are boys and have an Education, Health and Care Plan that contains reference to their behavioural, emotional and social difficulties. A high proportion of children are disadvantaged pupils who receive extra government funding in the form of Pupil Premium having met eligibility for free school meals, or are children who are Looked After. The proportion is well above the national average. Additionally, the proportion of pupils with SEND is above average. The pupils come from a range of ethnic backgrounds, reflecting the demographics of the borough. About half of the students are of White British heritage and most other students are from Black Caribbean or African heritages. None of the pupils are in the early stages of English language acquisition.

Setting B is an alternative provision free school. The type of SEND provision is listed as Social, Emotional and Mental Health. Details of the gender distribution were unavailable, and unlisted in the most recent Ofsted report. Almost a third of the pupils are known to be eligible for the Pupil Premium government funding. Almost half of pupils are from minority ethnic backgrounds, which is higher than the national average, and reflects the demographics of the London Borough. The proportion of pupils who receive special educational needs and disabilities support is above the national average. The number of pupils who have an Educational, Health and Care Plan and/or disability is far higher than the national average. None of the pupils are in the early stages of English language acquisition.

3.3 Participants

In both settings, eligible pupils needed to meet two specific selection criteria: (1) have a formal diagnosis of ADHD and (2) permanent exclusion from a mainstream setting to alternative provision.

In order to confirm the least possible harm to participants, all of the children and young people that took part were discussed in detail with the SENDCos and heads of each setting prior to approaching them as part of the initial stage of the recruitment process (Oates et al., 2021). The SENDCos and heads of school were considered key adults in the child or young people's microsystems that held a good understanding of whether each child or young person would be appropriate to approach to take part in the study without causing any distress. There were three young people, who had experienced more extensive exclusion to the point where they were educated in a building off site from the alternative provisions and with one individual educator. Their needs were too complex and their presentations too vulnerable to be included in the sample. It was decided that these young people would not be included at all, even initially, in the recruitment process, for ethical purposes. The SENDCos and heads of settings shared their views on whether they felt that the remaining children or young people, of which there were 15 identified, would be comfortable about being approached to take part in the study and how they thought that the children and young people may react. Following discussion, none of the participants were identified as at risk of discomfort as a result of being included in the recruitment process. Once each individual prospective participant had been discussed, they were recruited by the school SEND Co-ordinator to take part in the study. All of the children and young people who were approached agreed to take part. The total number of participants recruited through invitation, for whom

signed consent was received, was 15 children and young people (12 boys, 3 girls). The youngest participant was aged 11 years, 5 months and the eldest was aged 18 years and nine months. This secondary age group was chosen as it was considered that during adolescence, children and young people may more likely have the ability and experience to consider insights into their experiences (Brinkman et al., 2012; Charach et al., 2014). The participants' gender and ethnicity were recorded alongside the pseudonyms (see Table 1) however the ages of participants have not been included in the table in order to prevent breach of confidentiality.

Table 1. Participant characteristics

Pseudonym	Gender	Ethnicity
Neeve	Female	White, English
Tintin	Male	White, English
Lionel	Male	White, English
Kieran	Male	Mixed ethnic background
Nicky	Female	Black British
Mickey	Male	White, English
Poppy	Female	White, English
Handel	Male	White and Black Caribbean
Rummy	Male	Black Caribbean

Ricardo	Male	White, English
Michael	Male	White, English
Sorbonne	Male	White, English
Mario	Male	White and Black Caribbean
Rocky	Male	White, other
Jules	Male	White, English

One of the participants had an additional diagnosis of Autism Spectrum Disorder, six of the pupils had additional diagnoses of Oppositional Defiant Disorder, and three had diagnoses of Obsessive Compulsive Disorder. As the research was emancipatory, it was essential that children and young people were included irrespective of any co-occurring diagnoses, in order to retain the value of the research in giving a voice to this particular group. It was expected that the participants may hold other diagnoses as this is often the case for children and young people who have an ADHD diagnosis (Bélanger et al., 2018). Co-occurring diagnoses were not addressed during the interview, with the focus maintained on views and experiences of ADHD processes.

All participants held an Educational, Health and Care Plan and spoke English as their first language. All the children and young people were recorded as having been permanently excluded from mainstream settings earlier in their school attendance histories. Each participant was assigned an alternative name.

3.4 Materials

The approach to eliciting children and young people's views necessitates the use of strategies that facilitate children to engage in a meaningful way, thus enhancing the quality of the study findings (Kramer-Roy, 2015). In this case, methods employing personal construct psychology (PCP) tasks were used to facilitate an interactive, dynamic interview process, where I simultaneously took the roles of both an EP and a researcher. The children's schedule (see Appendix C) was designed to understand their experiences of having a diagnosis, how they were supported in school and how they felt about any intervention processes.

The interview schedule contained semi-structured but open questions that avoided leading, biased or unclear wording and contained a last one open-ended question that asked participants whether there was anything else they would like to discuss in the context of their experiences (Hennink et al., 2020). It was not possible (due to time constraints) to formally pilot the interview schedules however some of the questions had been very similar to those in my Year One research project (discussed in the introduction of this thesis). Furthermore, following the initial interviews, the elicited data appeared to sufficiently address the research questions as comprehensive and focused discussion was established with participants.

The use of participants from two school settings under the same LA with very similar demographics aimed to capture in depth the views of children with ADHD, without having to consider varying contexts. Additionally, given the limited time scale for the research process, this decision was also made for pragmatic reasons.

3.5 Pupil tasks

The use of personal construct psychology (PCP) tasks facilitated the interactive process and enabled the children to have some choice and creativity in how they could illustrate their ideas, and in addition provided a psychological tool for conveying more complex thoughts and concepts, bringing subconscious core constructs to consciousness (Kleine et al., 2016; Moran, 2001; Williams & Hanke, 2007). Furthermore, the child co-constructs meaning with the researcher in a manner that is meaningful and that provides an accurate account of the child's views. The use of PCP methods merges well with the critical realist epistemological stance of this practitioner research, as the application of PCP tools are facilitative to enabling children to communicate the meanings of their subconscious reality.

The interview schedule was completed first, followed by two PCP tasks. The decision was made to complete the process in this order as firstly, it was considered to be likely that the children and young people might more focused at the start of the process and that an interview might be more demanding than a PCP activity. However, I recognize that the PCP tasks might have helped orientate the participants to the issues we were going to discuss in the interviews and might have primed them for it.

Secondly, I felt that it would be more optimal to begin with talking to the children and young people about themselves and their personal experiences before helping them conceptualise at a more general level. Furthermore, it was considered that interviews alone would not be sufficient to elicit the children and young people's views in depth, as some young people give very limited responses to interview questions and therefore the

PCP techniques were used to extend on what had already been said during the interview (Ponizovsky-Bergelson et al., 2019).

The two PCP tools used were ‘The Ideal Self’ and ‘The Ideal School’ (Moran, 2001) both of which I had extensively used in my practice as a TEP with other children who had or were suspected of having an ADHD diagnosis. There are a range of tools that could be used however these were chosen as it was considered that they would work effectively with the children and young people taking part in this study. In a review by (Bloom et al., 2020) criteria were used to assess the quality of tools that might be used to elicit children and young people’s voices. PCP techniques were including those used in this study were reviewed according to several criteria (p.312) which were: ‘Respects children’s rights, Promotes social inclusion, Personal centred approach, Underpinned by the social model of disability, Empowers the child, Enables active participation, Works towards benefits and overcoming challenges of implementation’. The PCP methods were found to be highly effective according to these criteria with the only disadvantage deemed to be that interpretation by and adult is necessary to interpret the annotated drawings. In the context of this practitioner research study, this was not viewed as a disadvantage as the EP has a suitable skill set to interpret the annotated drawings in a manner that facilitates children and young people to say what they otherwise may be unable to say and also share their interpretation with each child or young person in an accessible, sensitive and age appropriate way in order to provide clarity to the organisation of their internal worlds (Archer, 2022). Furthermore, it was considered on reflecting on my personal experience and understandings as a trainee EP that using PCP techniques should facilitate and extend discussion beyond semi-structured

interview processes because drawings provide a participatory reference point which is abstract and therefore more sensitive to direct questioning. Additionally the process places the child or young person as the lead in the discussion, so that they may feel they have greater autonomy over the conversation. The Ideal Self requires children to draw fictional Ideal and non-Ideal versions of themselves. For both versions, children are asked questions about the pictorial child's behaviour and their lives, and also about their future. The task for the researcher and EP in the context of practitioner research is to understand children and young people's views of themselves and to respond to them in a manner that enables the development of new understandings and possibilities (Menter et al., 2011; Moran, 2001). The Ideal School is an adaptation of Moran's (2001) Ideal Self and has been employed in various research studies where authors reported finding the technique highly valuable (Bloom et al., 2020; Williams & Hanke, 2007). Children and young people were asked to illustrate a school that they would not like to go to, whilst providing details of how the school would look physically, how they would feel when they were in the school, and the behaviour and nature of the pupils attending as well as the teaching staff. After they were asked to illustrate a school that they would like to go to, that would be their Ideal school. The same details were requested as were asked to describe the non-Ideal school. Examples of the activities are provided in Appendix G.

The necessity to adapt the method of using each PCP task to each individual child or young person was recognised, to ensure that their responses would be optimised whilst ensuring their comfort during the tasks. This differentiation was key given that these children had varying needs, abilities, strengths and bio-ecological contexts. As some of the children needed more support in engaging with the interview process, the number and style of

questions was adapted accordingly where necessary. Additionally, when relevant, a member of school staff with whom the child had a positive and supportive relationship was present, to provide comfort. All the children and young people completed the illustration of their pictures, however the researcher carefully completed all the scribing of the children's responses verbatim, so that they were not required to write at all. The accuracy of the responses was checked during transcribing of the voice recordings. During both the interview schedule and the pupil's tasks, a 'Stop' sign was kept on the table for the participants to point to in case they wanted to end the process. The use of the sign was explained at the start of the process with each child and young person.

3.6 Procedure

First, ethical approval was sought via the Department of Psychology and Human Development at IOE, UCL's Faculty of Education and Society. Only after this was achieved, were participating schools approached. Across both settings, the process was carried out as follows. First, a SENDCo information sheet was shared with the SENDCo and head teacher of each setting and a discussion about the research was held. During the discussion, the current discourse around ADHD was discussed, with particular reference to how adverse context is associated with receiving an ADHD diagnosis. Signed, informed consent was provided. Second, pupils who met the criteria, and their parents, were approached and provided with a participant and parent participant information sheet and consent form. The discussion with parents was focused on gaining children and young people's views of their experiences, and how this enables EPs to better support them. Pupils and parents provided informed consent by signing the consent forms. Finally, pupils who had signed the consent forms were interviewed.

3.7 Data analysis

There were a considerable amount of data, and therefore a specific evidence-based technique was applied to the process of thematic analysis as described by Braun and Clarke (Braun & Clarke, 2021; Clarke et al., 2015) to analyse the qualitative data. Specifically, it was first considered that for the formulation of the semi-structured interview questions, Bronfenbrenner's bio-ecological model (Bronfenbrenner & Morris, 2007) was used as a template in order to probe the systems impacting the child or young person (see Table 1). It was thought that the same use of the bio-ecological model as a template may be used for analyzing the data. For this reason, it was decided that employing a two-step hybrid approach of qualitative methods of thematic analysis (Azungah, 2018; Fereday & Muir-Cochrane, 2006) of deductive followed by inductive analysis would work well.

For the first step, deductive analysis using Bronfenbrenner's bio-ecological model as a template was carried out as an initial step of data organisation into overarching deductive themes for subsequent interpretation (Azungah, 2018).

Table 2

The first step of data analysis enabled consideration of the impacting systems using Bronfenbrenner's bio-ecological model as a template, leading to the generation of corresponding deductive themes.

Impacting system probed through interview questions	Corresponding deductive themes
• **The outcomes of ADHD across time (chronosystem)**	• My school experience • Managing my context

• **Societal discourse of ADHD (macrosystem)**	• How my behaviour is understood
• **Local services in place for ADHD related care (exosystem)**	• My experience of medication • What I need
• **The nature of relationships between the child's key people (mesosystem)**	• How my behaviour is understood • Managing my context
• **Practices within family, school and classroom settings (microsystem).**	• What I need • Managing my context

The following six overarching deductive themes were generated (see Table 2):

- 1. What ADHD looks like to me
- 2. My school experience
- 3. What I need
- 4. How my behaviour is understood
- 5. My experience of medication
- 6. Managing my context

For the second step of the analysis, an inductive thematic analysis (Braun & Clarke, 2021) whereby meaning is taken from the collected data rather than from pre-existing concepts and frameworks was conducted (see Table 3). An inductive approach was used to attempt to maintain closeness to the meanings held within the data that had been

divided into each of the six overarching deductive themes (Azungah, 2018; Fereday & Muir-Cochrane, 2006). It was however acknowledged, in line with critical realism, that a purely inductive approach is not possible to achieve as the researcher formulates the meanings from the data through their own lens of interpretation that is shaped by pre-existing theoretical assumptions, personal and professional experiences and research training and experience (Braun & Clarke, 2021; Smith, 2003).

Table 3

The second step of analysis whereby the process of thematic analysis was employed according to Braun and Clarke's model (Braun & Clarke, 2021).

Steps of the thematic Analysis	Researcher's actions
1. **Transcription of the data**	Interviews transcribed from audio by researcher and then checked.
2. **Reading and familiarisation with the data**	The data were read several times whilst listening to the audio in parallel to gain an initial overall understanding of the data, and the records from both PCP activities were reviewed to provide more detailed understandings of the implications of what the children and young people had told the researcher, notes were taken by the researcher of any initial notable ideas or points that were emerging.
3. **Generation of initial codes to describe the data pertinent to the research question**	Using a deductive framework of 6 deductive themes that corresponded with the systems probed during interview (see Table 1) an inductive approach was used for the identification and naming of initial relevant codes from the interview data and both PCP activity records. The codes were revisited and recorded in table format with corresponding data excerpts to facilitate review. The data excerpts were used to highlight and later extract quotes within them that matched with the codes.
4. **Revisit the entire data set to review repeated patterns and identify themes, formulation of**	Codes were clustered together to form initial conceptual inductive sub-themes, which could be distributed across the six pre-identified deductive themes.

conceptual themes through combination of similar codes	
5. **Inductive sub-themes revisited and revised through revisiting of the data set (codes added or removed as part of a cyclical process) followed by collation of data extracts relevant to each overarching deductive theme**	During the process of revisiting of the inductive sub-themes, the researcher considered whether the inductive sub-themes were a good fit with the data to ensure they appropriately reflected the concepts that had emerged from the data.
6. Defining and naming of inductive sub-themes Final prevalent themes linked together to form an overall story	Inductive sub-themes were named to reflect the overall concepts that had emerged from voices of the children and young people within that section of data. The inductive sub-theme names and their meanings were reviewed with the researcher's thesis supervisors.
7. **Distribution of the inductive sub-themes across the six overarching deductive themes**	The researcher, using input from the thesis supervisors, reviewed the distribution of the inductive sub-themes across the six pre-identified deductive themes to ensure a clear fit that communicated the story that had emerged from the data set.
8. **Review of the organisation of the inductive sub-themes and production of the research thesis.**	Data extracts were used in the results section of this study, in conjunction with an analytic narrative that seeks to address the research question, therefore illustrating the views and experiences of the children and young people that took part.

In the Results section, the inductive sub-themes and concepts are illustrated through direct reference to the children's and young people's views from the data set. The data set refers to both the children's responses to interview questions and their responses to the PCP activities.

3.8 Ethical considerations

The ethical considerations and procedures used throughout the research process were defined and shaped by the British Psychological Society Code of Ethics and Conduct (2014) (Oates et al., 2021), the British Educational Research Association (2018) (Race & Vidal-Hall, 2019) and the UCL Code of Conduct for Research (University College London, 2013), (see Appendix).

At the level of the school, as previously discussed, an assessment was made through discussion of the aims of the research and the profiles of the children and young people identified as appropriate for the recruitment process with both the head of settings and the SENDCos. I worked as a trainee EP in the context of the provisions and LA which meant that I had access to some additional information about the children and young people's contexts, either through consultation and case work, or in staff meetings. I did not report the information in the thesis as it was not part of the ethical clearance. However, the information that I had access to enabled me to ensure that I spoke to the children and young people in an ethical way, that is using sensitivity and challenging negative self-perception. My awareness of adversities that the children and young people may have been exposed to and the possible effects those might have had enabled me to demonstrate sensitivity during the interviews and PCP activities and informed how I spoke to the children and young people throughout the process. Furthermore, I was prepared for any conversations that may have arisen had any of the children and young people shared sensitive information, in order to provide optimal care during the interview process, as is ethically appropriate. Using this approach, the two roles of EP and researcher were combined, for the best interests of the

children and young people by responding to our interactions with care and by drawing upon my professional knowledge and skillset.

The outcome of this process was that a conclusion was made in joint collaboration with the SENDCos and heads of settings as key adults, whilst holding in mind ethical considerations and applying my expertise from my EP training that the benefits of giving a voice to these children and young people as individuals prevailed over any potential harm caused by the distress of discussing uncomfortable experiences or views.

Next, the researcher shared an information sheet and consent form, with each child through contacting them alongside the SENDCo who had established relationships with each parent or carer. Signed parental consent was acquired from parents and carers of children and young people identified to take part in the recruitment process. The consent form (Appendix) outlined the aims of the research and the handling of data and parents or carers were reminded of their right to withdraw at any point in the process.

Accordingly, for children and young people, the right to withdraw, the right to have a chosen adult present if desired and the right to stop at any point without reason during the interview process were made clear through use of the participant consent forms (Appendices E and F) and also through verbal reminders. Additionally, the aims of the research and how the data would be stored and handled were detailed in the consent form. Participants were then asked to sign the consent form, which was formulated in accessible age-appropriate language with supporting pictures, and were developed according to my experience as an EP.

A £10 voucher of thanks was provided to the children and young people, at the end of the study to thank them for taking part. This action was based on having carefully considered the possible negative consequences of using incentives with children and young people in research and avoiding this by not introducing the reward to them during the study and ensuring they were aware they could withdraw from the study at any point (Wertheimer & Miller, 2008).

3.8.1 Data protection and anonymity

Participants' data were stored confidentially in a password secured, anonymised format accessible only to the researcher and supervisors of this study. Participants had been informed through the use of information sheets and consent forms, and verbally at the start of the interviews, that the interviews were audio recorded on an electronic recording device. It was explained that this data would be transcribed into an anonymised format to ensure confidentiality and anonymity and that their names would be stored separately to the data. Each participant was allocated an alternative name and these names were used in the transcribed data. Furthermore, any reference to names, particular incidents or places that might be linked to a child or young person were not included in the transcribed data and excerpts illustrating the data were carefully reviewed to ensure that the minimisation of the risk of breeching confidentiality.

3.10 Participant care

The likelihood of psychological distress or harm was discussed and this was also considered during the development of the interview schedule, to maintain sensitive and child-appropriate communication (Smith, 2003). None of the children and young people

that were considered were identified at risk of experiencing distress in relation to the questions in the schedule and for this reason all were approached and provided with an information sheet. Children and young people were informed that they did not have to answer any questions that they did not wish to, that they had a right to withdraw at any time, and that they were welcomed to make contact to discuss any questions or concerns regarding the research process. The email contact details for the researcher and supervisors was provided. Interviews took place on site at both settings, in a room familiar to pupils, and children and young people who preferred a specific member of staff to stay with them during the interview process were encouraged to do so. Inter-personal skills were used to employ a climate of warmth and responses were formulated to be empathetic and non-judgemental. If a child or young person presented as agitated at any point they were reassured and asked whether they would like to stop the process. None of the participants during the research process asked to stop the process prior to completion. The children and young people were informed that the findings would be shared with them through their settings after the research process and the production of the report had been fully completed. After the session, they were reminded that they could contact me at any point, either through my details on the information sheet or through the SENDCo or head at their setting. Children and young people were also given information on further support services available to discuss any concerns including ChildLine. My dual role as both EP and researcher enabled the children and young people to be more familiar with recognising me and knowing of me by name, which it was hoped would reassure them in being able to initiate contact me with any questions about the research process after interviews if they wished to do so.

Chapter 4: Results

I asked the children and young people questions across six different deductive themes, as outlined in the methodology chapter of this report. Within each deductive theme, I identified inductive sub- themes, all of which address the research question: How can the understandings and experiences of ADHD diagnosis and intervention processes for children and young people be conceptualised?

Figure 3: The six pre-identified deductive themes

Note. These six overarching deductive themes were used as a framework for understanding children and young people's lived experiences and in particular how the complexities of their context might shape their views and behaviour.

Deductive theme 1: What ADHD looks like to me

Within this deductive theme, two inductive sub- themes were identified: (1) I'm hyperactive and can't stay focused, (2) It's difficult to control my anger.

Inductive sub-theme 1.1: I'm hyperactive and can't stay focused

Several children and young people associated key aspects of their ADHD with experiencing challenges with being hyperactive and sustaining concentration. With regards to hyperactivity, children and young people explained how they were impacted.

For example, Rummy described being unable to sustain focus in more stressful situations: "… I had really bad ADHD… really hyperactive… still have difficulties … to learn like I get distracted… if someone was throwing pens… I wouldn't really care… but if there was a fight… I would get distracted…". Rummy also described how someone with ADHD might behave: "…really hyperactive, or like lose attention, or get distracted, really hyper fidgeting a lot … lot of energy… So I didn't really learn much… that's just how it was…". Handel explained that he related ADHD to being told that he was hyperactive as that was what he recalled being told at the time that he received the diagnosis, and the only part that he felt impacted him. Handel: "…they [CAMHS] just said you're like hyperactive… I was so young that was the only thing I understood…".

Ricardo felt that his challenges caused him to become restless in classroom situations: "(Someone with ADHD would) Get restless… start doing what I'm doing…. Fidgeting"…I'd say it's a hyperactive thing… when the teacher says 15 minutes 'till break…I'm just walking about the class... I don't know what they're doing… I just want to get to break…" Likewise, Neeve explained how hyperactivity affected her behaviour: "…I NEVER shut up, I do not shut my mouth… I have a really bad memory…. Aarghhh… then I also have a really, really good memory…" Neeve also talked about how hyperactivity affected her friends who also had a diagnosis. "…My friends that have ADHD… three of us

on the back of the bus like [demonstrates leg bounce]…it's really annoying… you like just do it, now I'm doing it, it's not going to stop, I do not control my leg, it just happens ….”

With regards to keeping focused, several children and young people explained how they were impacted. For example, Mason noted: “… I always thought that it was about attention span… like, my brain moves a lot… constantly switching from one thing to another, it’s hard to stay focused… Unless I'm 100 percent into a task, I forget about it…” Likewise, Michael explained being unable to manage several tasks at once: “…Like I couldn’t see anything around me…I just concentrate on one thing…” Tintin felt that poor focus from ADHD affects learning. He stated: “… It [ADHD] affects me in school obviously… you can tell [people with ADHD] are always a little bit detached from what is going on, someone might be just watching, or playing with their pen, or looking away...”. Tintin also explained that his difficulties with focus impacted his ability to manage being in school. “… I was just school refusing because I find it hard to concentrate and there wasn’t really a lot of support in school so I would just go in, get thrown out my lesson… end up in isolation or detention or whatever…”.

