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REVIEW ARTICLE

Nursing Interventions for Children with Attention Deficit Hyperactivity Disorder (ADHD): A Review

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ABSTRACT

Attention deficit hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorders of childhood, characterised by a persistent pattern of inattention, hyperactivity and impulsivity that interferes with the child's functioning or development. Globally it affects an estimated 5–8% of school-aged children, and Indian school-based studies report a comparable, and at times higher, prevalence. If left unrecognised and unmanaged, ADHD jeopardises the child's academic achievement, peer relationships, self-esteem and family harmony, and it carries a substantial risk of comorbid conduct, mood and learning difficulties extending into adolescence and adulthood. Current best practice favours a multimodal approach in which non-pharmacological interventions—behaviour therapy, parent training in behaviour management, classroom interventions and psychosocial support—form the foundation of care, with stimulant and non-stimulant medication added for school-aged children with moderate-to-severe impairment. The nurse occupies a pivotal position across this continuum: as an assessor, educator, behaviour-therapy facilitator, medication monitor, counsellor and advocate, and as the professional who links the child, family, school and health system. This review article describes the epidemiology, aetiology, clinical features and assessment of ADHD, and then provides a structured account of evidence-based nursing interventions for affected children, including a sample nursing care plan and a discussion of the Indian context. It is intended as a practical resource for nurses, nursing students and allied child-health professionals.

KEYWORDS

• Attention Deficit Hyperactivity Disorder • Behaviour Therapy • Child Psychiatric Nursing • Nursing Interventions • Parent Training • Psychosocial Care

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INTRODUCTION

Attention deficit hyperactivity disorder (ADHD) is a chronic neurodevelopmental condition that begins in childhood and is defined by an age-inappropriate and persistent pattern of inattention, hyperactivity and impulsivity. According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), several symptoms must be present before the age of twelve years, occur in two or more settings (for example, at home and at school), and produce clear evidence of interference with social, academic or occupational functioning.[1] The disorder is therefore not a matter of an occasionally restless or distractible child; it is a recognisable clinical syndrome that handicaps the child across multiple domains of life.

ADHD is among the best-investigated and most prevalent mental-health disorders of school-aged children, and it has attracted considerable clinical, scientific and public attention in recent years. Yet in many communities—particularly in low-and middle-income settings—awareness remains limited, and affected children are frequently mislabelled as lazy, naughty, dull or disobedient. Such children are often punished, ignored or ostracised by peers, teachers and family members, while their underlying difficulty goes unrecognised. The result is a cascade of secondary harms: falling academic performance, eroded self-esteem, strained relationships and increasing family distress.

Contemporary management of ADHD is multimodal, combining behavioural and psychosocial interventions with pharmacological treatment tailored to the child's age and the severity of impairment.[2,3] Within this model, nurses are not peripheral. They are frequently the first point of contact for worried parents, they spend sustained time with the child and family, and they are well placed to assess behaviour, deliver and reinforce behaviour-management strategies, administer and monitor medication, counsel and educate caregivers, liaise with schools, and advocate for the child within the health and education systems. This article reviews the nature of ADHD and sets out, in a structured and practical way, the nursing interventions appropriate for children affected by it.

EPIDEMIOLOGY AND BURDEN

Worldwide, the pooled prevalence of ADHD among children and adolescents is generally estimated at around 5–8%, with boys diagnosed roughly twice as often as girls.[4] Part of this gender gap is thought to reflect under-recognition in girls, who more often present with the predominantly inattentive form and fewer disruptive behaviours, rather than a true absence of the disorder.

In India, school and community-based studies report a broad range of prevalence figures, reflecting differences in sampling, age groups and diagnostic instruments. A study among school children in selected schools reported an overall prevalence of about 8.8%, with the inattentive presentation predominating.[5] A study of primary school children in Belagavi reported a prevalence of approximately 11%[6], and a large population-based survey of neurodevelopmental disorders across five regions of India identified ADHD as one of the more common conditions in the 2–9 year age group.[7] Across most Indian studies the male-to-female ratio is consistently in the range of 3:1 to 6:1, and prevalence tends to be higher among children from lower socioeconomic groups.

