IJNMI

Research Article

A Comparative Study on the Effectiveness of Educational Intervention in Enhancing Knowledge, Attitude, and Practices regarding Attention-Deficit Hyperactivity Disorder among School Teachers and Parents in a Metropolitan City

Rushikesh Madhukar Manwatkar[1], Nilima Sonawane[2]

[1]Department of Community Health Nursing, Institute of Nursing Education, Sir J J Group of Hospital, Mumbai, Maharashtra, India, [2]Assistant Director of Health Services Nursing, Public Health Department, Government of Maharashtra, Mumbai, Maharashtra, India

Abstract

Background: Attention-deficit hyperactivity disorder (ADHD) is a common neurodevelopmental condition in children that can adversely influence their academic achievements and social interactions. Early detection and effective management largely depend on the awareness and involvement of both educators and parents. This study aimed to evaluate and compare the impact of an educational program on the knowledge, attitudes, and practices (KAP) regarding ADHD among schoolteachers and parents.

Materials and Methods: A quasi-experimental approach was adopted with assessments conducted before and after the intervention. The study involved 120 participants – 60 school teachers and 60 parents – selected through purposive sampling from schools in a metropolitan area. A validated semi-structured questionnaire was utilized to measure participants' KAP levels pre- and post-intervention.

Results: Following the educational program, both groups showed statistically significant improvements in their KAP ($P < 0.05$). Teachers had a higher baseline knowledge compared to parents, but the intervention proved effective across both groups. In addition, strong positive correlations were identified among KAP scores.

Conclusion: The findings suggest that targeted educational initiatives can effectively improve ADHD-related awareness and behavior among parents and teachers. Integrating such interventions into teacher development programs and parent workshops is highly recommended.

Keywords: Attention-deficit hyperactivity disorder, educational intervention, knowledge, attitudes, practices, parents, teachers

Introduction

Attention-deficit hyperactivity disorder (ADHD) ranks among the most prevalent behavioral and neurodevelopmental conditions affecting children globally. It is marked by ongoing issues with attention, excessive activity, and impulsive behavior that disrupt normal development and daily functioning. These symptoms often result in academic difficulties, social interaction problems, and emotional strain for both the children and their families. Estimates indicate that ADHD affects approximately 5–10% of school-aged children worldwide, and in as many as 60% of cases, the symptoms can persist into adulthood.[1]

The American Psychiatric Association, in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), categorizes ADHD into three distinct types:

Date of Submission: 15-04-2025
Date of Revision: 06-05-2025
Date of Acceptance: 20-05-2025

Access this article online
Website: https://innovationaljournals.com/index.php/ijnmi
ISSN No: 2456-4656
DOI: 10.31690/ijnmi.2025.v010i02.003

Address for Correspondence:
Rushikesh Madhukar Manwatkar, Department of Community Health Nursing, Institute of Nursing Education, Sir J J Group of Hospital, Mumbai,Maharashtra, India.
E-mail: rushi.manwatkar17@gmail.com

The inattentive type, the hyperactive-impulsive type, and a combined type that features symptoms of both.[2] The causes of ADHD are diverse and involve a combination of genetic, neurological, and environmental influences. Research involving families indicates a hereditary pattern, as children with ADHD often have close relatives – such as siblings or parents – who also exhibit the disorder. Brain imaging studies have identified both structural and functional variations in individuals with ADHD, including imbalances in neurotransmitters like dopamine.[3]

The clinical presentation of ADHD varies among individuals. Inattentive children may display forgetfulness, disorganization, and difficulty maintaining focus, whereas hyperactive-impulsive children often exhibit restlessness, excessive talking, and difficulty waiting their turn. These symptoms, which typically begin before age 12, must be present across multiple settings and cause significant impairment to warrant a formal diagnosis.[4]

Diagnosing ADHD is complex and involves a multi-method assessment that includes medical evaluation, observation, and input from parents, teachers, and other caregivers using standardized rating scales and DSM-5 criteria. In young children, particularly preschoolers, diagnosis is even more challenging due to overlapping developmental conditions, such as language delays or anxiety disorders.