Inductive sub-theme 1.2: It is difficult to control my anger

Children and young people discussed being unable to control their feelings of anger. For example, Sorbonne stated: “…It [ADHD] doesn’t really bother me a lot but when I get angry it’s very, very, very hard to control my anger…” When Rocky described his non-ideal self, he talked about ADHD affecting the child’s ability to control his anger: “He has got ADHD, because he is upset… doesn’t listen and is always naughty…” Mario also explained his difficulty with anger control: “When I get angry it is very, very hard for me to control my anger. I can't control my temper too much… I behave but when I get angry no

one can stop me…". Michael described being overwhelmed by anger and experiencing loss of control. "[ADHD makes you] … get frustrated quickly… that's what I think … it can get you in trouble… if I get frustrated… it wouldn't go black but like I couldn't see anything around me…"

Kip explained his belief of being able to identify ADHD through someone experiencing a consistent lack of control over their anger: "…It ADHD makes your mood different… because I've got anger issues… it just feels the same… the majority is that [anger issues]… You can tell someone has ADHD by their mood'…. Just frustrated all the time…". Handel mentioned that experiencing poor anger control had been a lifelong experience and that he had been told that it was the result of adverse experiences: "…My anger is still there like I always have anger in me… I had pre-birth traumatic experience or something like that… CAMHS told me…".

Children and young people then went on to discuss how that they felt that people in their environments do not seem to support them to manage their anger control. Mario explained having met only one teacher who helped him with controlling his anger: "They try but no one could get me. One teacher could calm me down…"

Likewise, Rocky explained having a lack of tools from the school adults to enable him to control his anger: **"**I kick doors. I break every door. I don't want to because I don't want to pay for it. Children annoy me. Pissin' me off. When I am angry they [school staff] don't give me nothing [to help me to become calmer]…". Jules spoke about a lack of support with controlling his anger in his previous school: "I get angry very quickly… I was messing about a lot, having a lot of fights I didn't think I fitted into that school".

Sorbonne described his non-ideal school and how school staff being unaware of the children's need would cause difficulties with anger control: "the pupils are forced to do stuff… the teachers are going 'do more!', even if you're trying your best….there's no resources… I would feel I can't handle that school…I wouldn't go… I would feel frustrated, angry, sad, vexed and unsure". In one positive reflection, Mario described being unable to control his anger but recalled one member of staff with whom he had a good relationship who was able to help him regulate his anger. Mario described behaviour that being allowed to leave the classroom for a short period helped control his anger: "I get hot and bothered… sometimes [I shout]… I go out the class for a little while to calm down".

Deductive theme 2: My school experience

Within this deductive theme, four inductive sub-themes were identified: (1) I was separated from everyone else, (2) They didn't want me in school, (3) They didn't trust me in school and (4) Coping with the challenges of my school environment.

Inductive sub-theme 2.1: I was separated from everyone else

Several children and young people discussed how adults in school frequently separated them from their peers and that this was the main way that they were responded to in school. Children and young people talked about the different situations in which they had been separated and how this had impacted them. Poppy talked about how she felt unhappy in her previous school setting due to being separated from other children and being placed in a class with children who appeared to have more significant needs than her own: "… School before was quite hard…not really happy there… I was in classes with about 5 or 7 other autistic children… I felt like I was kind of like the outcast because I got a

different disability to what they have, because they've got like proper severe autism, but me I've got ADHD, anxiety… they're not like me…". Nicky talked about being sent to an isolation room for any misconduct following an incident where she had a fight with another pupil in school and that this led to her being sent there every day: "…Because' I got kicked out for the fight before… they put me in the isolation room, *every day*. Obviously, you get in isolation when you're in trouble… I was in trouble a lot. Stupid things like I didn't go to detention, so you get sent to isolation the next day…".

Mickey explained experiencing separation from others in the community since early primary school. He described this process escalating from the third year of primary school to a point where he had little or no contact with his peers. He spoke about spending all his time with different teaching assistants, in an isolated room distant from his peers, and experiencing loneliness. Mickey explained:

> "…Year 3 to when I left in year 6, I was put in a tiny room this size… with bars on the windows… I don't even know why… they had that on the top floor, there was like a whiteboard… my handwriting was terrible, like I used to practice that… I had a round-the-clock teaching assistant, like a person who was assigned just to me … like most of the time, just play some games, we would talk and just things like that… from a very young age I was very good at 'conversating' with adults… how I felt about things and… convey that to an adult… I enjoyed reading and they knew that so they would leave me to read for sometimes 6 hours a day in this really clinical white room … so I was in that kind of very, very lonely space, as a child. Even for football, I would go out and I would play with my one to one [teaching assistant]…".

Inductive sub-theme 2.2: They didn't want me in school

The children and young people discussed how they felt unwanted by adults in school. Often experiencing repeated exclusions or a lack of support. Some children and young people talked about the impact of being excluded. Sorbonne explained that being placed in an alternative provision meant that he was with other children who had behavioural difficulties, which interfered with his ability to learn effectively: "… I prefer to go back to mainstream because here everyone has ADHD and stuff like that and I think the best way for me to learn would be to go back and be with other kids and stuff…". Mickey explained that the experience of being excluded caused him to leave school during the day: "… It was just very rare that I was in internal exclusion or actual exclusion… there were a lot of times where I would just walk home. I would just walk outside the school and I would just go home because… I couldn't deal with it…".

Nicky described being isolated and then passed from one educational setting to another after experiencing her first permanent exclusion: "you go in isolation when you get excluded… I got sent to another place … and another place …I was just reckless... that's why I went to so many different schools…". Nicky added that reactions to her misconduct were always either isolation or exclusion, across four different settings: "…I stayed until end of year 8 in mainstream secondary. I fucked that up…I got into a next school… the same day I went there I had a fight… They withdrew my place… then I went back to the other school and I fucked that up so they said I can't be in school, because I got kicked out for the fight before…".

Handel described how after getting arrested outside of school he was placed in isolation inside school. "… I came into school and they put me into internal exclusion… then they left me there for the day… they said they can't have me in school… then Mum said they are going to kick me out…".

Inductive sub-theme 2.3: They didn't trust me in school

Some children and young people talked about feeling distrust from adults in the school after the way that they were managed, feeling excluded as a result. Ricardo discussed how after being excluded and entering a new setting, his behaviour was closely observed and he was suspected of having intent to harm others, despite not doing so, and excluded as a result: "…They thought they want to see how I am behaving… I had something sharp…they thought I was going to hurt someone so I got permed [excluded] that day…". Handel explained that he was excluded from his school despite him being involved in antisocial behaviour outside of school, as they did not trust having him in school following that incident. Handel added how at that time his academic achievement had improved, however he felt that his efforts went unrecognised: "…In year 11 they just gave up… they kicked me out… for something I did outside of school… year 10 I improved my behaviour because I realised GCSEs so… I was like trying to do better, but then something happened outside of school, which was nothing to do with education, so they kicked me out…"

Some children and young people talked about how the way that adults behaved towards them made them feel that they were not trusted, and this led to them wanting to leave their schools. Ricardo described his non-Ideal school and related the description to his own experiences: "…the teachers would be proper strict and blame you for stuff you

didn’t do, that’s why I walk out (at my current school)… they would start arguments with me, a lot of the teachers were doing that to me [in mainstream]. In that school I would feel like, I want to jump out the window, bored, blow something up in the science lab...”.

Mickey similarly described a feeling of being unimportant and invalidated by several school settings. He explained how he was referred for different psychiatric assessments due to his difficulty with controlling his anger, rather than being supported in school, and added that the assessments had varied depending on how he happened to be coping with his environment:

> “I was told there was no money, there was no funding… there was nothing for me …I was given the idea the whole time that I was not wanted… I didn’t like that … there was nothing for me… Basically I knew I didn't want to go back there [former alternative provision] … I am being tested for Asperger’s now because my main instinct now - as before it was lashing out and being aggressive, would be to shut down and not speak. I think they just couldn't meet my needs… I was too disruptive. That’s what school A, and then school B said… the same…”

Inductive sub-theme 2.4: Coping with the challenges of my school environment

The children and young people talked about the how being placed into particular settings, either mainstream or alternative provisions, impacted them and how they often needed to find ways to adapt. Mickey talked about the level of conflict between pupils in alternative provisions for pupils with social and emotional difficulties: “It’s like the same things that happen in a time in a regular school, happen over like the course of a day [in an alternative provision]. I was with a kid … all of sudden some kids started on me… I was fighting the two of them… then this other kid just flipped… then within five minutes, we

were fighting each other…". Mickey also spoke about how he felt that the way how his school experience impacted his behaviour and ability to manage school life:

> "…I was left alone all day with a one to one… in that kind of very, very lonely space, as a child. Even for football, I would go out and I would play with my one to one… then I was just shoved into a secondary school with a thousand kids!... It was just crazy because I was just so worried that people were going to make fun of me… I tried to control every conversation… and ended up making things much worse. "

Nicky spoke about the need to defend and maintain her position in the social hierarchy in a setting consisting of young people with emotional and behavioural difficulties and how this meant that she had to demonstrate intimidating behaviour towards her peers, to prevent becoming a target for bullies. She explained: "[In a PRU] you don't want to be person that everyone picks on, especially in that kind of school… you have to have your barrier up... I wouldn't go for my detention I would be going home… I was literally like fuck you … then the next unit and the next … had to have my back up… these kids are more crazier than I am... so… I had my fight at that centre…". Nicky also explained that felt able to learn, but the environment was disruptive and disorderly, and the learning tasks were not challenging: "…the work they were giving me was just STUPID like, so it weren't even that, the work I will bang out I will do it, but there were no boundaries or principles in that unit".

Rummy described how the behavioural challenges often seen from the children and young people in pupil referral units was a hindrance to learning, despite the adults being nurturing. Rummy explained: "At my last school [PRU] it was nice they were nice but it was really distracting, really hard to learn… a lot of students used to distract the lesson… [My

non-ideal school would be]…. Messy…'distractful'…adults would be unaware and not alert… uncaring and not take their jobs seriously… the kids would be hyperactive and always distracting others…".

Lionel described how the busy school environment was overwhelming for him and affected his ability to focus and concentrate: "… I couldn't stay in mainstream… too many people in one class… it's just too much when you're trying to work on something…". Tintin explained how he became increasingly defiant and refused to attend school due to feeling uncomfortable in the school environment. He explained that in an ideal school teachers would not see their input as disciplinary, but as helping people who are struggling: "…I find it hard to concentrate and there wasn't really a lot of support in school … I would just go in, get thrown out my lesson… quite disruptive… end up in isolation or detention or whatever so I stopped going into school altogether, then after about a year I got a place here so I started coming here… its really good…".

Deductive theme 3: What I need

Within this deductive theme, two inductive sub-themes were identified: (1) I need to be helped by adults and (2) Adults need to give me ways to help myself.

Inductive sub-theme 3.1: I need to be helped by adults

Some of the children and young people explained situations where their relationships with adults had caused challenges for them.

Neeve explained how a lack of relationship with an adult had made her feel uncomfortable and had made her stop accessing CAMHS services:

> "… I don't go to CAMHS… I've had really bad experiences with like therapists… one of them got really angry with me because I didn't want to speak one day… always pushing me to speak… always trying to get me to say stuff, even when I couldn't… I literally ended up having a panic attack… because it was just like *a lot*… she just wasn't a very nice person…"

The children and young people talked a lot about the impact of experiencing a lack of support during their interactions with their teachers.

For example, Lionel talked about his interactions with teachers in his previous mainstream setting, which he felt were not positive and caused him to struggle with achieving progress: "… In mainstream the help was: ...not a lot... I could put my hand the teacher would come eventually... but they could be rude, they could just say sly comments… sometimes they would take long to come to you… "

The children and young people described the differences in how they were impacted by a key adult with whom they had a trusting relationship. They talked about how despite their behaviour, some adults persevered in caring for them and made them feel understood, and in turn, they felt more able to control their behaviour. When referring to supportive key adults who were school staff, the children and young people talked about how this tended to be unavailable in mainstream settings, and when they had experienced it, they described individual teachers who had provided this type of care.

Nicky mentioned how her behavioural progress in her current alternative provision had been facilitated by adults who appeared to show a commitment to care for her: "… Nearly all the other schools couldn't handle me… when I explode I'm an explosion and you can't control it… you might burn yourself… they [teachers and support staff] didn't

mind burning themselves because you know the end result is I will feel better and I will be calmer…".

Handel described how a particular teacher seemed to understand him and his behaviour and that this support positively impacted how he managed in school:

> "I had one teacher called Mr O, who would help me and my other friends with like behaviour issues, just like taking us out of lessons because we couldn't concentrate. He would help me focus because he knew I used to just wake up in bad moods or just angry…he could tell, so he could tell which lessons I would be going to and if I needed help".

Mickey spoke about how his relationship with his therapist helped him understand how to manage his emotions: "… It was very hard for me to not understand when to show emotion… Like if I was in front of the therapist I could speak to them about it… but like if I was angry in front of people I would just kick off…". Mickey then talked about how his improvement after joining the current PRU had been impacted by various positive relationships including one of his key teachers: "… I was failing in everything… I couldn't put any effort in… When it came to Drama I just came alive you know? There was a teacher that I really liked…".

Rummy discussed how difficulties with hyperactivity and concentration during learning were noticeably less due to the support in his current alternative provision setting: "…They do pay attention a lot… they'll come to you they'll help you out, I feel like they are really good at doing what they do… being supportive… like if you don't understand anything they'll really help you…"

Handel mentioned that his current teachers did not judge him according to his diagnosis and responded accordingly: “I have support teachers who can like tell what mood I am in, the teachers I quite laid back…they are nice… in mainstream they are formal and strict… they help you more in here … people would see ADHD and they would just think I am a problem child … so I feel like I was probably judged by that…”

Sorbonne spoke about the impact of feeling listened to prevented him from having further difficulties: “I got excluded nearly every day. Then I moved…They [my class teacher] listened to me more”.

Neeve described the difference in her impression of the intentions of the school staff in her previous school compared to her current setting: “… I changed to here because my old school was just really bad and this school, I just feel like it will help me achieve what I want to achieve a lot more…”

Lionel described a lack of connection with the teachers in his previous setting, and compared it to the current one. He talked about the impact of feeling a supportive approach from teachers: “… [I have] quite a bit [of support] in school… I have a scribe, I would call them over and they would help me... they’ll normally just come straightaway... you can like have some jokes with teachers sometimes…”

Some children and young people explained their thoughts about the need to be understood in school through engagement in the non-ideal and ideal school tasks. They talked about the importance of having positive interactions with adults in school and how this would impact pupils.

Ricardo: “[My ideal school] would not be strict but they would get along with the children. They know what you’re talking about and they listen and understand you… If I was in that school, I would feel good, I would feel understood, feel calm, not stressed, more fun.”

Handel: “… [In my non-ideal school… the adults don’t have any understanding of children… no experience, just stuck up and rude… I would feel annoyed, irritated in that school… [In the Ideal school)] everyone would be compassionate and hardworking and I would feel safe there…”

Neeve: “... [In my ideal school] The teachers are very kind, they will give you help if you need it, they understand and they actually care. They are very empathetic…”

Nicky explained how she believed how nurturing context could have prevented her earlier difficulties:

> “…[Crying] So everyone is equal and even here [current alternative provision setting], it doesn’t matter if you’re disabled …the fact that it took me so long to find this place… for people to accept me for who I am…The process just took too long… I’m pretty sure that if I came here, before everything I went through, I would be a little bit better and I wouldn’t be as bad as I am?”

Some children and young people mentioned that particular key adults had helped them regulate their emotions through understanding them at a more personal level. Mickey explained feeling helped in specific ways that met his needs and how that had left an impression: “…The people I have bonded with have made a real impression on me… I thought of two people really, who helped me in two very different ways, in ways where I was vulnerable and in ways I needed help…”

Nicky felt that her teachers spending time getting to know what helps her enabled her to control her anger better: "…It's because I am feeling emotional when I'm angry do you know what I'm trying to say? If particular teachers sit down alone and try it will calm me down… My mum has been coaching the one to one and that's why she can handle me …" Poppy spoke about how her Grandmother's approach to understanding her beyond her behavioural presentation had impacted her:

> "… [my Nan] understands my morals, my thing, but my Mum and Dad… don't really understand, what is *in me* and who I am as an individual and how I am as a young person... They just seem to look what's on the outside of me … they've never really taken the time… on the outside I may look very strong, individual, and independent… inside I'm fragile…".

Inductive sub-theme 3.2: Adults need to give me ways to help myself

Children and young people discussed how they needing ways to enable themselves to become self-aware and regulate their behaviour. They talked about the noticeable impact having ways to help themselves had impacted them and their progress. This input came in a range of ways, from different key people in the community.

Tintin explained how someone with ADHD should be supported in school. He mentioned the importance of adults sensing that a young person is no longer engaged and then actively addressing their need, while still maintaining high expectations of them as a learner:

> "…If I zone out I'm not going to put up my hand and say 'can I have some help?' I'm just going to do something else… someone [needs] to come around and prompt

> them [diagnosed children] basically… then not lowering your work, but filtering it out, like with a worksheet that's filled with questions it always comes as an overload…"

Tintin also described his view of the need for children and young people to be provided with clear and appropriate feedback about their behaviour, so that they might prompted to alter their behaviour accordingly and maintain that pathway of development: "… No one has told him [my non-ideal self] about his bad aspects, like if someone is rude and you just ignore it. So he carried on the way he is…"

Poppy discussed how her Grandmother had provided her with a tool to conceptualise and communicate her internal states, and acknowledge those states, at a time when she was experiencing strong distress, and how this changed how she managed her feelings and improved her resilience:

> "If you look at parts of my body, that's all from self-harm, that's how like, bad I was… I was on tablets, I was very suicidal… my head wasn't in the right place… My Nan was actually the one who helped… she showed me this technique, through colours… it's kind of like a more different technique so yellow is happy, blue is calm, blue choppy is like moody, red, angry and black is death… my nan would always ask me, so what colour are you today?... I would say I'm blue today Nan; she would say you're calm… another day and I would say I'm blue choppy, I'm a little bit moody… I probably had a shit day at school… "

Mickey explained how the difficulties he had with his family since early childhood and understanding who he was remained unaddressed until he received psychotherapeutic support from a therapist at CAMHS which provided him with the tools to identify and understand his internal states: "… This was the first Christmas where I got

through it and I don't feel like shit… I try to be as subjective as possible. I think it's better to think and understand what I feel… something I could not do when I was younger… finding it now is something that has really helped me…"

Mickey also talked about ways to help related behaviour that he believed the child or young person should put into place for themselves by going and supporting adults in school and making them aware that they need to be responded to in a different way:

> "…Also in school, find a teacher or someone that you know you can speak to, and let them know about it. Like that I have ADHD… and if I get too much, can you try not to make it as big of a thing as someone just kicking off… if a teacher calls you out in front of the whole class, you build resentment towards them, and it makes you feel worse about yourself, then it's hard to go back into that environment, playing up to the stereotype the teacher has already given you…"

Rocky described being aware of not having had a way to help him make himself calmer when he felt angry: **"**When I am angry they don't give me nothing [to help me to become calmer]…". Nicky spoke about how being provided with different ways to feel calmer had made a difference for her: "…It will be good for students, with disabilities, to come here, because it's so calm here, they have a calming dog in this college…"

Deductive theme 4: How my ADHD behaviour is understood

Within this deductive theme, three inductive sub-themes were identified: (1) Others see a difference, I don't (2) My ADHD behaviour is not a problem (3) My ADHD shows depending on the situation.

Inductive sub-theme 4.1: Others see a difference, I don't

Some children and young people explained that they had had to accept that key adults perceived their behaviour as ADHD-related, even though they did not perceive themselves as having ADHD. Lionel explained that the key adults at home and school perceived him as having ADHD: "I feel normal but… I don't see a difference clearly but, everyone else [parents, teachers] does… when I say that, like fidgety, moving about, stuff like hyperactive, but I just… I just don't see it… and when I think of someone with ADHD I don't think of myself…"

Nicky explained that her behaviour being understood as ADHD appeared to be more significant to her mother. Her narrative appeared to be influenced by her mother:

> "... [My mum] she is very pro-ADHD she is in Facebook groups with kids' parents where their children have ADHD … and I have to know about myself… I still don't know that much about it… now I will accept that I have got ADHD now before I never accepted it, I thought fine I will accept it, it's really not that bad, it's really not that deep…".

The children and young people also talked about how their behaviour was perceived by peers and how this impacted them. Neeve expressed discomfort about how she was viewed by peers and attributed that to ADHD: "… To be honest it [ADHD] doesn't *really* make a difference, like I am like still myself, like people expect you to be completely different, because you have this [ADHD], like, you have this [ADHD]". Nicky explained that having ADHD in mainstream caused her to be viewed and treated differently by peers and this concern was removed at her current alternative provision, as many others had diagnoses: "You don't actually have to be insecure here, there is no reason for you to be

insecure because everyone is different in their own ways and everyone can actually accept it that we are different, it's not that deep…".

Poppy attributed her ADHD symptom behaviour, despite being positive, as annoying to peers without a diagnosis and being misunderstood by others in her environment: "People are like 'oh why are you so happy all the time, always talking, jumping around and active?' ...When people don't get things, I feel like you can't be friends because they don't understand...I think it kind of confuses them as well." Poppy also described having to manage comments from peers:

> "… [If people know I have ADHD] Sometimes generally they probably might take the piss. Like oh you're mad, you're crazy… I don't want to get into trouble… I say things that I think I need to say, because I can hear them [peers] talking about me and I can hear them so it just gets me really agitated...".

Inductive sub-theme 4.2: My ADHD behaviour is not a problem

Several children and young people believed that their ADHD related behaviours were unproblematic and could be perceived as positive. Ricardo felt that having ADHD was contributory to him feeling happy and feeling enthusiastic, and that he could justify this less commonly found part of his presentation through attributing it to ADHD: "Having ADHD isn't a bad thing... I feel like it is making me more excited about something in a game and smiling and I feel like that is something it is helping me with because I like to be happy."

Poppy described a distinction between being hyperactive and being full of energy as a consequence of feeling enthusiasm and enjoyment. Poppy explained that being

diagnosed with a disability and consequently being labelled as different to others was the part of ADHD that made her feel uncomfortable:

> "…I've got a disability… ADHD… Me? I'm normal… I'm rarely hyperactive… when I'm in a good lesson then, I'm just bursting with energy… being different from everyone else [is the less good part of ADHD]… ADHD doesn't mean I'm a different person… I've still got my looks… my personality… my identity...".

Inductive sub-theme 4.3: My ADHD shows depending on the situation

Some children and young people felt that a person with ADHD is different in ways that may explain their challenges with learning. Tintin explained experiencing ADHD at different times in different situations. He described being most impacted in learning situations: "I just see it [ADHD) as I'm quite hyperactive, but I'm not hyperactive all the time… just in normal situations… also like struggling to read and concentrate on quite a lot of stuff…". Tintin then referred to ADHD as an accepted life-long specific challenge with reading, however in this instance Tintin felt that this ADHD challenge did not exist at primary age, when he described himself as an able reader. Tintin spoke about his challenges beginning in secondary school and then decided that he had become used to them as he 'had always lived with them' despite explaining that such challenges were absent at primary age:

> "…. I used to read… I read the Lord of the Rings … but then when I got to year 7… it started diminishing… I just find it really hard to like concentrate on the words and not kind of lose track… I always thought it was because of ADHD…I've always lived with it so I don't mind… it's not really affecting me for a long time… it affects me in school obviously…".

Deductive subtheme 5: ADHD and medication

Within this deductive sub-theme, two inductive sub-themes were identified: (1) Maybe I need it, maybe I don't (2) Negative effects.

Inductive sub-theme 5.1: Maybe I need it, maybe I don't

Several children and young people communicated how they were unclear about the purpose and effects of taking prescribed medication for ADHD, for different reasons. Jules believed that his prescribed medication for ADHD was to relieve his feelings of anger, as one of his main perceptions of having ADHD was being unable to regulate his feelings of anger: "I got medication, I think it is… for my anger and my ADHD but they just gave me one tablet…". Tintin spoke about not noticing any effects of taking medication and therefore being unsure of the purpose of taking it: "…I think I got prescribed lots of different medication [for ADHD], to see which one worked but none of them worked… I didn't really feel the difference and I didn't really want to be taking medication if it wasn't helping so I just stopped taking it…".