Whatever the precise figure, the burden is substantial. ADHD is one of the leading reasons for referral to child guidance and child-psychiatry services, and it is strongly associated with academic underachievement, school dropout, accidental injury, peer rejection and family conflict. A significant proportion of children carry symptoms into adolescence and adulthood, where untreated ADHD is linked to mood disorders, substance misuse, antisocial behaviour and occupational difficulty.[1,4] These facts underline why early identification and sustained, well-organised nursing care matter.

AETIOLOGY AND RISK FACTORS

ADHD is widely understood to be multifactorial, arising from an interaction of genetic, neurobiological and environmental influences rather than from any single cause or from 'bad parenting'. Understanding these contributors helps the nurse counsel families accurately and relieve the guilt that parents frequently carry.

Genetic and Neurobiological Factors

ADHD is highly heritable; the disorder clusters strongly in families, and twin studies attribute a large share of the variance to genetic factors. At the neurochemical level, dysregulation of the neurotransmitters dopamine and noradrenaline within fronto-striatal circuits is thought to underlie the core difficulties with attention and impulse control, and this is consistent with the therapeutic action of stimulant medication.[1] Differences in the structure and maturation of frontal and subcortical brain regions have also been described.

Prenatal, Perinatal and Physical Factors

Maternal smoking, alcohol or substance use during pregnancy, prematurity, low birth weight, birth complications causing hypoxia, and early exposure to environmental toxins such as lead have all been associated with an increased risk of ADHD. Such associations are statistical rather than deterministic, but they reinforce the value of good antenatal and child health care.

Psychosocial and Environmental Factors

Family adversity—including marital discord, inconsistent or harsh discipline, chaotic home routines, low socioeconomic status and parental mental illness—does not cause ADHD but can worsen its expression and impede the child's ability to cope. Conversely, a structured, predictable and supportive environment can substantially moderate the child's difficulties, which is precisely why environmental and family-focused nursing interventions are so important.

CLINICAL FEATURES AND SUBTYPES

The DSM-5 organises ADHD symptoms into two clusters—inattention and hyperactivity–impulsivity—and recognises three clinical presentations depending on which symptoms predominate.[1]

Inattention

The child has difficulty sustaining attention in tasks or play, makes careless mistakes in schoolwork, does not seem to listen when spoken to directly, fails to follow through on instructions or finish tasks, struggles to organise activities, avoids tasks requiring sustained mental effort, loses things needed for tasks, is easily distracted by extraneous stimuli, and is forgetful in daily activities.

Hyperactivity

The child fidgets with hands or feet or squirms in the seat, leaves the seat when remaining seated is expected, runs about or climbs excessively in inappropriate situations, is unable to play quietly, appears to be 'on the go' or 'driven by a motor', and talks excessively.

Impulsivity

The child blurts out answers before questions are complete, has difficulty awaiting his or her turn, and frequently interrupts or intrudes on others' conversations or games.

Presentations: On the basis of the predominant symptoms, ADHD is classified as predominantly inattentive presentation, predominantly hyperactive–impulsive presentation, or combined presentation. Severity is graded as mild, moderate or severe according to the number of symptoms and the degree of functional impairment.[1] The World Health Organization's ICD-11 describes an essentially similar disorder, facilitating consistent recognition across settings.

Common comorbidities: Children with ADHD frequently have coexisting conditions, including oppositional defiant disorder, conduct disorder, specific learning disorders, anxiety, depression, tic disorders and autism spectrum disorder. These comorbidities complicate the clinical picture, increase functional impairment and must be considered in both assessment and care planning.