Management of ADHD primarily relies on a combination of medication and behavioral therapies. Stimulant drugs, including methylphenidate and amphetamines, are the most frequently used treatments and have shown significant effectiveness in reducing the primary symptoms of the disorder.[5] Non-stimulant drugs such as atomoxetine, guanfacine, and some antidepressants serve as effective alternatives to stimulant medications. While these treatments help manage symptoms, they do not offer a cure, and achieving optimal results typically demands careful dosage adjustments and ongoing monitoring.

Complementing pharmacological treatments, behavioral therapy, psychoeducation, social skills training, and parent/teacher-led interventions significantly contribute to improving functional outcomes.[1] Providing effective and well-rounded care for children with ADHD requires coordinated efforts from parents, teachers, healthcare providers, and mental health specialists. Studies highlight that structured educational programs play a key role in improving teachers' understanding, attitudes, and instructional strategies, all of which significantly influence the learning atmosphere for affected children.[6,7]

In school settings, children with ADHD are frequently perceived as disruptive due to their inability to sit still, follow instructions, or complete tasks without constant redirection. While some children with ADHD may grasp academic content quickly, others struggle due to attentional lapses and impulsivity. Teachers often experience frustration when faced with such behaviors, and in the absence of proper training, may inadvertently stigmatize or isolate these students. A compassionate, informed approach by educators – such as preferential seating, simplified instructions, use of visual aids, and individualized attention – can significantly support these students' academic and behavioral development.[8]

Similarly, parents play a vital role in managing their child's ADHD-related challenges. Positive parenting strategies, routine monitoring of schoolwork, and collaboration with teachers are critical in fostering consistent behavioral support both at home and in school. Evidence shows that educational interventions tailored to both teachers and parents can transform their understanding and approach toward ADHD, reducing stigma and enhancing the child's overall well-being.[9]

The historical evolution of ADHD as a recognized clinical entity spans centuries. Ancient Greek physician Hippocrates was among the first to describe behaviors consistent with ADHD, referring to "quickened responses to sensory experience" due to an imbalance in bodily humors.[8] The formal clinical characterization began in the 19th and 20th centuries with George Still's early documentation in 1902, and later classification changes through the successive editions of the DSM – from "minimal brain dysfunction" in DSM-I (1952) to the current ADHD subtypes described in DSM-5. Pharmacotherapy began with the use of stimulants in the 1930s, and today remains a foundational aspect of treatment alongside psychosocial interventions.[10]

Despite the growing awareness and availability of treatments, many teachers and parents still lack adequate knowledge and practical strategies for managing ADHD in real-life settings. This gap in understanding can delay identification and intervention, thereby exacerbating academic, emotional, and social difficulties for the child. Studies from various settings have emphasized that structured training programs significantly improve teachers' and parents' knowledge, reshape their attitudes, and enhance classroom and home management techniques.[8]

Considering the significant influence teachers and parents have on the growth and management of children with ADHD, implementing evidence-based educational programs is crucial. These initiatives should go beyond simply raising awareness – they should promote empathy, support early recognition, and encourage the adoption of effective, child-centered approaches. In light of this, the current study aims to assess the impact of such an educational intervention on the knowledge, attitudes, and practices (KAP) of both schoolteachers and parents.

Aim of the study

To assess and compare the effectiveness of an educational intervention in enhancing the KAP related to ADHD among school teachers and parents from selected schools in a metropolitan city.

Objectives

Primary objective

To evaluate the effect of an educational intervention on the KAPs regarding ADHD among school teachers and parents.