Kip described uncomfortable effects from taking ADHD medication and also talked about being used to the effects:

> "…I didn't take it today cos I couldn't be arsed... to take it… it's kind of boring… I get a weird sense in my stomach… but it's just like a normal thing it goes away… It's not BAD but …it's 7 years now I got used to it…. My mood calmed down…"

Some children and young people, such as Ricardo, described taking their medication being dependent on whether key adults felt that they needed it: "I supposed to be taking tablets or something like that… but my Mum don't think I need them…". Handel explained that he had been given medication since early secondary age as a way to

manage his behaviour in school: "… Mainstream wasn't the best… until year eight I was on medication most of my time… If I wasn't on medication the whole time they (school staff) probably would have kicked me out…".

Poppy explained that after initially taking medication, her mother decided to discontinue it: "… I was put on medication, age seven or eight then I think my Mum made the decision to take me off of it…". Kip explained that he continued to take medication for ADHD following the wishes of his mother: "… My mum and the person who prescribed it said you *have* to take it… My mum doesn't want me to stop taking medication…". Similarly, Lionel spoke about how he was expected to take the medication, despite him not experiencing any effect, as his parents and school staff wanted him to: "…I can't see the difference if I don't take it ... a lot of other people [mother and teachers] can...". Michael explained that his mother gave him the permission to discontinue the ADHD medication as he wanted to stop: "…I took them at the end of key stage 3 then I stopped… [My mum] said if you don't want to take them I don't have to…".

Inductive sub-theme 5.2: Negative effects

Mickey explained being uncomfortable about the known side effects of ADHD-related medication and refused to take it: "…I heard about the side effects so I said no…". Indeed, various children and young children talked about how they felt that medication for ADHD had a negative impact on them. Kip narrated:

> "… I would give myself a 7 out of 10 for how good I was before medication… After medication I was a 2… my body just completely changed… after the medication I felt completely different… I took it, but sometimes I don't want to take it…"

Sorbonne talked about the adverse impact of the medication on their appetite: "…My mum puts it [medication] in my breakfast …it makes me feel a little bit tired…". Likewise, Louis mentioned being unable to eat due to the effects of the ADHD medication: "… When I take my medication… it stops my hunger... I can't eat…".

Michael felt that the medication made him feel a sense of disconnect from himself and explained how his mother supported his decision to stop taking the medication for this reason: "… I don't like taking it because I don't feel myself… I feel like because I'm not being myself…I'm trying to be myself, but I can't be myself because I've took it… then I either act worse or I just act really weird...I might be more fidgety…".

Handel also explained that taking medication caused him to feel a sense of disconnect from himself, in addition to loss of appetite. He described that medication was the only tool that he had been provided with to mediate his behaviour, and that at the same time the result of discontinuing the ADHD medication caused negative impacts to his education:

> "I was going to CAMHS… they just gave me some ADHD medication that was it… I realised that I don't like it [the medication] so… I used to do like I was taking them but I was hiding them… then I would get like three or four detentions… then my Mum would realise… oh… you're not taking them [the medication]… I couldn't eat nothing when I was taking them …my appetite went away… I just felt low… I didn't feel like myself, I just felt controlled… I don't take the medication anymore. So they kicked me out in December time and in that [mainstream] school I was meant to do 10 GCSEs last year I think … because I come here, I couldn't do all of them…".

When describing the non-ideal self, Rocky spoke in the third person about having to unwillingly take medication for ADHD, describing the cause of hyperactivity in the person as a negative impact of the medication: “The sad one [non-ideal self]…has got ADHD because he is upset… [He] is on medication and that makes him hyper… in the future he will be homeless because he was naughty at school…” . Rocky also explained what was “less good” about ADHD: “…They put you on medicine…”.

One young person, Jules, spoke about how the impact of the medication had helped him manage his behaviour at school, but that overall he did not think that young people with ADHD should take medication: “…I still take it, now I am on a higher dose, I take it every day… It calms me down sometimes… I probably get in a bit less fights if I have it. I don’t think kids with ADHD should have it …”.

Deductive theme 6: Managing my context

Within this deductive theme, one main inductive sub-theme was identified: Your home life affects you.

Inductive sub-theme 6: Your home life affects you

The children and young people spoke about how their home environment and their family can have an impact on how they feel and behave. Jules, who had mentioned his anger being related to ADHD, talked about how context affected him: “I get angry very quickly… too many people in my house…”. Mario described the effect of being mistreated and uncared for on his non-ideal self: “The kid [the non-ideal self] is nasty, evil, not fair, disrespectful, and rude. He had a bad upbringing, bad teachers, bad parents, they didn't listen to him. Doesn't have a school bag…".

Poppy spoke about differing factors in the home life of her ideal self and how she overcame a challenging upbringing through secure relationships with various people, despite feeling fearful about not being accepted in her peer group:

> "She is very skilled with her family, and treats them with respect… She is good with her friends they are select, but very close. She most fears loneliness and rejection. The way she grew up was not great, she was bullied and criticised generally about herself… but she had good friends…".

Poppy explained that her ideal-self would have developed that way due to being a person who had a very different upbringing to her non-ideal self: "[My ideal-self] carries "educational books" in her bag, and grew up with a good upbringing, with love and support… [my non-ideal self] had a bad background… kind of like abusive… verbal abuse…swearing…".

Following from Poppy's description, during the ideal-self task, the children and young people spoke about contextual factors negatively impacting behaviour. The behaviour consisted of both antisocial actions and a poor attitude towards school and learning. Additionally, they described a well-behaved ideal self who is educationally successful and experiences positive well-being, having grown up in a supportive and nurturing family. For example, Kip explained the home life of his non-ideal self and the possible outcomes that he felt might occur without this person receiving support:

> "…He is moody…nasty… [because] his family fights every day… his father came back drunk every day… he's got one brother, three sisters and two fathers… he carries a knife and drugs in his bag, he's going to be an alcoholic and a drug addict, and that's how he will die…".

There was a stark contrast in how Kip spoke about his ideal-self, who Kip explained had developed in a positive way of growing up with privilege and positivity:

> "… The stepfather is better than the father… he hates his family, he is scared of everyone, so he's evil, unkind, disloyal, moody… he's a nasty person…[My ideal-self] he's got a gleaming face, he's happy, he's kind, he lived with a rich family, his parents were very joyful… he is scared of nothing…".

Lionel described the behaviour and context of his non-ideal self and listed some possible adverse contextual reasons, such as mistreatment, as to why the person had developed poorly:

> "… He's got a stupid face…he's naughty, clumsy, in his bag he's got a scary mask and a slingshot because he's stupid… he must have had a hard time… people could have passed away…people could have treated him badly, people could have taught him up like this…".

Rummy explained how having poor role models had impacted how his non-ideal self-had developed and caused him to behave in a destructive way:

> "… He [non-ideal self] grew up with gang members raising him… Maybe he was born angry… always with negative people and choosing the wrong path. He is disrespectful and horrible to his family, no manners. He is anti-social, rude, depressed, really not energetic, sluggish… cold-hearted and doesn't care about others… carries weapons and guns…".

Rummy then described his ideal self. When describing this version, he related the ideal development of the person entirely to having been raised in a caring and nurturing family:

"...Personality would be kind, loving, likeable, determined, ambitious, nice, caring, co-operative and reflective. Towards family he would be respectful, very caring and love-able and the same with his friends. He grew up in a caring family and was raised with manners and respect...".

Nicky explained about how she felt the behaviour of her non-ideal self was impacted by having to cope with a poor, neglectful relationship with her mother who was a single parent:

"…She doesn't have a good relationship with her mother, so she is kind of like a loose cannon, gets caught up in things that she's not supposed to… no sort of education, poor choice of friends… When she was growing up she had a single Mum… she wasn't getting that much attention that she was supposed to get at her age…she is unhappy, she is bitchy, lacks communication, so she is angry because she don't know how to speak, feels quite isolated… In her bag you would see contraband, everything besides her books, yeah... She doesn't have things she actually needs, just things she's not supposed to have at her age… That just explains everything… For her birthday she would want drugs. She treats her family horribly, disrespectful, don't listen, a rebel, don't come home… She is scared of the Police and of herself, because she knows what she is doing to herself is harming her, but she's not trying to fix it…".

Mickey similarly spoke about how he felt that the way a child is treated impacts on their perspectives, and in turn their behaviour: "I know that I am a product of my environment, I don't think there is such a thing as a bad child... ".

Handel discussed how experiencing poor anger control had been a lifelong experience and that he had been told that it was the result of adverse experiences. Although he talked about having poor anger control alongside his challenges with ADHD, he had attributed his anger to a different cause based on what he had been told by professionals: "…My anger is still there like I always have anger in me… I had pre-birth traumatic experience or something like that… CAMHS told me…".

Chapter 5: Discussion

This chapter begins with a general review of the findings. To address the research questions, the findings within each of the six deductive themes are discussed in the context of existing psychological theory and literature, before the implications of the findings for EP practice are suggested. Strengths and limitations of the study, as well as suggestions for further research, are presented.

From the perspective of EPs, the medical model of ADHD diagnosis focuses on behavioural presentation, without the use of any scientific baseline, and places factors underpinning behaviour as a biological deficit within the child (Hill & Turner, 2016). The contrasting approach deployed by many EPs is to instead consider contextual factors in the child or young person's ecosystem, across childhood, which may underpin their developmental trajectory and resulting behaviour. Within the group of children and young people included in this study, that consideration was of even greater significance based on their narratives about their life experiences. For that reason, using Bronfenbrenner's bio-ecological model, I identified significant factors across the child's systems to question them about six key deductive themes, with the aim of gaining a holistic picture of the contextual complexities underpinning their experiences and understanding of their behaviour and diagnosis. These six deductive themes were: What ADHD looks like to me, My school experience, What I need, How my behaviour is understood, My experience of medication, and Managing my context. The continuous interdependence between the systems of the bio-ecological model enables the opportunity to develop an overall understanding of the experiences of the children and young people in the study.

5.1 What ADHD looks like to me

Within this deductive theme, there were many findings that aligned with the reviewed literature. For example, children and young people in this study referred to ADHD as an inherent cause of their inability to sustain focused concentration and having poor control over their actions and their minds. These findings were also noted in the studies by Singh (2011) and Padilla-Petry et al. (2018) where children and young people described having very similar challenges.

In the same way, Brady (2014) found that when talking to children and young people about how their ADHD affected them in school, they appeared to mobilise a medical model of ADHD as a phenomenon that impacts them beyond their own control through effects on their cognition. They also talked about the impact of ADHD on their behaviour as a challenge beyond their control.

At other times, as observed in the children and young people's views in Brady's (2014) study they also presented views that were contradictory to ADHD being a medical disorder. The children and young people in this study referred to an uncontrollable impact of ADHD on their behaviour, whilst in parallel, referring to ADHD as a label that perhaps justified their need for support from teachers during learning situations. Moreover, such challenges posed by ADHD in learning situations appeared not to be an issue for children and young people when they felt understood or were being provided with learning support.

These views are similar to those highlighted in the studies by Brady (2014) and Singh (2011) where the authors found that diagnosed children neither accepted nor rejected the concept of ADHD as a medical disorder. For example, in the study by Singh (2011), a 'performance niche' was identified whereby children focused on ADHD as

negatively impacting on academic performance and achievement and a ‘conduct niche’ was identified that represented a view of ADHD as a behavioural disorder that manifests as aggression and anger. The children and young people in this study referred to ADHD causing difficulties with anger control, and that these difficulties were beyond their control. However they fluctuated between ADHD explaining their anger control difficulties and explanations of contextual factors, such as not feeling understood, as the cause. In the same light, a young person in the study by Padilla-Petry et al. (2018) talked about how ADHD medication altered his behaviour so that it was more positively viewed by his parents and the school and then referred to the possibility of his parents being prescribed medication to calm down, as opposed to himself. Padilla-Petry et al. also discussed that the young people who participated in their study had recalled demonstrating behaviour that was deemed problematic for both themselves and others and led them to feel ashamed about their own behaviour. Furthermore, the authors asserted that children and young people had interpreted their own unwanted behaviour as an expression of ADHD as a result of what they had been told by key adults in their ecosystem.

Singh identified that the children in their study did not personally believe that their unwanted behaviour was beyond their own control, however they were aware that adults did. Accordingly, children explained mobilising their diagnosis as a tool for excusing poor behaviour, relieving them of accountability. Similarly, the children and young people in this study appeared to justify the behavioural outcomes of their difficulties with anger control through using their diagnosis.

A study by Wiener et al., (2012) also suggested similar inconsistencies in descriptions of children's self-reported ADHD behaviour. The children shared feeling uncomfortable about their problematic behaviour and talked about it being beyond their own control. At the same time the children in the study rated their other less problematic ADHD related behaviours as less severe than their teachers and parents.

Singh's findings also highlighted the cultural subjectivity of ADHD, where children from the United States were less likely to disclose their diagnosis and were more often identified as holding a 'performance niche' construction. In contrast, children in the UK more typically held a 'conduct niche', which was often described by children as a consequence of ADHD and therefore beyond their own control, and the findings in this study also suggest that the children and young people held a conduct niche. A possible reason for this finding may be that ADHD is less commonly diagnosed in the UK with thresholds for meeting symptom criteria being higher (Danielson et al., 2018; Schwarz & Cohen, 2013).

The references to ADHD causing impacting anger control found in this study is consistent with previous literature (Brady, 2014; Moldavsky & Sayal, 2013; Padilla-Petry et al., 2018; I. Singh, 2011) and with the findings from my year one project. It appeared that the children and young people in this study wanted support with anger control and had felt that they had received this support when they interacted with specific teachers and at times with other key adults in their microsystem who understood them. They referred to improved abilities to self-regulate, or learning how to self-regulate, and to engage with learning tasks when supported by these adults.

It is possible, that for the children and young people in this study, positive relationships made in the alternative provisions through access to higher levels of individualised support

might have encouraged the development of self-awareness through access to experiences that have enabled them to better mediate their behaviour and enabled them to form trusting relationships (Michael & Frederickson, 2013). This was inferred through children and young people referring to an improvement in their behaviour as a result of holding positive relationships with staff. Similarly, Singh (2011) asserted that a child's cognitive and behavioural capabilities are inextricably linked with relational expectations. In turn, these expectations can motivate behavioural self-control. Singh noted that children reported making decisions to fight when they felt obliged, as they felt that there was no other option. Singh also reported that at other times, children mobilized their diagnosis of ADHD as a reason to avoid fighting in conflict situations. In line with such findings, in this study, the children and young people talked about ADHD as a medical construct causing poor anger control, whilst in parallel they showed a clear awareness of how either access to or lack of resources in their school or home contexts might mediate their behaviour.

5.2 My school experience

Children and young people with ADHD are far more likely to experience school exclusion (Parker et al., 2015) due to their anger or aggressive behaviour. As such, it is perhaps unsurprising that the children and young people in the current study described feeling that key adults in their school context responded to their needs and behaviour by separating them from their peers and eventually from the school community. They described either being placed in isolation on school premises, having a fixed term exclusion (often with no information about whether they would be re-joining school or being sent to a new setting) or being permanently excluded (and having to wait to find another setting that would accept them). As reflected in other studies (Michael & Frederickson,

2013) the key narrative of the participants in this study illustrated a strong sense of feeling unwanted, isolated and distrusted by key adults in their microsystem, often as a result of being involved in disruptive or aggressive behaviour and being seen as a risk to others.

The Department for Education (DfE, 2017) describe fixed-term and permanent exclusions, including internal exclusionary systems such as internal exclusion rooms or managed moves (Stanforth & Rose, 2020) as a “last resort” solution to disruptive behaviour that may place the pupil themselves or other pupils at risk. Internal exclusion rooms, or isolation units, are documented to exist in many British schools, with limited guidelines surrounding their use or evidence of their effectiveness. One of the requirements in the statutory guidance (DfE, 2017) on managing school exclusion is that decisions should be in line with the European Convention on Human Rights (Sealy et al., 2021). It appears from the experiences that the children and young people in this study had, this requirement is not being met in contemporary practice in some educational settings.

The DfE (2019) Timpson Review for exclusion (Graham et al., 2019) highlighted that 78% of pupils who had experienced permanent exclusion were children and young people who had been categorised as ‘in need’, in receipt of Pupil Premium or had a previously identified special educational need. Eleven per cent of all permanent exclusions had been to children and young people who met the criteria for all three characteristics (DfE, 2019). Sealy et al., (2021) assert that despite the DfE (2017) guidance stating that children and young people who are from groups identified as vulnerable to exclusion should be fairly treated, children who have special needs and who are from socio-economically disadvantaged backgrounds or meet other criteria are at far higher risk. The Timpson

Review acknowledges and reports these findings, however the use of exclusion is promoted in the document as an important constituent of school behaviour management (Sealy et al., 2021). As a policy that is at macrosystem level, when considering the child's ecosystem, it is a concern that the risk factors in a child's developmental background have not been taken into consideration.

That is, frameworks for regulating exclusions appear not to sufficiently consider the impact of life experiences on behaviours that might lead to exclusion. This would indicate the necessity for different responses to such experiences and behaviours.

The implications of this approach were starkly narrated by the children and young people in this study.

Stanforth and Rose (2020) conducted a study exploring the discourse of teachers and peers on internal exclusions. The authors highlighted language surrounding the construction of challenging pupils who had experienced exclusion. Terms used by teachers and the pupil's peers to describe challenging pupils included "difficult", "disruptive", "hyper" and "unmanageable problem" with their behaviour being classified as "deliberate" and them no longer "deserving" to be part of the group (p.1260), as their peers had become negatively impacted victims of their disruptive behaviour. The authors also stated identifying feelings of powerlessness among teaching staff in including challenging pupils through narrative such "no matter what you do" (p.1260). The authors asserted how these findings indicated a within-child interpretation of behaviour rather than a consideration of contextual factors, which likely fuelled the culture of exclusion. These findings resonated with the experiences that the children and young people in this study shared, of being communicated with and treated in a way that indicated a lack of trust from others, feelings

of being unwanted in school and a sense that key adults in their microsystem had ‘given up’ on them.

The adverse life outcomes highlighted in research (Pirrie et al., 2011) of children and young people who have experienced exclusion coincide with those identified in the outcomes of those seen in the long-term trajectories of ADHD diagnosed individuals (Arnold et al., 2020) and also in the maladaptive behaviours of the children and young people in this study. Children and young people in this study talked about how they had coped with internal and exclusion, describing escalating patterns of behaviour that included, an inability to manage social interaction, further defiance, periods without any access to education, using aggression as a resilience mechanism to cope with being grouped with other children who had been excluded, and experiencing a decline in their mental health.

The children and young people in this study had experienced various adversities during their development and referred to situations where their emotional needs had been met by an adult who they felt understood them. At the same time, they referred to adults who had not understood them and had responded to their needs by separating or excluding them, they described the adverse impact of this treatment on their emotional wellbeing. A report from the Centre for Mental Health (2020) explained that children who had experienced adverse childhood experiences were at particular risk of experiencing psychological harm from being placed in isolation, possibly triggering their experiences of relational trauma (Wall, 2021). Sealy et al. (2021) asserted that the internal isolation systems were built around a culture of obedience and conformity to discipline. Such a strategy entirely overlooks the emotional containment that children who have experienced

trauma and demonstrate disruptive behaviour are looking for (McLoughlin, 2010; Spinazzola et al., 2018). Trauma literature asserts the necessity for ‘connection before correction’ in enabling positive change for traumatised children and young people (Golding, 2015). Emotional containment according to Bion’s psychological theory (Szykierski, 2010) describes the process of the mother acting as a container for the child’s behavioural projections by interpreting them, giving them meaning and returning them to the child in a nurturing way that enables them to make sense of their experience, therefore helping them to feel contained. Children and young people look for this same process, of gaining containment, from key adults (McLoughlin, 2010).

The findings in this area also draw attention to the possibilities of key school adults of the children and young people in this study experiencing compassion fatigue as a result of high levels of emotional labour from trying to show compassion to pupils who have a multitude of challenges within their context (Hoffman et al., 2007; Stanforth & Rose, 2020). Children and young people in the current study spoke about expecting to be part of the school community and yet experiencing marginalisation and rejection. Studies have indicated that in some situations such as where teachers experience compassion fatigue from being in schools with a higher frequency of the need to report suspected child abuse, compassion fatigue leads to psychological disengagement from pupils and negative attitudes towards reporting abuse (Hupe & Stevenson, 2019).

Teachers who work with children who have experienced traumatic events are susceptible to secondary traumatic stress (Sharp Donahoo et al., 2018), and teachers who are empathetic, compassionate, and hardworking appear to be the most vulnerable (Krop, 2013).

The children and young people in the current study had come from contexts with various adversities. In line with the literature, it was likely that the challenge for key adults of needing to emotionally contain both them and also themselves may have instigated feelings of powerlessness and disengagement. Current literature pertinent to the study findings highlights the influence of the ADHD label on teachers' perceptions of children and young people's behaviour and the possibility that the ADHD label may lead to bias (Moldavsky & Sayal, 2013; Padilla-Petry et al., 2018). In a Canadian study (Ohan et al., 2011) 34 primary school teachers were asked to read different vignettes of the behaviour of children who met the symptom criteria for ADHD. The difference between the vignettes was either gender of the child, or the presence or absence of and ADHD diagnosis. The authors found that the vignettes describing the behaviour of children with an ADHD label were perceived as more serious with an expressed belief that the child would be more disruptive, that the impact on them as a teacher by this child would be distressing, that they had lower confidence in their competencies of being able to successfully manage these children and that they would be more likely to implement special educational needs measures and support medication. Additionally, teachers have been found to be more likely to view the behaviour of boys with an ADHD label in this manner rather than girls (Biederman et al., 2002; Isaksson et al., 2020) and this appears to be reflected in the gender ratio of boys to girls in this study sample. Diagnosed girls appear to be more often described as more cooperative, less oppositional, introverted and passive (inattentive ADHD symptoms) in their behaviour triggering a different response from their teachers (Hjörne & Evaldsson, 2015).

5.3 What I need

The concept of children and young people seeking emotional containment (as previously discussed) appears to apply strongly to this area of data where children and young people had clear notions of wanting to be contained by key adults, and noticing the impact on their own behaviour when they had interacted with adults who were successful in providing emotional containment for them. From a therapeutic lens, when considering children and young people who have experienced trauma, containment from a key adult is thought to occur when a person receives and understands the emotional communication of another (for example, in the form of challenging or disruptive behaviour) without being overwhelmed by it, and then communicates their interpretation of the emotional communication back to the child or young person in a nurturing way (Douglas, 2007; McLoughlin, 2010). This emotional containment process can reinstate the capability to think in the child or young person. For example, they will be in a position to regulate their behaviour, and choose an action that will enable progression (Spinazzola et al., 2018; Van der Kolk, 2015).

Accordingly, the children and young people in this study described the differences in their resilience in school through the impact of a key adult with whom they had a trusting relationship. They referred to the notion of feeling understood, which corresponded with feeling psychologically contained. The talked about how despite their behaviour, some adults persevered in caring for them and made them feel understood, and in turn, they felt more able to control their behaviour. They also described supportive key adults in their lives understanding their needs and responding to them, through interaction and also through providing them with tools, which they could use to contain themselves. The

children and young people discussed how such support tended to be unavailable in mainstream settings, and when they had experienced it, they described individual teachers who had provided this type of care as “the only” person who could “calm me down”.