DIAGNOSIS AND ASSESSMENT

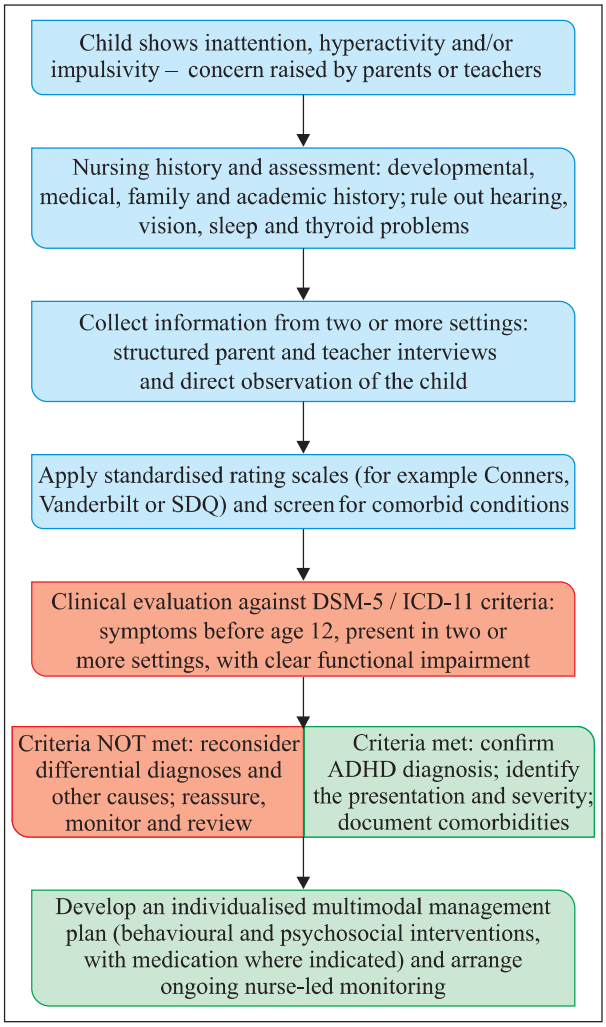
There is no single laboratory or imaging test for ADHD; the diagnosis is clinical. Best-practice guidelines recommend that the clinician gather information from multiple sources and across more than one setting, combining a careful developmental and medical history with direct observation, parent and teacher interviews, and standardised behaviour rating scales.[2,3] Combining clinical observation and interviews with validated rating scales improves diagnostic accuracy. Commonly used instruments include the Conners rating scales, the Vanderbilt ADHD Diagnostic Rating Scales and the Strengths and Difficulties Questionnaire. Importantly, the assessment must also screen for the comorbid and differential conditions noted above, and exclude other explanations for the behaviour

such as hearing impairment, sleep disorders, thyroid dysfunction, the effects of trauma, or simply a learning environment that is poorly matched to the child.

Nurses contribute meaningfully to this diagnostic process by eliciting a structured history, distributing and helping to interpret rating scales, observing the child in the clinic or ward, and ensuring that information from teachers is obtained and considered. The nursing assessment that supports diagnosis flows directly into the planning of interventions, described below.

ADHD Assessment Pathway

The nurse-led assessment of a child with suspected ADHD follows a logical, stepwise pathway that gathers information from several informants and settings before a diagnosis is confirmed. The flowchart below summarises this pathway and the points at which the nurse contributes.



Screening and Rating Tools Commonly Used in Nursing

Although the diagnosis of ADHD is clinical, standardised screening and rating tools give structure to the assessment, allow information to be gathered systematically from parents and teachers, and provide a baseline against which treatment response can be measured. Nurses frequently distribute, score and help interpret these instruments. The most commonly used tools are summarised below.