Secondary objectives

1. To assess the baseline levels of KAPs related to ADHD among school teachers and parents prior to the intervention
2. To examine the correlation between KAPs regarding ADHD among school teachers and parents
3. To determine the association between KAP scores and selected demographic variables (e.g., age, gender, education, and income) among school teachers and parents.

Materials and Methods

Research approach and design

This study adopted a quantitative research approach, aiming to measure the effectiveness of an educational intervention on KAP regarding ADHD among school teachers and parents. A quasi-experimental one-group pre-test post-test design was employed to evaluate the effect of the intervention.

Study population

The study population consisted of school teachers and parents from selected schools in a metropolitan city. The target population included those who met the inclusion criteria: school teachers actively teaching at primary or secondary levels, and parents of school-going children, all from the same metropolitan area. The accessible population comprised the subset of this group that was available and willing to participate during the data collection phase.

Sample and sampling technique

A total of 120 participants were selected for the study, comprising 60 school teachers and 60 parents. The sample size was determined based on feasibility, availability, and the thumb rule for educational intervention studies. Non-probability purposive sampling was employed to recruit participants who were most likely to provide relevant data for the study objectives.

Inclusion criteria

- Teachers working in selected metropolitan schools
- Parents of children enrolled in those schools
- Willingness to participate and provide informed consent.

Exclusion criteria

- Individuals who had previously undergone any formal training on ADHD
- Unwilling or unavailable participants during the intervention or follow-up phase.

Development and description of research tools

Three tools were developed by the investigator after an extensive review of the literature, consultation with nursing experts, and guidance from statisticians [Table 1]:

1. Structured knowledge questionnaire (tool I)
    - This instrument comprised 29 multiple-choice questions, categorized into seven domains: Concept of ADHD, high-risk groups, signs and symptoms, investigations, therapy/treatment, preventive measures, and government schemes. Each correct response was scored as 1, with a maximum score of 29.
2. Knowledge score interpretation
    - Excellent: ≥61%
    - Good: 51–60%
    - Average: 41–50%
    - Poor: <40%.
3. Five-point Likert attitude scale (tool II)
    - This scale included 22 items (11 positive and 11 negative statements) to measure participants' attitudes toward ADHD. Scores ranged from 1 (strongly disagree) to 5 (strongly agree), yielding a maximum score of 110.
4. Attitude score interpretation
    - Positive: ≥51%
    - Negative: <50%.
5. Self-reported practice checklist (tool III)
    - This checklist contained 12 dichotomous items (Yes/No) to assess behavioral practices related to ADHD management.
6. Practice score interpretation
    - Excellent: ≥61%
    - Good: 51–60%
    - Average: 41–50%
    - Poor: <40%

All tools were prepared in English and translated into Marathi for ease of understanding and validated by subject experts in community health nursing, psychiatry, and sociology.

Validity and reliability

Content validity of the tools was ensured through expert reviews, with modifications made according to their feedback. The reliability of the instruments was confirmed using appropriate statistical tests:

- Structured knowledge questionnaire - split-half method, r = 0.81
- Attitude scale - test-retest method, r = 0.97
- Practice checklist - test-retest method, r = 0.90

All tools were found to be statistically reliable, exceeding the acceptable threshold of 0.75.

Pilot study

A pilot study was conducted in April 2021 with 10% of the total sample *(n* = 12) to assess feasibility and refine the data collection procedure. Participants were selected using purposive sampling from an urban school setting. Pre-test data were collected, followed by a structured educational intervention using PowerPoint presentations, and post-test data were collected after 7 days. Results from the pilot affirmed the feasibility and practicality of the research design.