The anger control problems that the children and young people in this study had attributed to ADHD appeared to more likely be equated to an ongoing challenge with emotional distress as a result of experiencing childhood trauma (Van der Kolk, 2015), and having very little support through emotional containment from the environment, to help them to regulate that anger. It appears that children and young people in this study had mobilised their diagnosis as a way to explain their ongoing anger control challenges, whilst in parallel, being very aware of the nurture that they could sense that they needed. In this way, the children and young people demonstrated insight into their thoughts and emotions as reactions to their contextual experiences. However, it is possible that socially constructed notions of ADHD that children and young people in this study may have been exposed to, and perhaps a lack of access to EP support, may have resulted in these children and young people forming a compartmentalised story of themselves (Ringer, 2020). The medical model of ADHD seems to have been incorporated as a significant, important fact of their functioning, preventing the development of a more holistic understanding of how their lives impacted their emotional worlds and their behaviour.

For example, one child in this study, Rocky, who had experienced severe trauma referred to feeling anger during social interactions with both adults and children in his environment, and how he had not been given a tool by key adults, to support him with controlling his anger. In line with existing studies (Padilla-Petry et al., 2018), rather than exploring this narrative, this presentation was responded to by a narrative of ADHD being

the culprit behind the expression of anger, by Rocky and by key adults, rather than support mechanisms having been put into place that would facilitate both Rocky and key adults in his life to become aware of the internalised fear that triggered his aggressive outbursts. Distraction was used as a tool rather than emotional containment. This contextual factor of the impact of Rocky's adverse childhood experience would needed to have been highlighted, using an interactionist perspective; a role that EPs are well placed to fulfil (Atkinson & Kenneally, 2021). However, according to the SENDCo in the provision, Rocky had not been referred for support from an EP at any point in his time at school.

Other children and young people in the study appeared to have had similar experiences. Their narratives shifted between describing difficulties through the lens of having an ADHD diagnosis, then at other times they talked about their difficulties being a consequence of experiencing difficult emotions, such as discomfort, and these difficulties being inadequately responded to. Responses they experienced included not receiving emotional containment, sensing distrust from others, lacking the right support, exclusion, segregation and other challenging contextual factors. Through adding a behavioural diagnosis to the child's profile, ADHD and the narrative it brings appears to provoke and reinforce a fragmented sense of self, a feeling of separation between the self and one's own behaviours (Ringer, 2020). Such a process is also experienced by a child or young person who has not had the opportunity to experience containment by a key adult (McLoughlin, 2010). Experiences like these are likely to hinder a child or young person from learning to practice self-awareness and regulate their own behaviour in relation to their internal beliefs and emotions (Spinazzola et al., 2021). In a similar light where an interference in the development of sense of self is suggested, Blachman and Hinshaw

(2002) assert that children are disempowered in sharing their voice by the narrative of their diagnosis as one where their choices and perspectives are construed as impulsive, lacking in focus and poor in attention. Accordingly, from internalising the diagnosis, a child's sense of competency and agency may diminish. Psychosocial development during adolescence pertains to the establishment of a stable internal concept of the self, as an individual with domain specific identity facilitating a sense of autonomy and connectedness (Pfeifer & Berkman, 2018). Erikson's model of psychosocial development refers to the development of a consolidated form of identity during later childhood and adolescence (Orenstein & Lewis, 2022) enabled by an affinity between the young person and their social environment, through the provision of meaningful feedback that validates the internal self. Ringer (2020) argues that in light of existing studies, (which are also mirrored in this study) it can be inferred that the process of children and young people with an ADHD diagnosis forming a stable individual identity is likely interfered with by several factors. Firstly, their experience of a lack of control and trust over their mind, thoughts, emotions and behaviour (Brady, 2014) and secondly to the ambivalence that they experience with regards to their evaluation of their own functioning.

This is likely heightened further in children who have had to manage the impact of adverse contextual factors in their ecosystems.

In line with current literature (Gubi et al., 2019; J. Miller & Berger, 2021; Wassink-de Stigter et al., 2022), the findings highlight the need for teachers as key adults to be armed with awareness of how to provide emotional containment for children and young people who need it and the necessity for being able to also contain themselves. Containing themselves will prevent them from feeling overwhelmed by what is required from them in

their role so that they remain accessible to the children and young people who rely on them (Ford et al., 2018).

5.4 How my behaviour is understood

Children and young people in the current study explained that they at times had to accept that key adults (both parents and teachers) perceived their behaviour as ADHD-related, even though they did not perceive themselves that way. In addition, they felt that peers perceived their behaviour differently, which impacted them. These findings are consistent with existing literature. For example, studies of parent and teacher views often differ from the views expressed by diagnosed children. In a study of eight mothers and one father of sons diagnosed with ADHD, Harborne et al. (2004) found that parents believed ADHD to be a biological difficulty, but reported feeling that others considered psychological and social factors to be the basis for the disorder. The differences in these perspectives had several implications: parents endeavoured to encourage family members and professionals to adopt their views of ADHD as biological. Secondly, parents experienced blame from family and professionals for their child's difficulties. Furthermore, parents reported experiencing significant emotional distress due to the differences in their own views and those of others. In a larger-scale study, DosReis et al. (2010) interviewed 48 parents of 6- to 18-year-old newly diagnosed children and young people about their experiences surrounding the ADHD diagnosis. Approximately 77% described feelings of stigmatization; 44% expressed concerns about their children being labelled as problematic or "bad"; 40% shared fears that their children would be rejected or isolated; 27% held concerns that key people in the community such as teachers dismissed the seriousness of the problem and held negative views of them and their children and 20% expressed

concerns about negative media perceptions of ADHD. Furthermore, teachers also indicated concerns that children with ADHD are stigmatized. Special education needs and disabilities teachers in particular reported beliefs that diagnosed children are reluctant to disclose their diagnosis to peers and adults, hold a negative self-image, and worry about societal attitudes to ADHD (Bell, Long, Garvan, & Bussing, 2011). These findings are partly reflected in previous studies, which have suggested that children with high levels of ADHD symptoms as reporting a poorer emotional connection and lower levels of positive collaboration with their teachers than asymptomatic children (Padilla-Petry et al., 2018). Teachers also described a poorer emotional connection and viewed children with ADHD symptoms as problematic to work with in comparison to those without (Rogers, Bélanger-Lejars, Toste, & Heath, 2015; Rogers & Tannock, 2013). In contrast, Moldavsky & Sayal (2013) found that teachers who had undergone child psychology training held improved knowledge and more positive attitudes towards children with ADHD and their abilities.

A minority of the children and young people in this study also talked about their ADHD being unproblematic and low impacting, at times providing them with energy and enthusiasm. Simultaneously, however, they mobilised it as a reason for challenges with different areas of their learning. Other studies have demonstrated similar findings. Mahdi et al. (2017) interviewed groups of diagnosed young people with ADHD aged seven and above, as well as their caregivers, from five different countries. The participants discussed ADHD-related challenges such as cognitive and behavioural effects of ADHD. Additionally, the findings revealed positive features of ADHD such as excitability and enthusiasm. The sample was across five different populations, improving the generalisability of the findings. However, children and young people’s views were merged with adult’s views, making the

findings less clear. Despite this, the findings from the study do align with those from the views of children and young people in this study.

5.5 My experience of medication

Several children and young people communicated being unclear about the purpose and effects of taking prescribed medication for ADHD. They described that taking their medication was dependent on whether key adults felt that they needed it. (Charach et al., 2014; Moldavsky & Sayal, 2013; Padilla-Petry et al., 2018; Rashid et al., 2018; Walker-Noack et al., 2013). There was a clear discourse amongst the children and young children about how they felt that medication for ADHD impacted them negatively. These findings were very much in line with existing literature, where children and young people have been provided with medication and appear to feel obligated to take it, despite the negative physiological and psychological side effects of that are often experienced by children taking psycho-stimulant medication for ADHD (Carucci et al., 2021; Storebø et al., 2018; Timimi, 2014). Similarly, in existing studies, children and young people have also talked about a loss of agency from taking medication (Leyland, 2016; Padilla-Petry et al., 2018), questioning why medication is still found to be prescribed, despite statutory guidance on ADHD which clearly states that the use of medication is second line, after therapeutic intervention (Faltinsen et al., 2019). Furthermore, as asserted by Faltinsen et al. (2019), although the statutory guidance is well-intended and seeks to provide evidence based advice on optimal health care, many of the conclusions made on medication are based on systematic reviews that have methodological flaws, and this fact is not transparent to users of the guidance.

The widely acknowledged physiological and psychological negative impacts of medication on children and young people emphasises the need for a re-consideration of the use of medication. It appears that use should be child-centred, following full psychoeducation for the child or young person, their family and their educational setting (by an EP), drawing light on contextual awareness of the child's ecosystem and how it has driven behaviour. Therapeutic support should be first line in all cases, and a well-informed discussion should be provided to children and young people about the use of medication. It is interesting to see, both in the findings of this study and in existing research, that as children grow older, they opt out of medication, and in parallel their parents also share an increasing disinterest in the use of medication. As discussed in the reviewed literature it appears that the use of medication is encouraged by adults in the system to make children and young people more manageable and more adaptive to the environment, rather than addressing the psychological needs underpinning their behavioural presentation. This last suggestion is explored further in the next theme, which explores how children and young people have managed their home contexts, and how they believe their situations have impacted them.

5.6 Managing my context

The children and young people in the current study spoke about how the home environment and the family can have an impact on how they feel, develop and behave. The data in this section were very revealing, as many of the children and young people referred to adversities that may have been experienced by themselves, through the use of the PCP activities. The children and young people associated adverse situations, mostly consisting of abusive or neglectful households and maltreatment, with the development of

their non-ideal self. The non-ideal self was described as developing maladaptively, as someone with traits including low intelligence, “nasty”, “stupid”, “disrespectful”, “rude”, “depressed” and “clumsy”, and someone who has poor communication skills, poor social choices, destructive behaviour, gang affiliation, drug use or involvement in criminal activity.

The impact of socio-economic disadvantage was common in the children and young people’s discourse. They also talked about how being “poor” or having a poor family was a reason for the development of these traits and behaviours, whereas being “rich” was a common contextual circumstance described in the life of the ideal self, who is a person with traits including kindness, school success, pro-social behaviour and happiness. It appeared that the children and young people had a strong understanding, as in other themes in this study, of the impact of socio-economic disadvantage and lacking positive relationships. This is of course a factor that is widely understood in studies pertaining to child development and attachment (Choi et al., 2020; Stern & Cassidy, 2018). Children who have experienced relational adversity such as abuse, neglect and maltreatment, during childhood may not have received reciprocity and responsivity from their caregivers, consequently lacking in experiences that have provided co-regulation and thus self-regulatory skills (Dagan et al., 2022; Ensink et al., 2020; Ensink & Mayes, 2010; Fuentes-Balderrama et al., 2022; Laczkovics et al., 2020). These experiences become the child or young person’s means of gaining adult interaction and connection and at the same time lead to a high possibility of being interpreted as having ADHD symptoms (Timimi, 2014).

Houtepen et al. (2019) conducted a study where self-reports of ADHD diagnosed males with an average age of 35 years were compared with self-reports of non-diagnosed ‘at risk’ males of the same group, in order to explore the relationship between social

support and externalising behaviour. The participants with ADHD had higher levels of externalising behaviour and insecure attachment. Insecure attachment explained both anti-social and hostile behaviours. The authors suggested that attachment was a more important psychopathological risk factor for distinguishing differences between the two groups than ADHD as a risk factor. The authors suggested that psychiatric care in such cases should be focused on addressing the way that a person views themselves and others, how they experience emotional exchange in relationships with others and awareness of the extent to which they perceive being able to trust and depend on others. The disruptive behaviour seen in ADHD diagnosed children, particularly those with complex backgrounds, who are those more likely to experience eventual medicalisation and exclusion, coincides with the externalising behaviours that result from poor attachment experience. It appears that the outcomes of the adversities experienced during development by children and young people (as outlined by participants in the current study) are not sufficiently supported in schools, for a variety of reasons. Firstly, due to the discussed macrosystem level statutory guidance facilitating medicalisation and exclusion despite governmental guidance being well-intentioned, critiques by other authors (Faltinsen et al., 2019; Graham et al., 2019; Sealy et al., 2021) have highlighted weaknesses in their formulation in addition to a low level of emphasis and detail on the central importance of meeting the needs of children from high risk backgrounds. For example, the DfE (2017) guidance refers to particular consideration of fair treatment of children with more risk factors for exclusion. No further guidance or instruction on mechanisms is provided. In the NICE (2018) guidelines for ADHD, the baseline assessment for the use of medication refers to a review of whether the individual meets the

criteria for ADHD symptoms and the presence of co-existing mental health difficulties. How this process should be carried out when a child or young person has a history of trauma and the impact of the consideration process on diagnosis and medication use is not given, leaving clinicians to make a subjective judgement in the short space of time they have to assess patients (Timimi, 2014; Travell & Visser, 2006).

Developmental trauma, including both relational trauma and poverty, particularly when a child has an increasing number of ACEs (as acknowledged in the literature review section of this study) is associated with ADHD and with exclusion. A study by Choi et al. (2019) explored the impact on the social and emotional development of children who had experienced ACEs and socio-economic disadvantage. A sample of 2750 children and their parents was used. Logistic regression was used to determine the effect of ACEs alongside poverty. Early childhood adversity was associated with poor later behavioural outcomes and the authors suggested that the additional presence of continued socio-economic disadvantage likely propagated this outcome due to lacking adequate resources and support to overcome traumatic and stressful events. This places children and young people, such as those who took part in this study, at higher risk of the development and escalation of externalising behaviours that coincide with ADHD symptom behaviour, further difficulty with forming positive relationships in their microsystem, school failure, medicalisation and exclusion.

This current study highlights the complexity of ADHD and how it is conceptualised by children and young people who appear to have a sense of the contextual factors that have contributed to their feelings, thoughts and behavioural presentation whilst at the same time being impacted by external people’s formulations of feedback regard their

functioning. A consequent experience of ambivalence is likely experienced, leading to a lack of integration of the self and in turn a delay in children and young people's development of responsibility, autonomy and agency (Brady, 2014; Ringer, 2020). In line with similar assertions made in existing literature (Hill & Turner, 2016; Timimi & Leo, 2009; Van der Kolk, 2015), it appears that the medicalization of behaviour can interfere with the processes of understanding and interpreting the emotional intensities and impacts of adverse experiences and fuel the pathologizing of human reactions to experiences.

5.7 Summary

This study sought to understand children and young people's lived experiences of having an ADHD diagnosis and any intervention they had been provided with, and the impact of exclusion on children and young people whose behaviours have presented as disruptive and unmanageable. Children and young people, particularly those who were in their final years of education, talked about their life experiences and how they had been treated. How they were treated in terms of their ADHD diagnosis with the exception of their experiences of medication was inextricably linked to their experiences of school failure and the different aspects of their context. By looking at their narratives through this lens, every attempt to gain a holistic picture was made. Repeated experiences of not being listened to, of lacking support and care in the form of positive relationships and of a lack of acknowledgement of adversity were identified. Reference to having an ADHD diagnosis appeared to be one of the primary methods through which children and young people justified needing more support from adults and in turn school settings appeared to have provided learning support on this basis, rather than on the basis of providing emotional containment. Ford et al. (2018) describe the bi-directional relationship between exclusion

of children and young people and their mental health. Those who have poorer mental health are more likely to develop with maladaptive behaviours that school systems are not armed to support whilst at the same time, exclusion is associated with poor mental health and adverse later life outcomes. It appears that the children and young people in this study found it easier to manage education in an alternative provision, as the smaller, slower paced classes and greater pupil to staff ratio possibly provides a greater chance or opportunity for connection and containment than would be possible in a mainstream setting. However, the impact on their self-identity from experiencing ADHD diagnosis and exclusion appeared to have confirmed for the children and young people a sense of being unwanted, problematic, inherently deficient and marginalised.

5.8 Implications for Educational Psychologists

These findings emphasise the valuable and vital role that EPs could play as advocates for vulnerable children and young people during ADHD assessment and intervention processes. In particular, the findings draw light on the role of the EP in working therapeutically through providing and promoting alternatives to pharmaceutical interventions in order to support the mental health and wellbeing of this vulnerable population and in supporting key adults who care for such children and young people.

A facet of the role of the EP as a scientist-practitioner is to make key adults aware of the neurological impact of a child’s ecosystem and how this might manifest in their development and behaviour. For example, the children and young people in this study referred to feeling overwhelmed by the mainstream environment, referring to there being too many people, too much noise, or teachers who were forceful in their approach.

It may be possible that these experiences are an indication of the hypersensitivity and hypervigilance experienced by children and young people as a result of traumatic experience causing neurological changes such as over detection of threat from an enlarged amygdala in the brain following maltreatment or abuse (Briggs-Gowan et al., 2010; Donnellan et al., 2005; Farnfield & Onions, 2021; Messina et al., 2007; Pretorius, 2009; Robin et al., 2021; Spinazzola et al., 2021; van der Kolk, 2003; Yrondi et al., 2021). Although this example is speculative and beyond the scope of the research undertaken in this study, it has been written as an illustrative example of how psycho-education about the impacts of traumatic experience informs the social narratives created by key adults about children and young people's behaviour.

The children and young people talked about how small classes in alternative settings enabled them to feel calmer and throughout the data set, young people talked about needing resources, training and support to feel calm and learn how to regulate their emotions; particularly anger. It is possible that these needs are the result of a lack of co-regulatory experience and of trauma and emphasises the vital need for the EP to educate key adults about these processes as part of their role in informing professionals and caregivers to look beyond ADHD symptoms and behaviour and to look at underpinnings from an interactionist perspective.

5.8.1 Application of the findings to the EP's role

Prior to the aforementioned study by Hill & Turner (2016) it had not been highlighted in the existing literature base that a large proportion of EPs felt that a child or young person's context was not being incorporated into ADHD diagnosis and intervention processes. The children and young people in this study are echoing this assertion.

The children and young people's views, the literature reviewed in this study and the working context of EPs were collectively considered and lead to several conclusions for EPs to consider. These conclusions were then aggregated into a six-step process in the form of a framework named the 'Six-Step model' (see Figure 4). I am in a unique position as both practitioner and researcher in that I have trialed the formulated Six-Step model and found that it is highly effective. Here are the considerations that were integrated into the six steps of the Six-Step Model:

- The necessity of the incorporation by EPs of key contextual factors and experiences across a child or young person's development into assessment and intervention processes
- The importance of promoting awareness in key adults in a child or young person's ecosystem regarding how their views of themselves impact their behaviour
- Bringing to light the macro-level legislation pertinent to exclusion practices and how decisions should be mediated by the EP highlighting both protective factors and risk factors in a child or young person's ecosystem
- With reference to the NICE ADHD guidelines (Faltinsen et al., 2019, NICE, 2018) EPs should emphasise the reason for therapeutic intervention being first-line and provide clear alternative non-pharmacological interventions. For example, EPs can both directly provide and train professionals to use psycho-educational interventions to facilitate key adults to provide attuned relationships that offer co-regulation and emotional containment, to develop

self-awareness of internal states of being in children and young people (Siegel, 2010).

- Training key people in the wider community about ADHD as a list of descriptive behaviours, which do not explain any underlying cause and according to the evidence base have no scientific baseline
- EPs should provide psycho-education for children and young people in a creative and age accessible format about their presentation using information gathered, PCP tasks, emotion cards and scenarios, and information about how their brain functions to facilitate a better understanding of their needs, the impact of their experiences and a better integrated sense of self
- EPs should provide children and young people with interventions such as the Hand Model (see section 5.8.2 and Appendix I), which provides a framework for how to recognise and regulate their emotions to promote self-awareness and increasing autonomy
- EPs should use a framework such as the aforementioned Lundy's Model of Participation (Lundy, 2007) (see Figure 2) to elicit the child or young person's voice and update key adults as young people's views change over time. Interventions should be provided as an action and outcome of what has been understood from the views that the child or young person has shared (the 'Audience' section of Lundy's Model);

- The EP should however make full use of statutory work consultations, assessments, feedback and collaboration with schools and parents as a platform for promoting the role of the EP as a mental health expert who can provide therapeutic intervention and for building trusting relationships with both the settings and the children and young people,
- The EP should provide children and young people in need with therapeutic care to cultivate age appropriate understandings of the self as a person with lived experiences, strengths and needs. The child or young person should be supported in gaining a clear understanding of the tailored support that the EP will put into place and put into in order to address their unique profile of strengths and needs.

5.8.2 Further details of the tools incorporated into the Six-Step model

The Hand Model (Siegel, 2010) (see Appendix I) that I found useful in my work and which is incorporated into the Six-Step model (see Figure 4) can be used as a conceptual framework for children and young people to make sense of how their brain responds to situations in their environment. A hand is shown to the child or young person as a representation of the brain. A closed fist indicates an emotionally regulated brain where all of the brain parts: the amygdala, the prefrontal cortex and the brain stem (see Appendix I), are connected and synchronised. The connection enables the child or young person to use their ‘thinking and learning brain’ or prefrontal cortex (the area represented by the fingers of the fist) to make sense of their emotional and mental states and in turn think logically

and plan and formulate wise decisions. Children and young people are taught to understand through application to their lived experiences, that the use of this part of their brain enables them to think through their experiences, understand the behaviour of others and consider how principles, morals and values can guide them to make choices that will result in their progress.

When the fingers are lifted (see Appendix I), this represents a disconnect between the prefrontal cortex (the thinking and learning brain) and the amygdala (threat detector). Children and young people are taught that this occurs when we experience strong emotions, like anger or fear. They are taught that in such a state, the thinking and learning brain is no longer working, and this lack of connection means that the person has become controlled by their emotions and their threat detector, making it impossible to make useful and helpful choices.

A child centred approach may then be used to teach strategies that enable the brain to ‘reconnect’ again. A method such as this can facilitate the child or young person to develop self-awareness of their emotional and mental states and build an integrated self (Siegel, 2010). Integrated functioning supports children and young people to link their internal states to previous experience and in turn, mediate their behaviour (Singh et al., 2010; Van der Kolk, 2015). The mediation of their behaviour might include either independently making informed choices about how they should behave in a particular moment, or communicating what they feel in order to explain themselves, or seeking support or external resources such as approaching someone who they trust. It can also be used by adults to as part of providing attunement and co-regulation (Siegel et al., 2021). The use of this intervention enables the adult to provide emotional containment to the child

or young person in a consistent and highly informative yet nurturing manner (Martin & Martin, 2021; Siegel et al., 2021).

The use of the ideal self and ideal school tools (Moran, 2001) used as tools in this study inform the Interactive Factors Framework, which is often used by EPs (see Appendix H). It ensures the formulation of a thorough holistic understanding of the child across their ecosystem. Providing an accessible summarised version to SENDCos enables the ongoing development of schools in their awareness of the child within an ecosystem and how such an approach mediates socially constructed narratives about children and young people, safeguarding them from being misinterpreted.

Figure 4: The Six-Step model

Context

The EP should familiarise themselves with the child or young person's developmental history, taking into account factors across their ecosystem, to date, that may be underpinning their presentation. Factors that are more difficult to identify, such as whether the child is experiencing bullying, or parental separation, should also be considered.

The EP should observe the child during social interaction and in learning situations and familiarise themselves with the school's views of the child for information gathering purposes.

PCP & IFF

The EP should use PCP tasks, including the ideal school, and the ideal self.

The EP's analyses of the child or young person should be laid out in an Interactive Factors Framework (Appendix H) that should be used to facilitate an understanding of the child's presentation to key adults and also shared in the form of a mini-report with other services including medical practitioners.

Change

The EP should use individual work with the child to psycho-educate them on their presentation using all information gathered, using the PCP drawings, the Hand Model and visual emotion cards and scenarios to facilitate, modifying approaches according to age and cognitive ability.

Parent consultation should inform parents of responses from the sessions and functioning of the child, in an accessible way that facilitates an interactionist perspective and is sensitive to the contextual experiences of the family. In parallel, the EP should carry out family-school joint consultation to mediate the social narrative surrounding ADHD. Emphasis should be placed on including psycho-education to key adults for the impact of contextual factors in the child's bio-ecological system and on therapeutic intervention work to provide attunement and co-regulation and use of the Hand Model (Appendix J) when working with the child or young person.

ADHD aware

In parallel, the EP should provide in school training for ADHD to support staff and families in intervention, making reference to trauma and the use of co-regulation to provide emotional containment, the use of the Hand Model, knowledge of medication and contextual awareness. The EP should liaise regularly with medical services to facilitate contextual awareness as to supplement the medical model of ADHD.

Support

The EP should take part in ongoing support for schools in gaining, promoting and sharing children's and parents views (including the outcomes of therapeutic interventions) in a structured way, that feeds into review meetings by promoting an understanding of how the child or young person functions.

The EP should provide ongoing support in schools to support key adults in providing therapeutic care.

Voice

The EP should both conduct and support others in continued individual work to gain the child or young person's voice and update key adults as children and young people's views change over time. The EP should use general opportunities in school, during consultations, to shape the social narrative surrounding ADHD related behaviour, making consistent links to trauma and the needs of vulnerable children and young people.

Note. The application of interventions as part of wider service delivery provided by the EP are integrated into the Six-Step model (Figure 4) to move beyond the scope of behavioural diagnosis towards addressing the needs of vulnerable children and young people and those in their ecosystem who care for them.

It is widely noted within the profession that EPs should self-evaluate the commissioned work that they provide in relation to the expectations of service users in order to demonstrate that they have brought about positive change (Fallon et al., 2010). As the Six-Step model has been formulated through the application of evidence informing action, evaluating the Six-Step model as a future step to extend on this current study may facilitate the outcomes of action, in return, to strengthen the evidence base from which EPs choose their tools (MacKay et al., 2016a) to provide optimal outcomes for service users.

5.9 Strengths and Limitations

The findings of this study have provided a voice to a potentially vulnerable group of children and young people, whose voices are absent in current research and provide important insight for EPs into the experiences of children and young people who have likely suffered adversity and experienced exclusion and misinterpretation (De Luna & Wang, 2021; Diggins, 2021).

Furthermore, the findings draw light on an important and common area of work for EPs; their role in ADHD diagnosis and intervention pathways for children and young people who may be described as vulnerable. This area of knowledge amongst EPs appears to be lacking in clarity, with significant variance in approaches to practice used across the EP profession. EPs have expressed their hesitancy regarding their role, as highlighted in the study

discussed by Hill and Turner (2016) in the first chapter of this research, where a sample of 136 EPs were surveyed.

Application of Bronfenbrenner's bio-ecological model (Bronfenbrenner & Morris, 2007) framework facilitated a holistic understanding of the implications of EP practice, upholding the duty and approach of the EP and of the recommendations made in legislative documents critiqued in this study (Bright, 2017; Faltinsen et al., 2019; Graham et al., 2019), which all refer to careful consideration of a child or young person's background, especially when factors that indicate that they are more vulnerable are evident (Bright, 2017).

Using a hybrid deductive and inductive approach to analysis this study ensured that the voices of the participants were preserved whilst at the same time exploring when possible, the impact of children and young people's contexts with current legislation, societal attitudes and contemporary practice all being part of their systems. Using an interactive, dynamic approach to eliciting children and young people's voices whilst adhering to ethical considerations and also providing useful, therapeutic feedback through my dual role as an EP and researcher during interviews, enabled participants to engage meaningfully and openly.

It may have been possible to consider the use of additional tools to have facilitated children and young people's communication. However, the use of two different tasks in addition to semi-structured interview questions appeared to be adequate and it is possible that adding in other participatory techniques might have been overwhelming for the children and young people that took part. PCP tools have been shown to be useful on other vulnerable groups such as those with SEND (Finnegan & O'Donoghue, 2019; Garcia-Quiroga & Agoglia, 2020; Maxwell, 2006; Williams & Hanke, 2007).

There were three additional young people, who had experienced more extensive exclusion, who had highly complex needs and presented as very vulnerable. It was decided that these young people would not be included at all, even initially, in the recruitment process, for ethical purposes. This decision was made through consideration of Article 12 of the UNCRC (children's rights to be heard) (Lundy, 2007), that children are the experts of their own life experiences (Tisdall, 2016) and that vulnerable children's views should be considered through participatory research design and methods (Finnegan & O'Donoghue, 2019; Garcia-Quiroga & Agoglia, 2020). Not including these very vulnerable young people would have impacted the representativeness of the data, however the risk of harm on these potential participants was thought to be higher than the benefits of giving a voice (Cole-Albäck, 2019; Oates et al., 2021).

The sample used in this study was diverse and the gender ratio of a predominant proportion of males reflected that seen in ADHD populations more generally (Sayal et al., 2018) although there were female participants (male participants N=12 and female N=3). Although the sample was small it included ethnic diversities, reflecting the diversity of the borough and improving the representativeness of the sample. The small number of participants and the subjectivity of individuals within the constraints of two settings situated within the same LA limited the transferability of the findings, although at the same time importantly an in-depth understanding of a vulnerable group was facilitated.

As highlighted in the discussed literature (Fraticelli et al., 2022; Isaksson et al., 2020) gender differences have been widely noted in both perceptions and diagnostic patterns of ADHD. There were fewer female participants than males and this did reflect usual gender prevalence in the population. However, in this study the female participants

were comparable in presentation to the male participants in that their behaviour was also externalising and they had been excluded. Therefore the gender differences with regards to gender differences in ADHD were not reflective in the participants. As the girls were more extreme than the norm for females in their presentation, as such gender differences were not noticeable to me as the researcher.

The study complements current legislative shifts and discourse in educational psychology such as increasing focus on the voice and rights of the child (Hill & Turner, 2016; MacKay et al., 2016b) and the NICE (2018) ADHD guidelines. Including both parents and teachers views alongside children's views would have facilitated an insight into the social aspects of narrative surrounding ADHD, mental health and childhood, enhancing the understandings of the children and young people's ecosystem and the interpretation of the data from a critical realist stance. However, placing the voices of children and young people at the centre of this study appeared to have been a strength as it enabled their personal journeys within the context of their ecosystem and the impact on them to remain the primary focus, which is what this study aimed to achieve.

5.10 Key outcomes and future research directions

This study is of value as it is emancipatory research that has given a voice to a group of children and young people from a vulnerable population. It builds on the initially discussed study by Hill and Turner (2016) which explored the views of EPs with regards to ADHD diagnosis and intervention. Further, it highlights the significance of embedding context and moving away from the medical model towards a biopsychosocial model (Salamanca, 2014). Additionally, the value of the EP employing a therapeutic approach with children who have a profile consistent with ADHD by using approaches to build

metacognitive awareness and frame their life experiences is illustrated. EPs working in this way would add considerably to the psychological level of intervention and is in line with NICE guidance (Faltinsen et al., 2019).

Taking into account Lundy's model (Kennan et al., 2019) this study provides a Six-step model where a structure is provided for EPs to use with this population of children and young people. It is essential for future work to be aimed at gaining different perspectives and insights from other key stakeholders through multi-informant studies that aim to expand on the six-step model.

5.11 Conclusion

The children and young people appeared to have had the task of struggling to make sense of their diagnosis and how it applied to their own functioning, despite simultaneously demonstrating insightful awareness into contextual factors that had impacted them over time when reflecting on their own behaviour. It appeared that older children in the sample were more able to do this than younger children, highlighting the importance of early intervention.

It seemed that in line with existing studies (Charach et al., 2014; Honkasilta et al., 2016; Singh, 2011) and with my year one research project findings, children and young people had adopted some simplistic, and at times contradictory interpretations of their diagnoses.

However, what could also be seen, was that the children and young people's strong levels of insight into their own contexts and the impact on their emotions and behaviour left them burdened by an ambivalence between feeling awareness of the impact of their

contexts on the self and feeling that their ADHD diagnosis explained many aspects of their behaviour. Another impacting layer of complexity, fuelling this ambivalence, appeared to have been the social narrative of families', schools and medical professionals communicated to the children and young people, in response to their behaviour.

In light of this ambivalent mind set, it seemed that diagnosed children and young people consequently experienced some degree of disconnect from their behaviours, emotions and internal states, as aspects not related to their interactions with their environments but instead to their ADHD diagnoses. With a poorly integrated self, the ability to develop responsibility, autonomy and agency is likely highly compromised (Brady, 2014).

It appears that the medicalization of behaviour through behavioural diagnoses like ADHD may well interfere with the processes of understanding and interpreting human reaction to adverse life experience and add another facet of description about a person's behaviour that is questionable in its usefulness.

From talking to the vulnerable children and young people in this study, the involvement of different service providers appears not to have made a meaningful difference. Instead, the quality of interpersonal relationships with key people within their ecosystem appeared to be key. It seemed that those individual people who provided mentalisation and containment to these children and young people, for whom the child or young person was seen in their full humanity, ultimately made all the difference. It was in those moments where children and young people felt contained, that the concept of being diagnosed with a behavioural diagnosis became irrelevant. The child or young person's

needs had been met, facilitating regulated functioning, where the pre-frontal cortex is connected and synchronised with other brain parts.

It is the role of the EP, as an agent of change, to legislate compassion and kindness towards children and young people into existence. One of the key conclusions from this study is that policy which is aimed at the management of behaviour through the medicalisation and exclusion of children and young people in society does not validate or provide containment for the effects of human experience or promote dignity. The life stories of children and young people must be informed by psychology and be used as a lens to view each person; respecting their rights as ratified by the UNCRC. Contemporary practice is insufficient as it cannot meet the needs of children and young people who challenge the boundaries and expectations of the educational system. The default practice places such children and young people in situations where they are likely to become medicalised and segregated.

The role of conceptualising current resources used in contemporary practice to make them adequate to meet needs that have arisen through the complexity of human experience, falls on the EP. EPs have the skillset to provide psychological support for mental health and wellbeing for vulnerable children and young people in schools, to enable them to make a better transition to adulthood and break cycles of disadvantage.

EPs are not just excellently placed to take children and young people, schools, families, and other professionals beyond the simplistic interpretations that are shaped by the principles of discipline and behavioural diagnosis. They are also fundamentally, professionally and morally obliged to do so.

References

Archer, T. (2022). *Evaluation in Consultation-Based Educational Psychology*.

Atkinson, C., Corban, I., & Templeton, J. (2011). Educational psychologists' use of therapeutic interventions: Issues arising from two exploratory case studies. *Support for Learning*, *26*(4), 160–167.

Atkinson, C., & Kenneally, O. (2021). A model for therapeutic educational psychology practice. *Educational Psychology in Practice*, *37*(3), 284–302.

Atkinson, C., Thomas, G., Goodhall, N., Barker, L., Healey, I., Wilkinson, L., & Ogunmyiwa, J. (2019). Developing a student-led school mental health strategy. *Pastoral Care in Education*, *37*(1), 3–25.

Azungah, T. (2018). Qualitative research: Deductive and inductive approaches to data analysis. *Qualitative Research Journal*.

Barr, C., Swanson, J., & Kennedy, J. (2021). Molecular genetics of ADHD. In *Attention, genes, and ADHD* (pp. 173–195). Psychology Press.

Barra, S., Turner, D., Müller, M., Hertz, P. G., Retz-Junginger, P., Tüscher, O., Huss, M., & Retz, W. (2020). ADHD symptom profiles, intermittent explosive disorder, adverse childhood experiences, and internalizing/externalizing problems in young offenders. *European Archives of Psychiatry and Clinical Neuroscience*, 1–13.

Berchiatti, M., Ferrer, A., Badenes-Ribera, L., & Longobardi, C. (2021). School Adjustments in Children with Attention Deficit Hyperactivity Disorder (ADHD): Peer Relationships, the Quality of the Student-Teacher Relationship, and Children's Academic and Behavioral Competencies. *Journal of Applied School Psychology*, 1–21.

Biederman, J., Mick, E., Faraone, S. V., Braaten, E., Doyle, A., Spencer, T., Wilens, T. E., Frazier, E., & Johnson, M. A. (2002). Influence of gender on attention deficit hyperactivity disorder in children referred to a psychiatric clinic. *American Journal of Psychiatry*, *159*(1), 36–42.

Blanchfield, L. (2013). *The United Nations convention on the rights of the child* (Vol. 1). Congressional Research Service Washington, DC.

Bloom, A., Critten, S., Johnson, H., & Wood, C. (2020). A critical review of methods for eliciting voice from children with speech, language and communication needs. *Journal of Research in Special Educational Needs*, *20*(4), 308–320.

Brady, G. (2014). Children and ADHD: Seeking control within the constraints of diagnosis. *Children & Society*, *28*(3), 218–230. https://doi.org/10.1111/chso.12069

Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*.

Bright, C. (2017). Defining child vulnerability: Definitions, frameworks and groups. *Children's Commissioner for England*.

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nuture reconceptualized in developmental perspective: A bioecological model. *Psychological Review*, *101*(4), 568–586. https://doi.org/10.1037/0033-295X.101.4.568

Bronfenbrenner, U., & Morris, P. A. (2007). The bioecological model of human development. *Handbook of Child Psychology*, *1*.

Brown, N. M., Brown, S. N., Briggs, R. D., Germán, M., Belamarich, P. F., & Oyeku, S. O. (2017). Associations between adverse childhood experiences and ADHD diagnosis and severity. *Academic Pediatrics*, *17*(4), 349–355.

Carr-Fanning, K., & McGuckin, C. (2022). “I Find It Really Difficult to Control Myself Too”: A Qualitative Study of the Effects on the Family Dynamic When Parent and Child Have ADHD. *Education Sciences*, *12*(11), 758.

Carucci, S., Balia, C., Gagliano, A., Lampis, A., Buitelaar, J. K., Danckaerts, M., Dittmann, R. W., Garas, P., Hollis, C., & Inglis, S. (2021). Long term methylphenidate exposure and growth in children and adolescents with ADHD. A systematic review and meta-analysis. *Neuroscience & Biobehavioral Reviews*, *120*, 509–525.

Choi, J.-K., Wang, D., & Jackson, A. P. (2019). Adverse experiences in early childhood and their longitudinal impact on later behavioral problems of children living in poverty. *Child Abuse & Neglect*, *98*, 104181.

Cole-Albäck, A. (2019). Using the UNCRC as a frame of reference for ethical research with young children. In *The Routledge International Handbook of Young Children’s Rights* (pp. 504–518). Routledge.

De Luna, J. E., & Wang, D. C. (2021). Child Traumatic Stress and the Sacred: Neurobiologically Informed Interventions for Therapists and Parents. *Religions*, *12*(3), 163.

Diggins, J. (2021). Reductions in behavioural and emotional difficulties from a specialist, trauma-informed school. *Educational and Developmental Psychologist*, *38*(2), 194–205.

Dunsmuir, S., Brown, E., Iyadurai, S., & Monsen, J. (2009). Evidence-based practice and evaluation: From insight to impact. *Educational Psychology in Practice*, *25*(1), 53–70.

Dunsmuir, S., & Cobbald, A. (2016). A Framework for Promoting Child Mental Health in Schools. *Frameworks for Practice in Educational Psychology, Second Edition: A Textbook for Trainees and Practitioners*, 309–331.

Dunsmuir, S., & Hardy, J. (2016). *Delivering psychological therapies in schools and communities*. Leicester: British Psychological Society.

Ewe, L. P. (2019). ADHD symptoms and the teacher–student relationship: A systematic literature review. *Emotional and Behavioural Difficulties*, *24*(2), 136–155.

Ewe, L. P., & Aspelin, J. (2021). Relational competence regarding students with ADHD–An intervention study with in-service teachers. *European Journal of Special Needs Education*, 1–16.

Fallon, K., Woods, K., & Rooney, S. (2010). A discussion of the developing role of educational psychologists within Children's Services. *Educational Psychology in Practice*, *26*(1), 1–23.

Faltinsen, E., Zwi, M., Castells, X., Gluud, C., Simonsen, E., & Storebø, O. J. (2019). Updated 2018 NICE guideline on pharmacological treatments for people with ADHD: A critical look. *BMJ Evidence-Based Medicine*, *24*(3), 99–102.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92.

Finnegan, M., & O'Donoghue, B. (2019). Rethinking vulnerable groups in clinical research. *Irish Journal of Psychological Medicine*, *36*(1), 63–71.

Ford, T., Parker, C., Salim, J., Goodman, R., Logan, S., & Henley, W. (2018). The relationship between exclusion from school and mental health: A secondary analysis of the British Child and Adolescent Mental Health Surveys 2004 and 2007. *Psychological Medicine*, *48*(4), 629–641.

Fraticelli, S., Caratelli, G., De Berardis, D., Ducci, G., Pettorruso, M., Martinotti, G., Di Cesare, G., & Di Giannantonio, M. (2022). Gender differences in attention deficit hyperactivity disorder: An update of the current evidence. *Rivista Di Psichiatria*, *57*(4), 159–164.

Freitag, C. M., Haenig, S., Schneider, A., Seitz, C., Palmason, H., Retz, W., & Meyer, J. (2012). Biological and psychosocial environmental risk factors influence symptom severity and psychiatric comorbidity in children with ADHD. *Journal of Neural Transmission*, *119*(1), 81–94.

Garcia-Quiroga, M., & Agoglia, I. S. (2020). Too vulnerable to participate? Challenges for meaningful participation in research with children in alternative care and adoption. *International Journal of Qualitative Methods*, *19*, 1609406920958965.

Gershon, J. (2002). Gender differences in ADHD. *The ADHD Report*, *10*(4), 8.

Graham, B., White, C., Edwards, A., Potter, S., Street, C., & Hinds, D. (2019). *Timpson review of school exclusion: Consultation outcome: May 2019*.

Gubi, A. A., Strait, J., Wycoff, K., Vega, V., Brauser, B., & Osman, Y. (2019). Trauma-informed knowledge and practices in school psychology: A pilot study and review. *Journal of Applied School Psychology*, *35*(2), 176–199.

Hill, V. (2013). Working across diverse contexts with wider populations: The developing role of the educational psychologist. *British Educational Psychology: The First Hundred Years. Leicester: The British Psychological Society*.

Hill, V. C., & Turner, H. (2016). Educational psychologists' perspectives on the medicalisation of childhood behaviour: A focus on Attention Deficit Hyperactive Disorder (ADHD). *Educational & Child Psychology*, *33*(2), 12–29.

Hjörne, E., & Evaldsson, A.-C. (2015). Reconstituting the ADHD girl: Accomplishing exclusion and solidifying a biomedical identity in an ADHD class. *International Journal of Inclusive Education*, *19*(6), 626–644.

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics*, *139*(1).

Hoffman, S., Palladino, J. M., & Barnett, J. (2007). Compassion Fatigue as a Theoretical Framework to Help Understand Burnout among Special Education Teachers. *Online Submission*, *2*(1), 15–22.

Howells, H. (2021). *An exploration of Educational Psychologists' perceptions of enabling and restricting factors affecting children's involvement in statutory assessment processes and outcomes.* [PhD Thesis]. University of East Anglia.

Ilie, S., Sutherland, A., & Vignoles, A. (2017). Revisiting free school meal eligibility as a proxy for pupil socio-economic deprivation. *British Educational Research Journal*, *43*(2), 253–274.

Isaksson, J., Ruchkin, V., & Lindblad, F. (2020). Unseen and stressed? Gender differences in parent and teacher ratings of ADHD symptoms and associations with perceived stress in children with ADHD. *Journal of Attention Disorders*, *24*(11), 1565–1569.

Jackson, D. B., Jindal, M., Testa, A., Ganson, K. T., Fix, R. L., & Nagata, J. M. (2022). Adverse childhood experiences and adolescent police contact in the United Kingdom. *Pediatrics*, *150*(4).

Jackson, D. B., Testa, A., & Vaughn, M. G. (2021). Adverse childhood experiences and school readiness among preschool-aged children. *The Journal of Pediatrics*, *230*, 191–197.

Karlén, M. H., Nilsson, T., Wallinius, M., Billstedt, E., & Hofvander, B. (2020). A bad start: The combined effects of early onset substance use and ADHD and CD on criminality patterns, substance abuse and psychiatric comorbidity among young violent offenders. *Journal for Person-Oriented Research*, *6*(1), 39.

Kay, D. (2019). On the participation of children with medical conditions in risk assessment: A case for development of self-advocacy. *Educational Psychology in Practice*, *35*(4), 357–367.

Kendall, J., Hatton, D., Beckett, A., & Leo, M. (2003). Children's accounts of attention-deficit/hyperactivity disorder. *Advances in Nursing Science*, *26*(2), 114–130.

Kendall, L. (2016). 'The teacher said I'm thick!'Experiences of children with Attention Deficit Hyperactivity Disorder within a school setting. *Support for Learning*, *31*(2), 122–137.

Kennan, D., Brady, B., & Forkan, C. (2019). Space, voice, audience and influence: The Lundy model of participation (2007) in child welfare practice. *Practice*, *31*(3), 205–218.

Kofler, M. J., Irwin, L. N., Soto, E. F., Groves, N. B., Harmon, S. L., & Sarver, D. E. (2019). Executive functioning heterogeneity in pediatric ADHD. *Journal of Abnormal Child Psychology*, *47*(2), 273–286.

Lawrence, D., Houghton, S., Dawson, V., Sawyer, M., & Carroll, A. (2021). Trajectories of academic achievement for students with attention-deficit/hyperactivity disorder. *British Journal of Educational Psychology*, *91*(2), 755–774.

Leyland, S. (2016). *"I was good when I didn't have it": Giving the 'ADHD child' a voice: An interpretative phenomenological analysis.*
https://wlv.openrepository.com/handle/2436/618627

Lundy, L. (2007). ‘Voice’is not enough: Conceptualising Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal*, *33*(6), 927–942.

MacKay, T., Lauchlan, F., Lindsay, G., Monsen, J., Frederickson, N., Gameson, J., Rhydderch, G., Harker, M. E., Dean, S., & Wagner, P. (2016a). *Frameworks for practice in educational psychology: A textbook for trainees and practitioners*. Jessica Kingsley Publishers.

MacKay, T., Lauchlan, F., Lindsay, G., Monsen, J., Frederickson, N., Gameson, J., Rhydderch, G., Harker, M. E., Dean, S., & Wagner, P. (2016b). *Frameworks for practice in educational psychology: A textbook for trainees and practitioners*. Jessica Kingsley Publishers.

Martin, B., & Martin, B. C. (2021). *Mindful, Aware Parenting: The Pathway to Raising Emotionally Regulated Children*.

Maxwell, T. I. M. (2006). Researching into some primary school children’s views about school: Using personal construct psychology in practice with children on the special needs register. *Pastoral Care in Education*, *24*(1), 20–26.

Mayes, S. D., Calhoun, S. L., Waxmonsky, J. G., Kokotovich, C., Baweja, R., Lockridge, R., & Bixler, E. O. (2019). Demographic differences in disruptive mood dysregulation disorder symptoms in ADHD, autism, and general population samples. *Journal of Attention Disorders*, *23*(8), 849–858.

Mayes, S. D., Castagna, P. J., DiGiovanni, C. D., & Waschbusch, D. A. (2020). Relationship between ADHD, oppositional defiant, conduct, and disruptive mood

dysregulation disorder symptoms and age in children with ADHD and autism. *International Journal of Clinical Psychiatry and Mental Health*, *8*(1), 47–57.

McGoldrick, D. (1991). The United Nations convention on the rights of the child. *International Journal of Law, Policy and the Family*, *5*(2), 132–169.

McLoughlin, C. (2010). Concentric circles of containment: A psychodynamic contribution to working in pupil referral units. *Journal of Child Psychotherapy*, *36*(3), 225–239.