Educational intervention

The intervention consisted of structured sessions on ADHD delivered through audiovisual presentations. Key topics included definition, causes, signs and symptoms, diagnosis,

Table 1: Frequency and percentage distribution of school teachers and parents according to demographic variables (*n*=120)

Variable	Category	Teachers (*n*=60)		Parents (*n*=60)	
		Frequency	%	Frequency	%
Age (years)	21–30	10	16.67	27	45.00
	31–40	14	23.33	24	40.00
	41–50	28	46.67	9	15.00
	51 and above	8	13.33	0	0.00
Gender	Male	43	71.67	46	76.67
	Female	17	28.33	14	23.33
	Transgender	0	0.00	0	0.00
Educational stream	Arts	15	25.00	11	18.33
	Science	33	55.00	16	26.67
	Commerce	12	20.00	7	11.67
	Other	0	0.00	26	43.33
Educational qualification	Illiterate	0	0.00	0	0.00
	Primary	0	0.00	6	10.00
	Secondary school	0	0.00	8	13.33
	Higher secondary	0	0.00	17	28.33
	Graduate	6	10.00	17	28.33
	Postgraduate	5	8.33	8	13.33
	D.Ed.	24	40.00	1	1.67
	B.Ed.	25	41.67	3	5.00
Religion	Hindu	44	73.33	45	75.00
	Muslim	6	10.00	2	3.33
	Christian	2	3.33	3	5.00
	Buddhist	8	13.33	10	16.67
	Other	0	0.00	0	0.00
Monthly family income (INR)	Up to 10,000	11	18.33	15	25.00
	10,001–15,000	6	10.00	11	18.33
	15,001–20,000	15	25.00	18	30.00
	Above 20,000	28	46.67	16	26.67
Heard about ADHD	Yes	23	38.33	22	36.67
	No	37	61.67	38	63.33
Source of information about ADHD	Newspaper/Books	7	30.43	7	31.82
	Social Media/TV	6	26.09	7	31.82
	Friends/Relatives	4	17.39	4	18.18
	Hospital	5	21.74	4	18.18
	Other	1	4.35	0	0.00

ADHD: Attention-deficit hyperactivity disorder

treatment modalities, behavior management strategies, and the role of parents and teachers.

Data collection procedure

Data were collected from May 10 to May 31, 2021. After obtaining formal permission from school authorities, informed written consent was taken from all participants. Pre-tests were conducted using the structured tools. Educational intervention sessions were administered in small groups using PowerPoint presentations. Post-tests were conducted on the 7th day after the intervention using the same tools.

Data analysis

Data were analyzed using both descriptive and inferential statistics with the Statistical Package for the Social Sciences.

- Descriptive statistics: Frequencies, percentages, mean, and standard deviation were used to analyze demographic variables and pre-/post-test scores
- Inferential statistics were employed to analyze the effectiveness of the educational intervention and relationships among study variables. The paired *t*-test was used to compare the pre- and post-intervention scores of KAP to assess the impact of the intervention. The Chi-square test helped determine the association between KAP scores and selected demographic variables such as educational qualification, stream, and income. In addition, Karl Pearson's correlation coefficient was applied to evaluate the relationship among KAP scores, revealing significant positive correlations.

Results

Among the 120 participants (60 teachers and 60 parents), the largest age group for teachers was 41–50 years (46.67%), whereas for parents, it was 21–30 years (45%). The majority of both groups were male – 71.67% of teachers and 76.67% of parents. Regarding educational background, most teachers came from a science stream (55%), while a significant portion of parents (43.33%) reported having an "other" educational background. In terms of qualification, teachers were predominantly B.Ed. (41.67%) and D.Ed. (40%) holders, whereas most parents had completed graduate (28.33%) or higher secondary education (28.33%).

A majority of participants followed Hinduism – 73.33% among teachers and 75% among parents. Regarding monthly

Table 2: Pre- and post-test distribution of knowledge, attitude, and practice scores among teachers and parents (*n*=120)

KAP level	Score (%)	Pre-test teachers (%)	Pre-test parents (%)	Post-test teachers (%)	Post-test parents (%)
Knowledge					
Excellent	≥61	3 (5.00)	1 (1.67)	27 (45.00)	18 (30.00)
Good	51–60	9 (15.00)	4 (6.67)	24 (40.00)	22 (36.67)
Average	41–50	18 (30.00)	20 (33.33)	9 (15.00)	14 (23.33)
Poor	<40	30 (50.00)	35 (58.33)	0 (0.00)	6 (10.00)
Attitude					
Positive	≥51	23 (38.33)	27 (45.00)	42 (70.00)	43 (71.67)
Negative	<51	37 (61.67)	33 (55.00)	18 (30.00)	17 (28.33)
Practice					
Excellent	≥61	5 (8.33)	4 (6.67)	32 (53.33)	28 (46.67)
Good	51–60	10 (16.67)	7 (11.67)	25 (41.67)	20 (33.33)
Average	41–50	20 (33.33)	21 (35.00)	3 (5.00)	12 (20.00)
Poor	<40	25 (41.67)	28 (46.67)	0 (0.00)	0 (0.00)

Table 3: Effect of educational intervention on knowledge, attitude, and practice scores among teachers and parents (within-group comparison, *n*=120)

KAP variable	Group	Test	Mean	SD	*t*-value	*P*-value
Knowledge	Teachers	Pre-test	12.18	3.03	20.96	0.000
		Post-test	17.00	2.39		
	Parents	Pre-test	11.45	2.76	15.49	0.000
		Post-test	15.66	2.83		
Attitude	Teachers	Pre-test	65.68	20.19	4.89	0.000
		Post-test	78.33	19.82		
	Parents	Pre-test	62.23	15.18	4.99	0.000
		Post-test	73.90	17.54		
Practice	Teachers	Pre-test	5.31	1.85	23.19	0.000
		Post-test	8.28	1.67		
	Parents	Pre-test	4.91	1.77	16.97	0.000
		Post-test	7.80	1.64		

income, the largest segment of teachers (46.67%) reported earning above INR 20,000, while most parents fell in the INR 15,001–20,000 bracket (30%).

Interestingly, only 38.33% of teachers and 36.67% of parents had previously heard about ADHD. For those who had, the most common sources of information were newspapers/books (30.43% teachers and 31.82% parents) and social media/TV (26.09% teachers and 31.82% parents).

Table 2 summarizes the pre- and post-intervention levels of KAP regarding ADHD among teachers and parents. Before the intervention, the majority of participants demonstrated poor knowledge (50% teachers and 58.33% parents), negative attitudes (61.67% teachers and 55% parents), and poor practices (41.67% teachers and 46.67% parents). Only a small percentage scored in the excellent category across domains.

Post-intervention, there was a significant improvement in all areas. Excellent knowledge scores rose to 45% for teachers and 30% for parents. Positive attitudes increased to over 70% in both groups, and excellent practice scores improved to 53.33% among teachers and 46.67% among parents. Notably, the proportion of participants with poor knowledge and practices dropped to 0% among teachers. These results indicate the clear effectiveness of the educational intervention.

Table 3 presents the within-group comparison of pre- and post-test scores for KAP regarding ADHD. The intervention significantly improved all three domains in both teachers and parents. Knowledge scores increased by nearly 5 points for teachers and 4.2 points for parents. Likewise, mean attitude and practice scores improved markedly, and the *P*-values (<0.001) confirm that the changes were statistically significant.

Table 4 compares the performance of teachers and parents in each domain of KAP. Although teachers consistently scored slightly higher than parents in both pre- and post-tests, the difference was statistically significant only for post-test knowledge scores ($P = 0.006$). No significant differences were observed in attitude and practice scores, indicating that both groups benefited comparably in these areas.

Table 5 highlights the statistical relevance of the educational intervention across all domains. Significant improvements were observed within both groups across KAP. However, the only statistically significant between-group difference after the intervention was seen in knowledge scores, favoring teachers.

This section presents the correlation analysis between KAPs regarding ADHD among both school teachers and parents using Karl Pearson's correlation coefficient.