Menter, I., Elliot, D., Hulme, M., Lewin, J., & Lowden, K. (2011). *A guide to practitioner research in education*. Sage.

Merrell, C., Sayal, K., Tymms, P., & Kasim, A. (2017). A longitudinal study of the association between inattention, hyperactivity and impulsivity and children's academic attainment at age 11. *Learning and Individual Differences*, *53*, 156–161.

Michael, S., & Frederickson, N. (2013). Improving pupil referral unit outcomes: Pupil perspectives. *Emotional and Behavioural Difficulties*, *18*(4), 407–422.

Milich, R., Balentine, A. C., & Lynam, D. R. (2001). ADHD combined type and ADHD predominantly inattentive type are distinct and unrelated disorders. *Clinical Psychology: Science and Practice*, *8*(4), 463.

Miller, J., & Berger, E. (2021). Supporting First Nations Students with a Trauma Background in Schools. *School Mental Health*, 1–13.

Miller, L. L., Gustafsson, H. C., Tipsord, J., Song, M., Nousen, E., Dieckmann, N., & Nigg, J. T. (2018). Is the association of ADHD with socio-economic disadvantage explained by child comorbid externalizing problems or parent ADHD? *Journal of Abnormal Child Psychology*, *46*(5), 951–963.

Moldavsky, M., & Sayal, K. (2013). Knowledge and attitudes about attention-deficit/hyperactivity disorder (ADHD) and its treatment: The views of children, adolescents, parents, teachers and healthcare professionals. *Current Psychiatry Reports*, *15*(8), 1–7.

Moran, H. (2001). Who do you think you are? Drawing the ideal self: a technique to explore a child's sense of self. *Clinical Child Psychology and Psychiatry*, *6*(4), 599–604.

Murphy, K. R., Barkley, R. A., & Bush, T. (2002). Young adults with attention deficit hyperactivity disorder: Subtype differences in comorbidity, educational, and clinical history. *The Journal of Nervous and Mental Disease*, *190*(3), 147–157.

Noonan, K., Burns, R., & Violato, M. (2018). Family income, maternal psychological distress and child socio-emotional behaviour: Longitudinal findings from the UK Millennium Cohort Study. *SSM-Population Health*, *4*, 280–29

National Institute of Clinical Excellence. (2018, March). Attention deficit hyperactivity disorder: diagnosis and management. Guidance and guidelines. Retrieved April 5, 2018, from https://www.nice.org.uk/guidance/ng87/chapter/Recommendations

Novak, A. (2022). The Association Between Adverse Childhood Experiences, Neuropsychological Deficits, and Experiences of Exclusionary Discipline in Early Childhood. *Journal of Developmental and Life-Course Criminology*, 1–31.

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021). *BPS Code of Human Research Ethics*.

O'Regan, F. (2010). *Exclusion from school and attention-deficit/hyperactivity disorder*.

Padilla-Petry, P., Sòria-Albert, C., & Vadeboncoeur, J. A. (2018). Experiencing Disability in the School Context: Voices of Young People Diagnosed with ADHD in Spain. *International Education Studies*, *11*(8), 79–90.

Ponizovsky-Bergelson, Y., Dayan, Y., Wahle, N., & Roer-Strier, D. (2019). A qualitative interview with young children: What encourages or inhibits young children's participation? *International Journal of Qualitative Methods*, *18*, 1609406919840516.

Poon, K. (2020). The impact of socioeconomic status on parental factors in promoting academic achievement in Chinese children. *International Journal of Educational Development*, *75*, 102175.

Ringer, N. (2020). Living with ADHD: A Meta-Synthesis Review of Qualitative Research on Children's Experiences and Understanding of Their ADHD. *International Journal of Disability, Development and Education*, *67*(2), 208–224. https://doi.org/10.1080/1034912X.2019.1596226

Rucklidge, J. J. (2008). Gender differences in ADHD: Implications for psychosocial treatments. *Expert Review of Neurotherapeutics*, *8*(4), 643–655.

Russell, G., Ford, T., Rosenberg, R., & Kelly, S. (2014). The association of attention deficit hyperactivity disorder with socioeconomic disadvantage: Alternative explanations and evidence. *Journal of Child Psychology and Psychiatry*, *55*(5), 436–445.

Ryan, D. P.-J. (2001). Bronfenbrenner's ecological systems theory. *Retrieved January*, *9*, 2012.

Salamanca, L. M. (2014). Biopsychosocial perspective of ADHD. *Open Journal of Epidemiology*, *2014*.

Sayal, K., Prasad, V., Daley, D., Ford, T., & Coghill, D. (2018). ADHD in children and young people: Prevalence, care pathways, and service provision. *The Lancet Psychiatry*, *5*(2), 175–186.

Shier, H. (2019). Student voice and children's rights: Power, empowerment, and "protagonismo". In *Peters, MA (ed.). Encyclopedia of Teacher Education*. Springer Nature.

Siegel, D. J. (2010). *Mindsight: The new science of personal transformation*. Bantam.

Siegel, D. J., Schore, A. N., & Cozolino, L. (2021). *Interpersonal Neurobiology and Clinical Practice (Norton Series on Interpersonal Neurobiology)*. WW Norton & Company.

Singh, I. (2011). A disorder of anger and aggression: Children's perspectives on attention deficit/hyperactivity disorder in the UK. *Social Science & Medicine (1982)*, *73*(6), 889–896. https://doi.org/10.1016/j.socscimed.2011.03.049

Singh, N. N., Singh, A. N., Lancioni, G. E., Singh, J., Winton, A. S., & Adkins, A. D. (2010). Mindfulness training for parents and their children with ADHD increases the children's compliance. *Journal of Child and Family Studies*, *19*(2), 157–166.

Sjöberg, M. N., & Dahlbeck, J. (2018). The inadequacy of ADHD: A philosophical contribution. *Emotional and Behavioural Difficulties*, *23*(1), 97–108.

Sonuga-Barke, E., & Harold, G. (2018). Conceptualizing and investigating the role of the environment in ADHD. *Oxford Textbook of Attention Deficit Hyperactivity Disorder*, 25.

Spinazzola, J., Van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of Traumatic Stress*, *31*(5), 631–642.

Spinazzola, J., Van der Kolk, B., & Ford, J. D. (2021). Developmental trauma disorder: A legacy of attachment trauma in victimized children. *Journal of Traumatic Stress*, *34*(4), 711–720.

Stanforth, A., & Rose, J. (2020). ‘You kind of don’t want them in the room’: Tensions in the discourse of inclusion and exclusion for students displaying challenging behaviour in an English secondary school. *International Journal of Inclusive Education*, *24*(12), 1253–1267.

Starbuck, L., Kirsche Walker, J. W., Rigby, E., & Hagell, A. (2020). Innovative ways of engaging young people whose voices are less heard. *Embedding Young People’s Participation in Health Services: New Approaches*, 112–144.

Storebø, O. J., Pedersen, N., Ramstad, E., Kielsholm, M. L., Nielsen, S. S., Krogh, H. B., Moreira-Maia, C. R., Magnusson, F. L., Holmskov, M., & Gerner, T. (2018). Methylphenidate for attention deficit hyperactivity disorder (ADHD) in children and adolescents–assessment of adverse events in non-randomised studies. *Cochrane Database of Systematic Reviews*, *5*.

Szykierski, D. (2010). The traumatic roots of containment: The evolution of Bion’s metapsychology. *The Psychoanalytic Quarterly*, *79*(4), 935–968.

Testa, A., & Jackson, D. B. (2020). Adverse childhood experiences and food insecurity in adulthood: Evidence from the national longitudinal study of adolescent to adult health. *Journal of Adolescent Health*, *67*(2), 218–224.

Testa, A., Jackson, D. B., Ganson, K. T., & Nagata, J. M. (2022). Adverse childhood experiences and criminal justice contact in adulthood. *Academic Pediatrics*, *22*(6), 972–980.

Timimi, S. (2014). *Pathological child psychiatry and the medicalization of childhood*. Routledge.

Timimi, S., & Leo, J. (2009). *Rethinking ADHD: From Brain to Culture*. Bloomsbury Publishing.

Tisdall, E. K. M. (2016). Participation, rights and ‘participatory’methods. *The SAGE Handbook of Early Childhood Research*, *1*, 73–88.

Travell, C., & Visser, J. (2006). ‘ADHD does bad stuff to you’: Young people’s and parents’ experiences and perceptions of Attention Deficit Hyperactivity Disorder (ADHD). *Emotional and Behavioural Difficulties*, *11*(3), 205–216.

Tudge, J. R., Merçon-Vargas, E. A., Liang, Y., & Payir, A. (2017). The importance of Urie Bronfenbrenner’s bioecological theory for early childhood education. In *Theories of early childhood education* (pp. 45–57). Routledge.

Tudge, J. R., Payir, A., Merçon-Vargas, E., Cao, H., Liang, Y., Li, J., & O’Brien, L. (2016). Still misused after all these years? A reevaluation of the uses of Bronfenbrenner’s bioecological theory of human development. *Journal of Family Theory & Review*, *8*(4), 427–445.

UK, N. G. C. (2018). *Attention deficit hyperactivity disorder: Diagnosis and management*.

Ullebø, A. K., Posserud, M.-B., Heiervang, E., Obel, C., & Gillberg, C. (2012). Prevalence of the ADHD phenotype in 7-to 9-year-old children: Effects of informant, gender and non-participation. *Social Psychiatry and Psychiatric Epidemiology*, *47*(5), 763–769.

Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Van der Kolk, B. A. (2017). Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401–408.

Wall, S. (2021). ‘A little whisper in the ear’: How developing relationships between pupils with attachment difficulties and key adults can improve the former’s social, emotional and

behavioural skills and support inclusion. *Emotional and Behavioural Difficulties*, *26*(4), 394–411.

Walsh, D., McCartney, G., Smith, M., & Armour, G. (2019). Relationship between childhood socioeconomic position and adverse childhood experiences (ACEs): A systematic review. *Journal of Epidemiology and Community Health*, *73*(12), 1087–1093. https://doi.org/10.1136/jech-2019-212738

Wassink-de Stigter, R., Kooijmans, R., Asselman, M. W., Offerman, E. C. P., Nelen, W., & Helmond, P. (2022). Facilitators and Barriers in the Implementation of Trauma-Informed Approaches in Schools: A Scoping Review. *School Mental Health*, 1–15.

Weiss, M., Worling, D., & Wasdell, M. (2003). A chart review study of the inattentive and combined types of ADHD. *Journal of Attention Disorders*, *7*(1), 1–9.

Wiener, J., Malone, M., Varma, A., Markel, C., Biondic, D., Tannock, R., & Humphries, T. (2012). Children's perceptions of their ADHD symptoms: Positive illusions, attributions, and stigma. *Canadian Journal of School Psychology*, *27*(3), 217–242.

Williams, J., & Hanke, D. (2007). 'Do you know what sort of school I want?': Optimum features of school provision for pupils with autistic spectrum disorder. *Good Autism Practice (GAP)*, *8*(2), 51–63.

Young, S., & Cocallis, K. (2021). ADHD and offending. *Journal of Neural Transmission*, *128*(7), 1009–1019.

Zeng, S., Corr, C. P., O'Grady, C., & Guan, Y. (2019). Adverse childhood experiences and preschool suspension expulsion: A population study. *Child Abuse & Neglect*, *97*, 104149.

Appendices

Appendix A: Child Interview Schedule

Child Interview Schedule (This schedule will precede the 2 activities, 'The Ideal Self' and 'The Ideal School')

'Hello! Thank you so much for coming to talk to me today.
As you know from our chat we had last time we met, my name is Nisha, and I am talking with children to find out about how they have found school, and what their thoughts are about ADHD. I will also be chatting with the parents and the teachers of the children I talk to, if they have time and are happy to talk to me.

I am really interested to know what you think, so that I can share what I find out with people who make decisions about how to help children like you to feel happy, both generally and in school.

When we meet on another day, there are two activities we will do together, one is about how you would like to be and what you hope for, for yourself, now and later when you become an adult. The other activity is to try to understand how you would like school to be.

Today, I will just ask you some general questions, to learn about how things have been and are for you at the moment.
Is that okay? Before we begin, is it okay if I record us talking? It is going to be tricky to remember everything we talk about and I will not be able to write it down fast enough! After the interview, I will listen to the recording and type it out, and then delete the recording. I will not put your name or any of your details on the paper that is typed.

Here is a stop card on the table. It is important to know that this is a STOP card that I will put here on the table. If you want to stop at any time, you just point to it and we will stop our chat. You do not have to tell me why you want to stop.
If you want to carry on but for me not to record it, and just write down notes, that is okay too.

Okay, is there anything that you would like to ask me?
Okay, let's start our chat.'

Primary question 1: Tell me a bit about you

Probe:

- How long have you been at this school?

- What year group are you in?
- Which school did you go to before?
- Why did you change from that school to this one?

Primary question 2: Your ADHD diagnosis and what it means to you

- How did you find out that you had an ADHD?
- What do you think that means?
- How does that make you feel about yourself?
- How can you tell someone has ADHD?
- Is there anything good about it?
- Is there anything not so good about it?

Primary question 3: Ways that you get help

- In what ways do adults help you in school?
- In what ways do you get help outside school?
- What do you think works well and why?
- What do you think doesn't work so well for you?
- Do you have any medication, what do you think about it?

Primary question 5: Your school

- Where were you at school before this one?
- How did you find being at that school? What kind of help did you get at that school?
- Why do you change to this one?
- Who made the decision to change schools from your last one to this one?

Primary question 5: What advice would you give to someone with ADHD?

- What do you think would help them to feel happy outside of school?
- What do you think would help them to feel happy in school?
- What kind of school do you think they should be in?

'This is the end of the interview! Thank so much for chatting with me. Before you go, do you have any questions for me?

I will see you another time to complete the two activities that we have talked about, which will include some drawing, and a bit more chatting.

Once I have finished talking to everyone, I will send a letter to the school about what I found out, for the parents and the teachers. I will send a poster for all of the children I have chatted to, to share with you what I have found out.

If you would like to ask me anything, you can contact me by asking teacher X to send me a message. If you need to talk to someone about anything, there is a phone number on your information sheet for people who can help you, like ChildLine.

Thank you so much for talking with me today! See you again soon when we will complete the activities.'

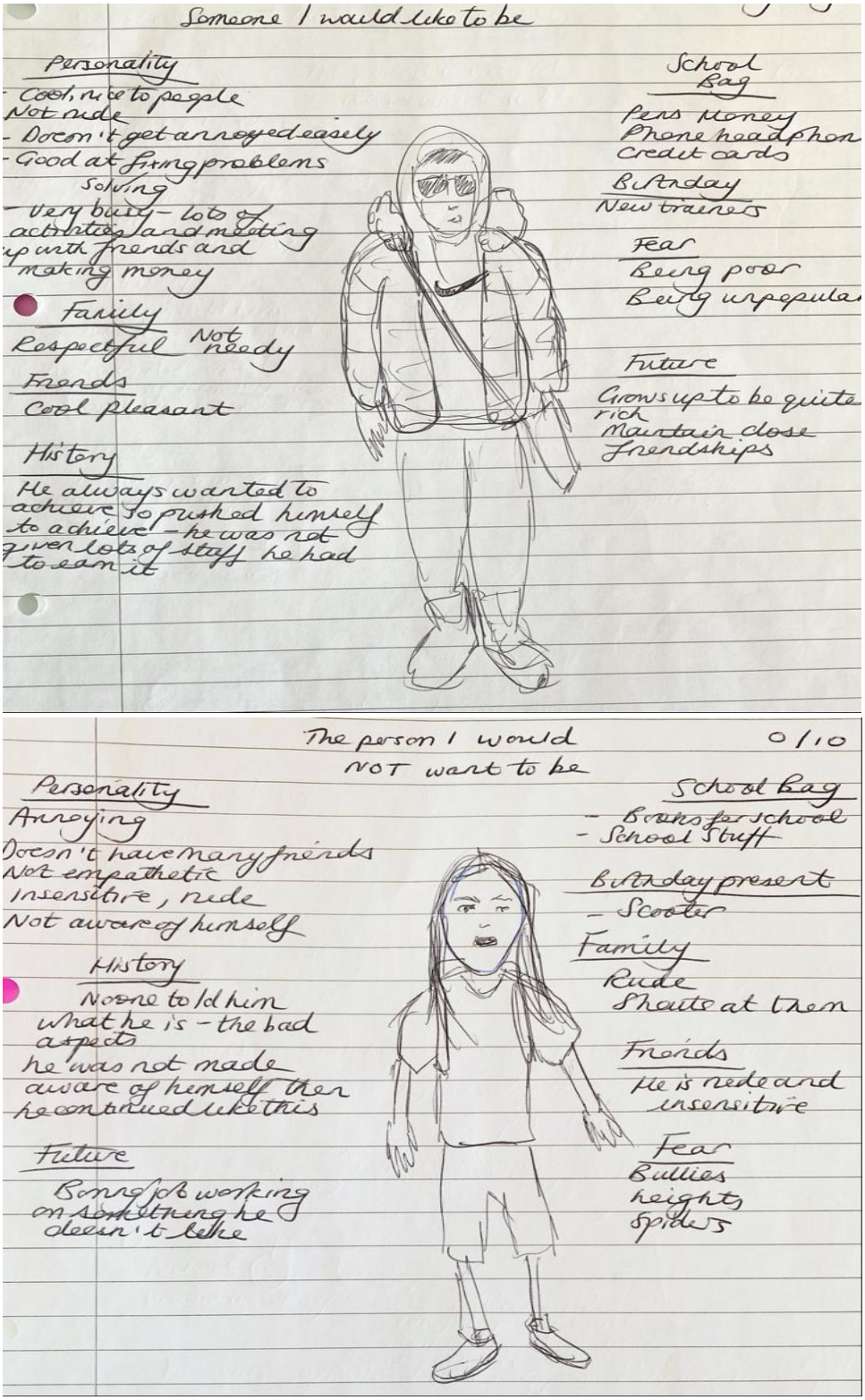
Appendix B: The ideal-self activity instructions and example drawing

Instruction excerpt taken from Moran (2001) as was followed for use in this study.

1. Think about *the kind of person you would not like to be like*. This is not a real person, but someone in your imagination. Make a quick sketch in the middle of the page. How would you describe this person, what is he (or she) like? Tell me three things about the kind of person he (or she) is. (Therapist writes the labels.)
2. This person goes to school each day with a bag. Draw their bag and the things a person like this would take with them? (Therapist writes the labels.)
3. It is this person's birthday. Draw what a person like this would like as a present? (Therapist writes the labels.)
4. What is this person like at home with their family? Draw something to show how they usually are at home. (Therapist writes the labels.)
5. Everyone has something that they are afraid of. What would be the biggest fear of a person like this? (Therapist writes the labels.)
6. How did this person come to be like this? Were they always like this or did they change somehow to become like this? What happened to them? (Therapist writes the labels.)
7. What do you think might happen to this person in the future? (Therapist writes the labels.)

This completes the first picture that is put to one side (see example on the left-hand side of Figure 1.) Produce a second picture, beginning by asking the child to draw *the kind of person they would like to be like* and describing this person. Repeat steps 2–7 in the same manner as for the first drawing. When the two drawings are complete, they can be looked at side by side and similarities and differences between the two may be explored. Place the third piece of paper (in landscape layout) in between the two pictures and draw a horizontal line along it from one picture to the other. Now the child can rate himself along this construct of self ('the kind of person I would *not* want to be like' and 'the kind of person I *would* like to be like').

Figure 5: Drawings completed by a young person during an 'ideal/non-ideal' self PCP activity.



Appendix C: Instructions for Drawing the Ideal School technique and example drawing

Instruction excerpt taken from Williams & Hanke, (2007), as was followed for use in this study.

In summary this type of work attempts to: *'understand the child's unique perspective on life through the careful use of questions and extremely sensitive note of the child's answers.'* (Moran, 2001) The technique itself is simple to use once the child understands what is expected. This sheet gives guidelines for the adult completing the technique to follow and the next two pages list how to complete the technique.

Guidelines for use1. Equipment needed: a black pen and two sheets of plain A4 sized paper.

2. Allow about an hour to complete the activity, perhaps with a short break if necessary.

3. Explain to the pupil that you are going to be doing the writing today, acting as scribe. This is to take the pressure off the pupil and keep the process moving

4. The pupil is asked to make quick draw§ wings or sketches (rather than detailed drawings). Reassure the pupil that it doesn't matter if an error is made.

5. It is important to record *exactly* what the pupil says using their own words.

6. If the pupil is overly anxious about drawing, either model stick people drawings first or just record the pupil's verbal responses.

7. Allow time for the pupil to process the requests – repeat/reword/simplify the questions if not understood.

8. Provide reassurance that there are no right or wrong answers or responses.

9. Provide encouragement and praise for the pupil's involvement with the activity.

10. Be sensitive about sharing the drawings with others, ask the child's permission and ensure that other adults understand that the child has trusted you in revealing such views, which must be respected.

11. Talk to other colleagues about planning any follow-up work that might be indicated.

Part 1: Drawing the kind of school you would not like

1. The school

Think about the kind of school you would not like to go to. This is not a real school.

Make a quick drawing of this school in the middle of this paper.

Tell me three things about this school.

What kind of school is this?

2. The classroom Think about the sort of classroom you would not like to be in. Make a quick drawing of this classroom in the school. Draw some of the things in this classroom.

3. The children

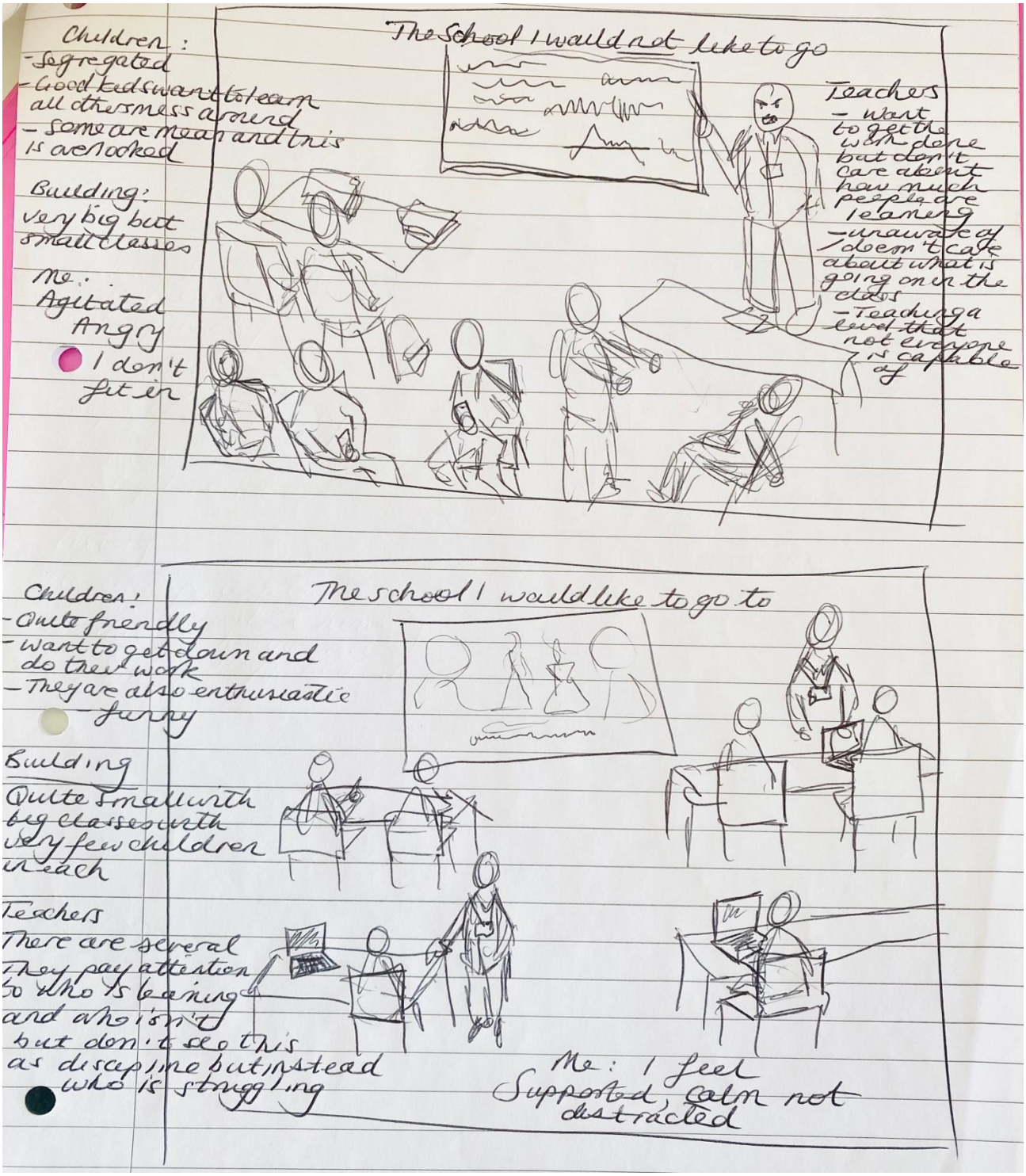
Think about some of the children at the school you would not like to go to.