Among teachers, all correlations were statistically significant ($P < 0.05$), with the strongest association observed between knowledge and practice ($r = 0.78$). This indicates that teachers with greater knowledge also demonstrated better practices.

Similarly, parents showed significant positive correlations across all domains, with the strongest correlation between knowledge and practice ($r = 0.73$).

These findings confirm that increased knowledge is directly associated with more positive attitudes and better behavioral practices toward managing children with ADHD [Table 6].

The level of knowledge regarding ADHD was found to have a statistically significant association with the following demographic variables: educational stream, educational qualification, monthly income, and prior awareness about ADHD ($P < 0.05$). No significant association was observed with age, gender, religion, or source of information [Table 7].

Table 4: Comparison of post-test knowledge, attitude, and practice scores between teachers and parents (between-group comparison, *n*=120)

KAP variable	Test time	Teachers mean (SD)	Parents mean (SD)	*t*-value	*P*-value
Knowledge	Pre-test	12.18 (3.04)	11.45 (2.76)	1.38	0.160
	Post-test	17.00 (2.39)	15.67 (2.83)	2.79	0.006
Attitude	Pre-test	65.70 (20.20)	62.20 (15.20)	1.06	0.290
	Post-test	78.30 (19.80)	73.90 (17.50)	1.30	0.190
Practice	Pre-test	5.32 (1.85)	4.92 (1.78)	1.21	0.230
	Post-test	8.28 (1.68)	7.80 (1.64)	1.59	0.110

Table 5: Summary of statistical significance across KAP domains

KAP dimension	Within-group improvement	Between-group post-test difference
Knowledge	S (*P*<0.001)	S (*P*=0.006)
Attitude	S (*P*<0.001)	NS (*P*=0.190)
Practice	S (*P*<0.001)	NS (*P*=0.110)

S: Significant, NS: Not significant

Table 6: Correlation of knowledge, attitude, and practice scores among teachers and parents (*n*=120)

Group	Variables correlated	Correlation coefficient (r)	*P*-value	Interpretation
Teachers	Knowledge↔attitude	0.65	0.000	Significant positive correlation
	Attitude↔practice	0.66	0.000	Significant positive correlation
	Knowledge↔practice	0.78	0.000	Strong, significant positive correlation
Parents	Knowledge↔attitude	0.68	0.000	Significant positive correlation
	Attitude↔practice	0.67	0.000	Significant positive correlation
	Knowledge↔practice	0.73	0.000	Strong, significant positive correlation

Table 7: Association between knowledge levels and demographic variables (pre-test, *n*=120)

Variable	Chi-square value	df	*P*-value	Significance
Age	2.47	3	0.48	NS
Gender	0.25	1	0.61	NS
Educational stream	83.41	3	0.000	S
Educational qualification	31.52	6	0.000	S
Religion	3.45	3	0.32	NS
Monthly family income	40.82	3	0.000	S
Heard about ADHD	10.04	1	0.002	S
Source of information	3.75	4	0.44	Not significant

S: Significant, NS: Not significant

Table 8: Association between attitude levels and demographic variables (pre-test, *n*=120)

Variable	Chi-square value	df	*P*-value	Significance
Age	4.89	3	0.17	NS
Gender	0.11	1	0.74	NS
Educational stream	38.24	3	0.000	S
Educational qualification	10.96	6	0.089	NS
Religion	6.22	3	0.100	NS
Monthly family income	16.06	3	0.001	S
Heard about ADHD	4.13	1	0.042	S
Source of information	1.81	4	0.77	NS

S: Significant, NS: Not significant

Table 9: Association between practice levels and demographic variables (pre-test, *n*=120)

Variable	Chi-square value	df	*P*-value	Significance
Age	2.74	3	0.43	NS
Gender	0.21	1	0.64	NS
Educational stream	49.02	3	0.000	S
Educational qualification	32.57	6	0.000	S
Religion	5.46	3	0.14	NS
Monthly family income	17.83	3	0.000	S
Heard about ADHD	1.54	1	0.21	NS
Source of information	2.06	4	0.72	NS

S: Significant, NS: Not significant

The attitude toward ADHD was significantly associated with educational stream, monthly income, and having prior knowledge about ADHD. No significant association was observed with age, gender, religion, educational qualification, or source of information [Table 8].