Make a quick drawing of some of these children.

What are the children doing? Tell me three things about these children.

4. The adults
Think about some of the adults at the school you would not like to go to.
Make a quick drawing of some of these adults.
What are the adults doing? Tell me three things about these adults.
5. Me
Think about the kind of school you would not like to go to.
Make a quick drawing of what you would be doing at this school.
Tell me three things about the way you feel at this school.
'Do you know what sort of school I want?'
Part 2: Drawing the kind of school you would like
6. The school
Think about the kind of school you would like to go to. This is not a real school.
Make a quick drawing of this school in the middle of this paper.
Tell me three things about this school. What kind of school is this?
7. The classroom
Think about the sort of classroom you would like to be in. Make a quick drawing of this classroom in the school. Draw some of the things in this classroom.
8. The children
Think about some of the children at the school you would like to go to.
Make a quick drawing of some of these children.
What are the children doing? Tell me three things about these children.
9. The adults
Think about some of the adults at the school you would like to go to.
Make a quick drawing of some of these adults.
What are the adults doing?
Tell me three things about these adults.
10. Me
Think about the kind of school you would like to go to. Make a quick drawing of what you would be doing at this school. Tell me three things about the way you feel at this school.

Figure 6. An 'ideal/non-ideal school' drawing completed by a young person during a PCP activity.



Appendix D: SENDCo information sheet and consent form

Information Sheet for Head of School/SENDCo

Dear SENDCo,

My name is Nisha Parekh and I am a trainee educational and child psychologist at UCL Institute of Education. I am inviting you and your school to be part of my research, which aims to understand the views and experiences of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) who have been excluded from a mainstream school and are attending an Alternative Provision setting. In this research, I hope to elicit the views of the pupils.

I would very much appreciate arranging a visit at your school setting to discuss my research in further detail with you and find out whether you would like to take part.

If you would be happy for me to come and visit, I am available for contact at the following email address: Nisha.Parekh.14@ucl.ac.uk

Thank you in advance for your time.

Best wishes,

Nisha

Dear Head of school/SENDCo,

Following our meeting, please kindly see the below for information pertaining to my research study. The research study aims to understand the views and experiences of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) who have been excluded from a mainstream school and are attending an Alternative Provision setting. In this research, the views of the pupils with regards to their experience of diagnosis, any intervention experiences and how their needs are best managed at school are considered.

Why is this research important?

Under current legislation, the voices of children with Special Educational Needs and Disabilities regarding important decisions made about them, such as how their needs are understood and addressed, must be listened to by adults and used to inform decision making processes that apply to their home and school lives and, therefore, their everyday life experiences.

In the long term, I hope that my research will encourage key adults who are involved with such children, to seek these children's views and incorporate them into diagnosis and intervention decision making and into their education, health and care plans.

How can schools help with this research?

I am seeking support from schools in advertising the study and recruiting potential participants. As part of the study I would like to:

- Interview children who fit the criteria of having a diagnosis of ADHD and who have been excluded from a mainstream school and are attending an Alternative Provision setting,

To be included in the study, a child must meet the following criteria:

- The child must be in Year 7 to 11,
- The child must have a diagnosis of ADHD,
- The child must be willing to take part in the interview.

If a child is included in the study, I will ask to observe them in class, and interview them over the course of two separate meetings.

Do we have to take part?

It is completely up to you whether or not you participate in the study. If you do decide to take part, I hope you would also find this process and the resulting findings useful when aiming to meet the needs of children with an ADHD diagnosis.

Are there any potential risks if we take part?

Although I do not anticipate any risks associated with taking part in the study, it is possible that discussing personal experiences can cause distress.

Some children may be uncomfortable when talking about their educational experiences, especially if they have negative experiences related to how their needs have been or are managed. If there are obvious signs of distress, I will end the interview immediately and inform relevant staff at the school (to ensure the welfare of the child is monitored). Children will be asked whether they would still like to go ahead with the research; if not, but they would still like to be part of the project, an alternative time and date for the interview to take place will be offered. Children will also be given information on further support services available to discuss any concerns including ChildLine.

Asking parents to talk about their own difficulties may also prove to be sensitive or uncomfortable. In such cases, parents will be asked whether they would still like to go ahead with the research; if not, but they would still like to be part of the project, an alternative time and date for data collection to take place will be offered. Information about relevant sources

of support will be provided in the form of counselling services available within the Local Authority.

Participants will be provided with both the researcher's email address as well as the email address of the academic supervisor should they have any questions about the research.

Is there anything else we need to know?

If you choose to take part, we have some important information to tell you about the way we will use your data (the information you provide us). The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk_UCL's Data Protection Officer can also be contacted at data-protection@ucl.ac.uk

Further information on how UCL uses participant data can be found here: www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice

The legal basis that would be used to process your personal data will be performance of a task in the public interest. The legal basis used to process special category personal data (e.g., ethnic origin) will be for scientific and historical research or statistical purposes/explicit consent. If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk

Thank you for taking the time to read this information sheet! If you have any further questions about the research, you can contact:

- Nisha Parekh (trainee educational and child psychologist)

Email: Nisha.parekh.14@ucl.ac.uk

- Vivian Hill (Supervisor and Course Director for the Doctorate in Professional, Educational, Child and Adolescent Psychology at UCL Institute of Education)

Email: v.hill@ucl.ac.uk

- Dr Laura Crane (Supervisor and Associate Professor at UCL Institute of Education)

Email: l.crane@ucl.ac.uk

If you would like to be involved, please complete the following consent form and return to Nisha.parekh.14@ucl.ac.uk by November 10th, 2019.

This project has been reviewed and approved by the Department of Psychology and Human Development at UCL Institute of Education.

Thank you very much for taking the time to read this information sheet.

Best wishes,

Nisha

Appendix E: Parent information sheet and consent form

Parent Information Sheet

Shared on _____

Dear Parents and Carers,
My name is Nisha Parekh and I am a trainee educational and child psychologist from UCL Institute of Education.
I have designed a research study as I hope to understand the views and experiences of children who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and who have been excluded from a mainstream school and are attending an Alternative Provision setting.

What is the reason for this study?
Children with special needs should be at the centre of their own assessments. Children's own views are greatly important when decisions, such as whether they have a diagnosis and the care plan they will receive, are made. I would like to find out about your child's experiences of these processes. I hope that my research will support and encourage schools and families in finding the best ways to support children with an ADHD diagnosis. We would like to invite your child to be involved in the project and we very much hope that they will like to take part.

What does taking part involve?
Children they will be asked to share their views and experiences of ADHD and of school through interviews. The interviews will be conducted over one or two separate meetings with your child.

Does my child have to take part in the study?
It is completely up to you whether or not you would like your child to participate. At the end of this information sheet there are consent forms to sign if your child would like to take part and you agree for them to do so. After signing the forms for you and/or your child, it is possible to withdraw at any time without giving reason (and it is possible for your child to decide that they do not want to take part). This will not affect your child's education or access to resources in any way.

Who is conducting the research?
I will carry out this research under the supervision of Vivian Hill and Dr Laura Crane from UCL Institute of Education. I am a trainee educational psychologist and the research is part of my training .It will be used for my thesis, which is a written report of my research.
Are there any benefits to taking part in the study?

Although there may not be any direct benefits, it is hoped that the study will provide the chance to learn more about what children with ADHD think and how to support them in school.

Are there any risks to taking part in the research?
We do not anticipate any major risks to study participants. It is important to note that the interviews will involve your child talking about their personal experiences, some of which may be negative. It is possible that, at the end of the research, you decide that you would like to access further support. At the end of the study, some signposts to appropriate services will be provided. If you choose not to take part in the study, you would still be able to have access to the signposts.

Will the information I provide be kept confidential?
Yes – we will not use your name, your child's name, or any other identifying information in reports. Any personal information you provide will only be accessible to the research team. It will be stored securely at UCL Institute of Education for a minimum of ten years (in line with UCL guidance).

What should I do next?
In order for your child to take part, please explain the research study to them, using the attached children's information sheet and discuss whether they would like to take part. It is important that your child knows that they do not have to take part. Your child should also know that if they do agree to take part, they can withdraw from the study at any time, without reason.
I will ask your child if they agree to take part at the start of their interview sessions and explain that they can stop whenever they wish.

If you agree to take part in an interview yourself, it is essential to know that you are not obliged to do so and that you can also withdraw from the study at any time, without reason. If you and your child would like to take part in the study, please kindly complete the consent forms that are attached to this information sheet. One consent form is for agreeing to your child taking part, and the other is for you to sign if you would like to take part individually in the study.

Is there anything else I need to know?
If you choose to take part, we have some important information to tell you about the way we will use your data. The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk
UCL's Data Protection Officer can also be contacted at data-protection@ucl.ac.uk

Your personal data will be processed so long as it is required for the research project. Further information on how UCL uses participant information can be found here: www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice

The legal basis that would be used to process your personal data will be performance of a task in the public interest. The legal basis used to process special category personal data (e.g., ethnic origin) will be for scientific and historical research or statistical purposes/explicit consent. If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk

Thank you for taking the time to read this letter!
If you have any further questions about the research, you can contact:

- Nisha Parekh (trainee educational and child psychologist)
  Email: Nisha.parekh.14@ucl.ac.uk
- Vivian Hill (Supervisor and Course Director for the Doctorate in Professional, Educational, Child and Adolescent Psychology at UCL Institute of Education)
  Email: v.hill@ucl.ac.uk
- Dr Laura Crane (Supervisor and Associate Professor at UCL Institute of Education)
  Email: l.crane@ucl.ac.uk

If you would like to be involved, please complete the following consent form and return to Nisha.parekh.14@ucl.ac.uk by **30.10.19.**
This project has been reviewed and approved by the Department of Psychology and Human Development at UCL Institute of Education.

Thank you very much for taking the time to read this information sheet.

Consent form for agreeing to your child taking part

I have read and understood the project information sheet
YES / NO
I have been given the opportunity to ask questions about the project.
YES / NO
I agree to my child taking part in the project. Taking part in the project will include my child completing interviews, where they will be asked to share their views.
YES/NO
I understand that taking part is voluntary; me or my child can withdraw from the study at any time and we do not have to give any reasons for why we no longer want to take part.
YES / NO
I understand my personal details (such as phone number and address) will not be revealed to people outside the project.
YES / NO
I understand that my child's words may be quoted anonymously in publications, reports, web pages, and other research outputs.
YES / NO
I agree for the data I provide to be stored electronically, in an anonymous format, by the research team for a minimum of ten years
YES / NO
I understand that I can contact Nisha Parekh by email (Nisha.parekh.14@ucl.ac.uk) or by telephone (00352-661-808-082) to discuss this study at any time.
YES / NO
My child has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). Please note any additional diagnoses here:
_____
YES / NO
Name of Child:
Gender of child:
Date of Birth:
Contact email:
Contact phone:
Name of Participant: **Date:**
Researcher: **Date:**

Signature of Participant: _____**Signature of Researcher:** _____

Appendix F: Child Information Sheet and consent form

Information sheet

Hi 💻 my name is Nisha. Here is a picture of me.

I am doing a project about how children feel about having “Attention Deficit Hyperactivity Disorder” or “ADHD”. I have spoken to your parents and they have said that you can join in, if you want to. I would like to know if you would like to join in.
If you decide to join in, then you will be asked to speak with me.
I will meet you two times to ask you questions so that I can try to:

- understand how you would like school to be;
- understand what kind of person you hope to be;
- understand your thoughts about ADHD;
- understand how the ADHD diagnosis happened and if you took part, were things explained to you?
- understand how you are being helped with ADHD;
- think and talk about things that are tricky for you;
- think and talk about things that are going well.

All of the answers you give me in the interviews about what you think will be kept between you and me. I will not put your name on any of your answers. It is important to know that you can say whatever you like in the interview. However, if you tell me something that makes me worried about your safety, I will need to tell someone in your school about it.
It is okay if you do not want to take part in the chat. If you do take part, it may be very interesting and helpful.
If you decide to take part, I will ask you to write your name on an Agreement Form that says:

1. You understand what the project is about

2. You agree to join in with the project

If you want to take part, I look forward to working with you and listening to what you think.

Nisha

For more information about how researchers use the information you provide, please visit this website:
https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice

Agreement form For Pupils

I have talked with Nisha and understood the project information sheet
YES / NO
I have had a chance to ask Nisha questions about the project.
YES / NO
I agree to take part in the project. This means that Nisha will interview me and I will be asked to talk about what I think about myself and my views about school and ADHD.
YES / NO
I understand that I do not have to take part in the study and that I can leave the study at any time. If I decide to leave, I should tell Nisha before the Christmas holiday. I do not have to say why I want to leave.
YES / NO
I understand that the things I say in interview will be kept between me and Nisha.
YES / NO
My name will be replaced with a number so that my name will not appear with my answers.
YES / NO
I understand that I can ask Nisha anything I want to about the project and that my parents have her phone number and email address.
YES / NO

Your name: **Date:**

Researcher (Nisha): **Date:**

Eligibility Review Sheet

For the SENDCo / Head of school

Section A
Please answer Yes or No.

Is the child in Year 7 or above?	YES \ NO

Do the child's parents/carers feel comfortable for their child to share their views and experiences about themselves, their school lives and ADHD?	YES \ NO

Section B
Please answer Yes or No.

Does the child have a diagnosis of ADHD?	YES \ NO
Is the child currently taking any prescription medication to modify an aspect of their behaviour?	YES \ NO

Institute of Education

UCL

Appendix G: Doctoral Student Ethics Application Form

Anyone conducting research under the auspices of the Institute of Education (staff, students or visitors) where the research involves human participants or the use of data collected from human participants, is required to gain ethical approval before starting. This includes preliminary and pilot studies. Please answer all relevant questions in simple terms that can be understood by a lay person and note that your form may be returned if incomplete.

Registering your study with the UCL Data Protection Officer as part of the UCL Research Ethics Review Process

If you are proposing to collect personal data i.e. data from which a living individual can be identified **you must be registered with the UCL Data Protection Office before you submit your ethics application for review**. To do this, email the complete ethics

form to data-protection@ucl.ac.uk. Once your registration number is received, add it to the form* and submit it to your supervisor for approval.

If the Data Protection Office advises you to make changes to the way in which you propose to collect and store the data this should be reflected in your ethics application form.

Section 1 Project details			
a.	Project title		How can Educational Psychologists promote the voices and engagement of children with ADHD, with respect to diagnosis and intervention?
b.	Student name and ID number (e.g. ABC12345678)		Nisha Rupa Parekh ID: PAR14130615
c.	***UCL Data Protection Registration Number**		Date issued
c.	Supervisor/Personal Tutor		Vivian Hill and Laura Crane
d.	Department		Department of Psychology and Human Development
e.	Course category (Tick one)	PhD ☐	EdD ☐
		DEdPsy ☐	
f.	**If applicable,** state who the funder is and if funding has been confirmed.		

g.	Intended research start date	November 5th, 2019
h.	Intended research end date	December 18th, 2019
i.	Country fieldwork will be conducted in *If research to be conducted abroad please check www.fco.gov.uk and submit a completed travel risk assessment form (see guidelines). If the FCO advice is against travel this will be* ***required*** *before ethical approval can be granted: http://ioe-net.inst.ioe.ac.uk/about/profservices/international/Pages/default.aspx*	United Kingdom, England

j.	Has this project been considered by another (external) Research Ethics Committee?	
	Yes ☐	External Committee Name:
	No ☒ *go to Section 2*	Date of Approval:

If yes:

- Submit a copy of the approval letter with this application.
- Proceed to Section 10 Attachments**.**

Note: Ensure that you check the guidelines carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES) or Social Care Research Ethics Committee (SCREC). In addition, if your research is based in another institution then you may be required to apply to their research ethics committee.

Section 2 Research methods summary (tick all that apply)

☒Interviews	☐ Controlled trial/other intervention study
☐ Focus groups	☐ Use of personal records
☐ Questionnaires	☐ Systematic review ☐☐***if only method used go to Section 5.***
☐ Action research	☐ Secondary data analysis ☐☐***if secondary analysis used go to Section 6.***
☐ Observation	
☐ Literature review	

	☐ Advisory/consultation/collaborative groups ☐ Other, give details:

Please provide an overview of the project, focusing on your methodology. This should include some or all of the following: purpose of the research, aims, main research questions, research design, participants, sampling, data collection (including justifications for methods chosen and description of topics/questions to be asked), reporting and dissemination. Please focus on your methodology; the theory, policy, or literary background of your work can be provided in an attached document (i.e. a full research proposal or case for support document). *Minimum 150 words required.*

Aim of the study in the context of existing literature:

Current legislation, as stipulated by the United Nations Convention of the Rights of the Child (UNCRC) (United Nations, 1991, 2005, 2009), the Children's Act (2004), the Children and Families Act (2014), the Working together to Safeguard Children (2010) guidance, and guidelines pertinent to Attention Deficit Hyperactivity Disorder (ADHD) (National Institute of Clinical Excellence, 2018), state the importance of supporting children in sharing their views, and taking those views into account during the process of diagnosis and intervention for ADHD. Furthermore, professionals involved in this process must be conscious that children's opinions will alter as they mature and therefore revisiting their opinions over time is necessary (Kennedy, 2015; Lundy, McEvoy, & Byrne, 2011).

ADHD has been associated with poor life outcomes (Biederman et al., 2004; Wehmeier, Schacht & Barkley, 2010). Various aspects of quality of life have been proposed as being adversely affected in both children and adults with ADHD, particularly emotional well-being, social and emotional competence and parent-child relationships (Araujo, Pfiffner & Haack, 2017; Peasgood et al., 2016; Schmidt & Patermann 2009; Semrud – Clikeman & Schafer, 2000). Literature suggests that school-aged children with ADHD experience numerous academic and educational difficulties (Arnold, Hodgkins, Kahle, Madhoo and Kewley, 2015). In comparison to children and young people without an ADHD diagnosis, children with an ADHD diagnosis are more likely to utilise school SEND resources (LeFever, Viillers, Morrow & Vaughn 2002) and present with behavioural problems that lead to exclusion (Pirrie and Macleod 2009). Whear, Marlow and Boddy, (2014) assert that various studies indicate that children with a diagnosis of ADHD are significantly more likely to experience exclusion from school.
This study focuses on eliciting the views of children who have an ADHD diagnosis, who have experienced school exclusion and who have been placed in an Alternative

Provision (AP) setting. AP settings provide education to children and young people who have been excluded from mainstream education for social, emotional and mental health difficulties.

The views of children and young people with ADHD have been identified as lacking in current literature (Herz and Haertel, 2016) despite the disorder being one of the most widely studies childhood disorders (Singh et al., 2010). Current research and practice are not reflective of existing legislative stipulations and recommendations on the rights of the child to share their voice. As the child's view may differ from the views of adults, this can have strong impacts on wellbeing and self-esteem, and affect how receptive the child is to intervention.

The study is emancipatory in its aims to promote excluded children with ADHD's voices, facilitate their increased participation and empowerment, and discover the child's perspective as this has been rarely explored in other studies. Noted effects of school exclusion in the UK include educational underachievement, isolation and social exclusion (Wright, Weeks & McGlaughin, 2000). The added vulnerability of these children due to their complex needs adds to the necessity for professionals to promote their communication and facilitate the acknowledgment and incorporation of their views into decisions made about them. This will ensure that their ADHD diagnosis and intervention processes are tailored to their individual needs and, therefore, lead to better life outcomes.

The proposed study is multi-informant and will include eliciting the views and experiences of the children themselves, as well as eliciting the views of their parents/carers and teachers. Within existing literature, studies pertaining to diagnosed children's views of having an ADHD diagnosis can be found (Singh, 2012; Singh et al., 2010). However, to our knowledge, no studies have elicited the views of children with an ADHD diagnosis who had experienced school exclusion and placement in an AP setting; a particularly vulnerable group. In addition, from reviewing existing studies of the views of children with ADHD, it appears that the provision of information necessary for children's decision-making is lacking, as are the corresponding processes of the elicitation and consideration of children's views (see, for example, Kendall et al., 2003; Moldavsky & Sayal, 2013; Travell & Visser, 2006). Whilst children in these studies held views and were prompted to share them, it is unclear as to the nature of the information they had received and used to formulate those views. It is hoped that the multi-informant nature of this study will enable an understanding of the information children and their families receive during the ADHD diagnostic and post-diagnostic processes. Many studies highlight that processes do not meet the requirements for children's rights, resulting in diagnosis and intervention processes that are ill-fitting and that place

constraints on children's self-concept and agency. It is likely that the social and educational disadvantage experienced from exclusion (Gazeley, 2010) might exacerbate these constraints.

In the current study, parents and teachers will be interviewed through the use of a semi-structured interview schedule (please see Appendix 5).
For eliciting the views of child participants, in addition to the use of a semi-structured interview schedule the study will use child friendly evidence-based techniques, specifically 'The Ideal Self' and 'The Ideal School' tasks (Moran, 2001, 2006) in which the children are asked to draw their non-ideal and ideal selves and schools and discuss these with the researcher (please see Appendix 1 and Appendix 2). Collectively these methods have been chosen in order to gain an understanding of children's experiences and involvement in the processes of diagnosis and intervention for ADHD. It is hoped that the contribution made by children through each of these techniques will enhance the quality of data through clarifying more subtle messages and uncovering nuances. While there are limits to what children can and may wish to do in the process of an adult-led interaction (O'Kane, 2008), UNCRC-informed approaches might assume the use of strategies that facilitate children to engage in a meaningful way, thus enhancing the quality of the study findings (Greig, Taylor, & MacKay, 2007).
It is hoped that the findings may be used to inform the development of a UNCRC-informed framework for Educational Psychologists to use to promote children's voices and engagement during diagnosis and intervention processes for ADHD.

Research questions:
1. What are the views and experiences of children who have a diagnosis of ADHD with respect to the processes of ADHD diagnosis and intervention?
2. What are the views and experiences of these children's parents and teachers with respect to the processes of ADHD diagnosis and intervention? And to what extent are these similar to/different from those of the child?
3. How can this information used to formulate a template to enable EPs to elicit the views of CYP decision making during diagnosis and intervention processes and to inform their EHCPs?

Research design and data collection:
The current study will employ qualitative research methods. The study will be multi-informant in nature, across two different alternative provision settings, thus enabling in-depth exploration (Simons, 2014).