The level of practice regarding ADHD showed a statistically significant association with the educational stream, educational qualification, and monthly income. Other demographic factors, including age, gender, religion, prior awareness about ADHD, and source of information, did not show any significant association [Table 9].

Discussion

This study aimed to evaluate the effectiveness of an educational intervention on the KAP regarding ADHD among school teachers and parents. The discussion is presented in relation to the objectives of the study.

Pre-intervention results showed that the majority of both teachers (50%) and parents (58.33%) had poor knowledge of ADHD. Following the intervention, knowledge scores significantly improved among teachers (mean increase from

12.18 to 17.00) and parents (from 11.45 to 15.66), with $P < 0.001$ in both cases. These findings align with Latouche and Gascoigne,[11] who demonstrated that a brief professional development workshop significantly enhanced teachers' ADHD knowledge and self-efficacy, underscoring the impact of structured educational programs.

Initially, a negative attitude was prevalent in both groups, with 61.67% of teachers and 55% of parents scoring below the median. Post-intervention, positive attitudes were observed in 70% of teachers and 71.67% of parents, with statistically significant improvement ($P < 0.001$). This is consistent with Youssef *et al*., who noted that while baseline attitudes among teachers were generally positive, targeted training programs significantly improved understanding and tolerance toward students with ADHD.[12]

In the pre-test, poor and average practices were commonly reported. Post-test findings revealed a substantial shift, with 53.33% of teachers and 46.67% of parents demonstrating excellent practice behaviors related to ADHD management, and no participant scoring in the poor category. This improvement reflects findings by Schroeder and Kelley (2009),[13] who emphasized that supportive family environments and structured behavioral strategies enhance ADHD management, although effectiveness may vary between children with and without ADHD.

A statistically significant positive correlation was observed among the KAP components in both teachers and parents. Among teachers, there was a strong correlation between knowledge and attitude (r = 0.65), attitude and practice (r = 0.66), and knowledge and practice (r = 0.78). Similarly, in parents, knowledge correlated positively with attitude (r = 0.68), attitude with practice (r = 0.67), and knowledge with practice (r = 0.73). These findings suggest that improved knowledge is closely linked to the development of more positive attitudes and enhanced behavioral practices, highlighting the integral role of education in shaping comprehensive ADHD management strategies.

Significant associations were identified between knowledge levels and variables such as educational stream, educational qualification, monthly income, and prior awareness about ADHD ($P < 0.05$). Similarly, attitude was significantly associated with educational stream, monthly income, and awareness. Practice scores showed significant links with the educational stream, qualification, and income.

These associations emphasize the role of educational and socio-economic factors in shaping perceptions and responses to childhood ADHD. It underscores the importance of targeting interventions across diverse socio-demographic backgrounds to ensure equity in ADHD education and support.

Conclusion

The study concluded that the educational intervention significantly improved the KAPs of school teachers and parents regarding ADHD. Strong correlations among KAP scores and associations with key demographic factors highlight the effectiveness and relevance of the intervention.

Acknowledgements

We are appreciate to all study participant for their willingness to complete our questionnaire.

Conflict of Interests

N/A.

Funding

Self funded.

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How to cite this article: Manwatkar RM, Sonawane N. A Comparative Study on the Effectiveness of Educational Intervention in Enhancing Knowledge, Attitude, and Practices regarding Attention Deficit Hyperactivity Disorder among School Teachers and Parents in a Metropolitan City. Int J Nurs Med Invest. 2025;10(2):15-21.