In total, the aim is for ten pupils, ten parents and ten teachers to participate in the study. All of the pupils will have received a formal diagnosis of ADHD. The age range will be across the secondary age range, from 11 to 16 years, including both boys and girls.

The ten pupils will be interviewed through a process across two sessions that will consist of taking part in a semi-structured interview and The Ideal Self and The Ideal School activities (please see Appendix 1 and 2).

The ten teachers will be interviewed through the use of a semi-structured interview schedule (Appendix 5).

The ten parents will be interviewed through the use of a semi-structured interview schedule (attached).

All information collected will be treated in the strictest confidence in line with the Data Protection Act and GDPR. The consent of all participants, including parental consent, will be sought. All personal data will be stored separately from interview data and in accordance with UCL Data Protection Policy.

Section 3 Research Participants (tick all that apply)

☐ Early years/pre-school ☒ Ages 5-11 ☒ Ages 12-16 ☐ Young people aged 17-18	☐ [Symbol] Adults - parents and teachers of participant children ☐ Unknown – specify below ☐ No participants

NB: Ensure that you check the guidelines carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES) or Social Care Research Ethics Committee (SCREC).

Section 4 Security-sensitive material (only complete if applicable)

Security sensitive research includes: commissioned by the military; commissioned under an EU security call; involves the acquisition of security clearances; concerns terrorist or extreme groups.

a.	Will your project consider or encounter security-sensitive material?	Yes ☐ *	No ☐
b.	Will you be visiting websites associated with extreme or terrorist organisations?	Yes ☐ *	No ☐
c.	Will you be storing or transmitting any materials that could be interpreted as promoting or endorsing terrorist acts?	Yes ☐ *	No ☐
* *Give further details in* ***Section 8 Ethical Issues*** ☐			

Section 5 Systematic reviews of research (only complete if applicable)			
a.	Will you be collecting any new data from participants?	Yes ☐ *	No ☐
b.	Will you be analysing any secondary data?	Yes ☐ *	No ☐
* *Give further details in* ***Section 8 Ethical Issues*** ☐ *If your methods do not involve engagement with participants (e.g. systematic review, literature review)* ***and*** *if you have answered* ***No*** *to both questions, please go to* ***Section 8 Attachments.***			

Section 6 Secondary data analysis (only complete if applicable)				
a.	Name of dataset/s			
b.	Owner of dataset/s			
c.	Are the data in the public domain?	Yes ☐	No ☐	
			If no, *do you have the owner's permission/license?* Yes ☐ No* ☐	
d.	Are the data special category personal data (i.e. personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a		Yes* ☐	No ☐

	natural person, data concerning health or data concerning a natural person's sex life or sexual orientation)?		
e.	Will you be conducting analysis within the remit it was originally collected for?	Yes ☐	No* ☐
f.	**If no,** was consent gained from participants for subsequent/future analysis?	Yes ☐	No* ☐
g.	**If no,** was data collected prior to ethics approval process?	Yes ☐	No* ☐

** Give further details in **Section 8 Ethical Issues***

*If secondary analysis is only method used **and** no answers with asterisks are ticked, go to **Section 9 Attachments.***

Section 7 Data Storage and Security

Please ensure that you include all hard and electronic data when completing this section.

a.	**Data subjects -** Who will the data be collected from? Approximately ten children with a diagnosis of ADHD, ten parents and ten teachers.
b.	**What data will be collected?** Please provide details of the type of personal data to be collected Data collected will be the voice recorded views expressed by the children, parents and teachers that will participate in individual interviews. These data will then be transcribed into written form (removing identifying information from the transcripts) and the voice recordings will be permanently deleted. Annotated drawings from the Ideal self and Ideal School will be collected in paper form. They will be scanned and stored electronically, before the original versions, before the original versions are destroyed.

c.	**Is the data anonymised?** Yes ☐ No* ☒ Do you plan to anonymise the data? No ☒ Yes ☐ Do you plan to use individual level data? Yes* ☒ No ☐ Do you plan to pseudonymise the data? Yes* ☒ No ☐ ** Give further details in **Section 8 Ethical Issues***
e.	**i. Disclosure** – Who will the results of your project be disclosed to? The results of my project will be shared with participants (in an accessible format) and also presented in my DEdPsy thesis. Also, my thesis will be made available in UCL university library and may be prepared for publication. **ii. Disclosure** – Will personal data be disclosed as part of your project? No.
f.	**Data storage** – Please provide details on how and where the data will be stored i.e. UCL network, encrypted USB stick**, encrypted laptop** etc. Data will be stored on the UCL network online, which requires password protected access. In addition, the network login is carried out on either an encrypted desktop computer or an encrypted laptop computer. ** Advanced Encryption Standard 256 bit encryption which has been made a security standard within the NHS
g.	**Data Safe Haven (Identifiable Data Handling Solution)** – Will the personal identifiable data collected and processed as part of this research be stored in the UCL Data Safe Haven (mainly used by SLMS divisions, institutes and departments)? Yes ☐ No ☒
h.	**How long will the data and records be kept for and in what format?** In accordance with UCL research protocols, all data will be stored for a minimum of 10 years. The participant voice recordings will be deleted after transcription.

	The hard copy data, consisting of participant consent forms and drawings will be scanned into electronic format and then stored on the UCL network. The hard copies will then be destroyed. **Will personal data be processed or be sent outside the European Economic Area?** (If yes, please confirm that there are adequate levels of protections in compliance with GDPR and state what these arrangements are) No Will data be archived for use by other researchers? (If yes, please provide details.) No
i.	**If personal data is used as part of your project, describe what measures you have in place to ensure that the data is only used for the research purpose e.g. pseudonymisation and short retention period of data'** The hard copy consent forms comprising personal data will be scanned and placed on the UCL Network in password protected format before the originals are destroyed. In accordance with UCL research protocols, all data will be stored for a minimum of 10 years.
	** Give further details in **Section 8 Ethical Issues***

Section 8 - Ethical Issues	
Please state clearly the ethical issues which may arise in the course of this research and how will they be addressed. **All** issues that may apply should be addressed. Some examples are given below, further information can be found in the guidelines. *Minimum 150 words required.*	
− Methods − Sampling − Recruitment − Gatekeepers − Informed consent − Potentially vulnerable participants − Safeguarding/child protection	− International research − Risks to participants and/or researchers − Confidentiality/Anonymity − Disclosures/limits to confidentiality − Data storage and security both during and after the research (including transfer, sharing, encryption, protection) − Reporting − Dissemination and use of findings

− Sensitive topics	

Informed Consent

At the start of the process, participants will be provided with information and consent forms (please see Appendix 3 and 4, respectively).

For children: First I will gain informed consent from the child's parent/carer. Having gained this consent I will spend time talking each child through the child versions of the information and consent forms, which have been adapted to be as accessible as possible to children of secondary school age. For example, a photo of myself has been inserted to provide a clear idea of who I am and that I am the person running the project. Children will be reminded that they are not obliged to take part, and that they can withdraw at any time without reason.

At the end of this process, children will be asked whether or not they would like to sign the consent form. Based on my professional judgement (as a trainee educational psychologist, experienced in working with this group of children), if the children appear to understand what the interview conversation will be about, why the project is being conducted and state being sure they would like to take part, their signed consent will be accepted.

For adult participants: The information sheets will state the purpose of the project and the value of gaining the views of the participants. It will emphasise that participants can withdraw their personal data at any time, however their interview data might not be possible to withdraw if it has already been analysed and reported in publications. A timeframe is provided in the participant information sheets (please see Appendix 3) by which participants would need to withdraw their interview data. Participants will be reminded of these points during the interviews. It will also be explained that at the start of the interview, participants will be briefed about what will be expected of them, in terms of tasks and their respective duration, so that all participants understand what is involved. All participants will be provided with details to contact myself or my supervisors should they require further information about the study.

Potentially vulnerable participants

Potential challenges related to emotional difficulties may arise when interviewing children with a diagnosis of ADHD. Furthermore, the children participating in this study, who have experienced exclusion and attend an AP setting, are likely to experience compromised social emotional and mental health (SEMH), increasing the likelihood of such challenges.

As a trainee educational psychologist, I have gained and continue to gain (on an ongoing basis) the experience of working in AP settings for children with SEMH. In addition to gaining skills in forming a positive rapport with such children and young people, I am familiar with protocols that are in place to protect both staff and children and young people. A 'walkie – talkie' device is provided and used so that assistance can be summoned at any time from other members of staff, all of whom carry them. The door is fixed open using a hook, and school staff to whom the child and their individual needs is familiar are seated outside in rooms opposite or in close vicinity. If it is recommended, the child or young person's key worker may also be present during the interview.

Interviews will take place in an environment where children/young people feel comfortable, such as in a room they choose in their setting, and the interviews will be worded in a way that makes the research accessible. Participants will also be told that they can take a break from all the activities involved in the data collection process at any time. In case children/young people may feel reluctant to interrupt and ask to stop the process, there will be a 'Stop card' on the table, so that they can point to it and be reminded of the possibility to stop the process at all times. If participants would like a parent/carer or staff member present for the interview they will be allowed to have someone with them.

Sensitive Topics

As a trainee educational psychologist and former primary school teacher, I have had and continue to have various opportunities to gain experience in talking to children about their experiences, which very often include sensitive topics. I have been able to gain sound skills in building rapport and facilitating children to share their voice in situations where it may be challenging for them.

Some children may be uncomfortable when talking about their educational experiences, especially if they have negative experiences related to how their needs have been or are managed. If there are obvious signs of distress, the researcher will end the interview immediately and inform relevant staff at the school (to ensure the welfare of the pupil is monitored).

Asking parents to talk about their own difficulties may also prove to be sensitive or uncomfortable. In such cases, these children will be asked whether they would still like to go ahead with the research; if not, but they would still like to be part of the project, an alternative time and date for data collection to take place will be offered. In addition, in the event of parents experiencing upset/distress during the interview process, parents will be provided with details of support 'parent counselling' services that are available to them through the local offer?

Children will also be given information on further support services available to discuss any concerns including ChildLine. ChildLine describes itself as an organization that is reachable through email communication, internet messaging or phone call to help anyone under 19 in the UK with any issue they're going through. The people providing the service are described as trained counsellors. The contact is described as free, confidential and available at any time of day or night.

Participants will be provided with both the researcher's professional email address as well as the email address of the academic supervisor should they have any questions about the research. Information about relevant sources of support will be provided in the form of the counselling services available for parents in the local offer of the local authority in which the study will take place.

Confidentiality/Anonymity

In order to ensure confidentiality, participants and schools will each be provided with an ID number that will then be used on interview transcripts or on photos of drawings. The ID number will also be used in the written form of the research thesis. Annotated activities will only contain the participant's ID number and will be stored separately from the consent forms so participants are unlikely to be recognised.

Disclosures/limits to confidentiality

All participants will receive an explanation about the limitations to confidentiality. This will be explained through the consent forms (please see Appendix 4), and also at the start of the interview.

If a pupil makes a disclosure during an interview that may require further disclosure, the protocol would consist of sharing this both verbally and in writing with the lead safeguarding officer in school, as well as the school SENDCO (who would likely be involved in supporting the research and the child). The child would need to be informed, at the start of the interview that I will have to disclose this information as part of their

safeguarding. If parents or teachers make a disclosure the protocol would be to report to the lead safeguarding officer in school.

Data storage and security both during and after the research (including transfer, sharing, encryption, protection

The hard copy versions of the completed and signed participant consent forms will be scanned into electronic format at the end of the data collection process, and then destroyed. Electronic versions will be stored on the UCL network which would either be accessed through an encrypted UCL computer or an encrypted laptop computer.
At the start of the interviews, participants will be reminded that the interview is being recorded.
In the event of participants deciding not to consent to the use of a voice recorder during the interview, they would still be provided with the opportunity to take part in the interview. In this case, detailed notes would be taken throughout the interview discussion. Interviews will be recorded using a voice recorder application inside of a laptop. This provides password protected access to the recordings. The voice recordings will be transcribed into text format following the interview, before the original audio files are deleted. Any contents in the recording that have the potential to capture personal information (e.g., names, addresses) will be edited during the transcription process to protect the confidentiality of the information. Transcribed data will be stored in electronic password protected format on the UCL network which can be accessed through either a UCL computer or an encrypted laptop. They will be stored separately from the participant consent forms, as these will contain personal data.

Dissemination and use of findings

The participants will be informed of the findings in the final term of the current academic year, after a final draft of the DEdPsy thesis has been reviewed by supervisors and is deemed adequate for submission. An executive summary of research findings will be shared in the form of a briefing for schools and parents. Additionally, a ‘Rich Picture’ format will be used to produce a one page child-friendly summary of the findings to share with all of the pupils.

The results of my project will be presented in my DEdPsy thesis. Also, my thesis will be made available in the UCL library and results may be prepared for publication.

Please confirm that the processing of the data is not likely to cause substantial damage or distress to an individual
Yes ☒

Section 9 Attachments Please attach the following items to this form, or explain if not attached			
a.	Information sheets, consent forms and other materials to be used to inform potential participants about the research *(List attachments below)* Appendix 1: The Ideal Self Appendix 2: The Ideal School Appendix 3: Participant Information sheet Appendix 4: Participant consent form Appendix 5: Semi Structured Interview	Yes ☒	No ☐
	If applicable/appropriate:		
b.	Approval letter from external Research Ethics Committee	Yes ☐	
c.	The proposal ('case for support') for the project	Yes ☐	
d.	Full risk assessment	Yes ☐	

Section 10 Declaration
I confirm that to the best of my knowledge the information in this form is correct and that this is a full description of the ethical issues that may arise in the course of this project. I have discussed the ethical issues relating to my research with my supervisor. ☒Yes I have attended the appropriate ethics training provided by my course. ☒Yes

I confirm that to the best of my knowledge:

The above information is correct and that this is a full description of the ethics issues that may arise in the course of this project.

Name	Nisha Rupa Parekh
Date	20th October 2019

Please submit your completed ethics forms to your supervisor for review.

Notes and references

Professional code of ethics
You should read and understand relevant ethics guidelines, for example:
British Psychological Society (2018) *Code of Ethics and Conduct*
or
British Educational Research Association (2018) *Ethical Guidelines*
or
British Sociological Association (2017) *Statement of Ethical Practice*
Please see the respective websites for these or later versions; direct links to the latest versions are available on the Institute of Education
http://www.ucl.ac.uk/ioe/research/research-ethics

Disclosure and Barring Service checks
If you are planning to carry out research in regulated Education environments such as Schools, or if your research will bring you into contact with children and young people (under the age of 18), you will need to have a Disclosure and Barring Service (DBS) CHECK, before you start. The DBS was previously known as the Criminal Records Bureau (CRB). If you do not already hold a current DBS check, and have not registered with the DBS update service, you will need to obtain one through at IOE.

Ensure that you apply for the DBS check in plenty of time as will take around 4 weeks, though can take longer depending on the circumstances.

Further references
The www.ethicsguidebook.ac.uk website is very useful for assisting you to think through the ethical issues arising from your project.

Robson, Colin (2011). *Real world research: a resource for social scientists and practitioner researchers* (3rd edition). Oxford: Blackwell.
This text has a helpful section on ethical considerations.

Alderson, P. and Morrow, V. (2011) *The Ethics of Research with Children and Young People: A Practical Handbook.* London: Sage.
This text has useful suggestions if you are conducting research with children and young people.

Wiles, R. (2013) What are Qualitative Research Ethics? Bloomsbury.
A useful and short text covering areas including informed consent, approaches to research ethics including examples of ethical dilemmas.

Departmental use

If a project raises particularly challenging ethics issues, or a more detailed review would be appropriate, the supervisor **must** refer the application to the Research Development Administrator (via ioe.researchethics@ucl.ac.uk so that it can be submitted to the IOE Research Ethics Committee for consideration. A departmental research ethics coordinator or representative can advise you, either to support your review process, or help decide whether an application should be referred to the REC. If unsure please refer to the guidelines explaining when to refer the ethics application to the IOE Research Ethics Committee, posted on the committee's website.	
Student name	
Student department	
Course	
Project title	
Reviewer 1	
Supervisor/first reviewer name	Laura Crane
Do you foresee any ethical difficulties with this research?	Whilst there are many ethical issues associated with this research, these have been careful thought through, to ensure risks are minimized. This, coupled with Nisha's extensive professional experience, reassure me about the ethical integrity of the work.
Supervisor/first reviewer signature	[redacted]
Date	
Reviewer 2	Vivian Hill
Second reviewer name	
Do you foresee any ethical difficulties with this research?	Nisha has carefully considered the many ethical issues that may emerge during the study and has thought about how to manage these. As a trainee EP in the study context she is well versed in the management of these issues.
Supervisor/second reviewer signature	[redacted]
Date	18th October 2019
Decision on behalf of reviews	

Decision	Approved	☐
	Approved subject to the following additional measures	☐
	Not approved for the reasons given below	☐
	Referred to REC for review	☐
Points to be noted by other reviewers and in report to REC		
Comments from reviewers for the applicant		
Once it is approved by both reviewers, students should submit their ethics application form to the Centre for Doctoral Education team: IOE.CDE@ucl.ac.uk.		

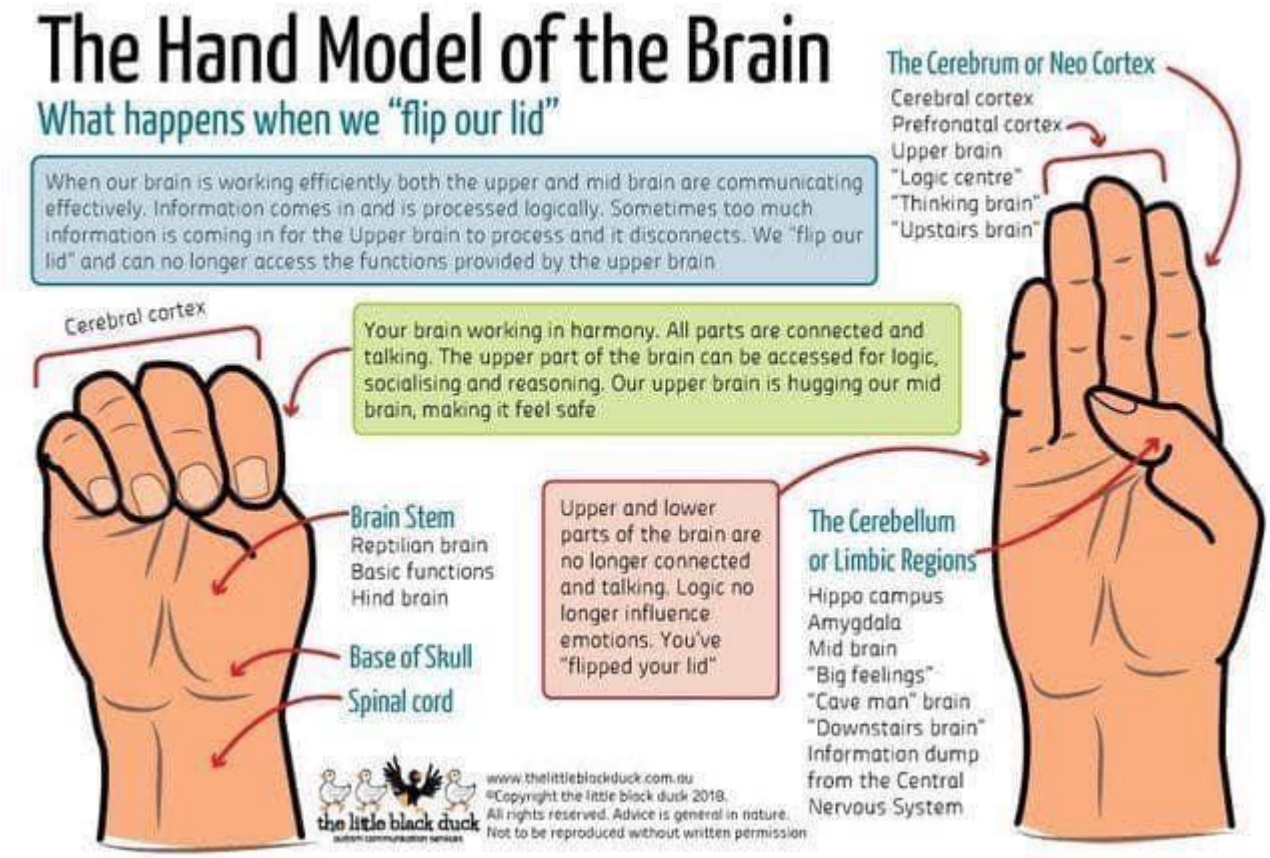
Appendix H: Interactive Factors Framework **Environmental Factors**	https://schools.local-offer.org/send-toolkit/send/assess-plan-do-review/assess/iff-prompt/ **Within-Child Factors**	
Family, School, Community Factors ● Family dynamics (including CEC, adopted and CYP with SGO's) ● (siblings, extended family, links and relationship to school and education) ● Family Stressors ● Financial stress ● Housing	**Biological Factors** ● Family history including: Early development, Physical development, Medical conditions and diagnoses/difficulties ● General health ● Medication ● Dietary needs ● Sensory needs ● Addictions e.g. smoking, drink, drugs	
	Cognitive Factors Assessable Factors: ● Memory ● Language	**Affective Factors** ● Experience of developr trauma

● Home Learning Environment ● Parental attitude to school/education ● Trauma/significant life events ● Adverse Childhood Events ● Family views ● Bereavements/relational losses ● Key adults / members of staff (significant relationships both positive and negative in and out of school) and level of school commitment to child ● Travel distance to school ● School attendance ● Child's views/preferences ● School-parent relationship ● Peer group dynamics ● School Learning Environment ● Access to interventions and support ● Curriculum/Exam boards ● Teacher expectations ● Teacher/staff understanding/knowledge ● Attainment-based grouping ● Influences in school and the local community ● Other agency involvement - Police, YOT, CAMHS, Speech and Language Service, Fair Access, SENAT, Virtual School, SGO Advisor, Intensive Planning Team, Prevent, CSE, Early	● Executive functioning: including emotional and behavioural regulation/development ● Attention and concentration ● Visual spatial ability ● Phonological processing ● Processing speed ● Non-verbal reasoning ● Verbal ability (e.g. word problems, verbal presentation) ● Logical reasoning ability ● Literacy skills ● Attainment Factors which can be identified through observation and consultation: ● Signs of developmental trauma impacting on ability to participate in learning ● Ability to problem-solve ● Flexibility of thought and action ● Self-awareness	● Confidence ● Self-esteem ● Emotional understandi expression ● Sense of enablement ● Sense of self ● Sense of belonging ● Motivation (intrinsic or ● Resiliency ● Mood ● Anxiety ● Aspirations ● Perseverance / determ ● Sense of humour ● Self-control ● Social skills ● Empathy
	Behavioural Factors ● Ability to develop and maintain friendships and relationships ● Positive achievements ● Care/concern for others, volunteering, helping ● Dangerous or risk taking behaviour ● Verbal / physical abuse ● Self-harm ● Bullying ● Truancy	

Years, School Nurse, Portage, Early Help, Social and Caring Services Health Services involvement	

Appendix I: The Hand Model of the Brain

The Hand Model of the Brain (Siegel, 2010) can be used to teach mindsight (awareness of internal states).



FLIPPING your lid
PREFRONTAL CORTEX
"THINKING BRAIN"
CEREBELLUM
"BIG FEELINGS"
FLIPPED LID
CEREBRAL CORTEX
BRAIN STEM
BASE OF SKULL
SPINAL CORD
CALM MIND
You lose access to your prefrontal cortex, your "thinking brain." Your amygdala activates the fight, flight, freeze response, and you operate from a place of fear.
Since all of the parts of your brain are working in harmony, you feel calm, balanced, and alert yet relaxed.
ASSET
EDUCATION