Screening / rating tool	What it assesses and format	Typical informant and age group
Conners Rating Scales (Conners 3, Conners EC)	Parent, teacher and self-report scales assessing inattention, hyperactivity–impulsivity, executive function and related behavioural and emotional problems.	Parent / teacher / youth; preschool to adolescence
Vanderbilt ADHD Diagnostic Rating Scales (VADPRS & VADTRS)	Free parent and teacher forms mapped directly to DSM criteria; also screen for common comorbidities (oppositional, conduct, anxiety and mood symptoms) and performance.	Parent / teacher; ages 6–12
Strengths and Difficulties Questionnaire (SDQ)	Brief 25-item behavioural screen covering emotional, conduct, hyperactivity–inattention, peer and prosocial domains; useful for broad screening and case identification.	Parent / teacher / self; ages 2–17
ADHD Rating Scale-5 (ADHD-RS-5)	Eighteen items corresponding to the DSM-5 symptom criteria, with home and school versions; used for screening, severity rating and monitoring treatment response.	Parent / teacher; children and adolescents
SNAP-IV (Swanson, Nolan and Pelham)	Rates inattention, hyperactivity–impulsivity and oppositional symptoms; widely used to monitor change over time and response to intervention.	Parent / teacher; school-aged children
Child Behaviour Checklist (CBCL) / Teacher's Report Form	Broad-band screen for a wide range of emotional and behavioural problems; not ADHD-specific but valuable for detecting coexisting conditions.	Parent / teacher; ages 1.5–18

These instruments are screening and rating aids that support, but do not replace, a comprehensive clinical assessment. Scores must always be interpreted alongside the history, direct observation and information from more than one setting.

IMPACT OF ADHD ON THE CHILD AND FAMILY

The consequences of ADHD extend well beyond the classroom. Academically, inattention and disorganisation translate into incomplete work, poor grades and, in severe cases, grade repetition or school dropout. Socially, impulsivity and intrusiveness lead to peer rejection and few stable friendships, while repeated criticism corrodes the child's self-esteem and may precipitate anxiety, low mood or oppositional behaviour. Physically, impulsivity raises the risk of accidents and injuries.

Families bear a heavy load as well. Parents often experience frustration, exhaustion, self-blame and conflict with one another over how to manage the child, and siblings may resent the disproportionate attention the affected child requires. Mothers, in particular, frequently report high levels of stress. A central aim of nursing care is therefore to support not only the child but the whole family unit, recognising that a calmer, better-informed and better-resourced family is itself a powerful therapeutic agent.

THE ROLE OF THE NURSE IN ADHD CARE

Because ADHD is chronic, multidimensional and managed across home, school and clinic, it calls for the kind of continuous, relationship-based, family-centred care at which nursing excels. The nurse's role is best understood as a set of overlapping functions: assessor and observer of behaviour; educator who explains the disorder and its treatment to child, family and teachers; facilitator of behavioural and social-skills interventions; administrator and monitor of medication; counsellor who supports self-esteem and family coping; coordinator who links the family with the school and other services; and advocate who promotes the child's rights and reduces stigma.[2] The interventions that follow are organised around these functions.

NURSING ASSESSMENT

Comprehensive, individualised nursing care begins with thorough assessment. The nurse should gather and document the following:

- Detailed history of the presenting behaviours—their onset, frequency, severity, triggers and the settings in which they occur (home, school, play).
- Developmental, birth, medical and family history, including any family history of ADHD, learning or mental-health disorders.
- Academic history and current school functioning, ideally with input from teachers and rating scales.
- The child's strengths, interests, temperament and coping abilities—not only problems—since these are the building blocks of intervention.
- Family structure, parenting practices, routines, level of knowledge about ADHD, and the family's stress, support and resources.
- Screening for comorbid conditions such as oppositional, conduct, anxiety, mood or learning disorders, and for safety concerns such as risk of injury.

This assessment yields the data needed to formulate nursing diagnoses and to plan interventions that fit the particular child and family.

COMMON NURSING DIAGNOSES

Depending on the individual child, the nurse may identify nursing diagnoses such as the following:

- Risk for injury related to impulsivity, hyperactivity and poor awareness of danger.
- Impaired social interaction related to impulsivity, intrusiveness and difficulty reading social cues.
- Chronic low self-esteem related to repeated failure, criticism and negative feedback.
- Ineffective coping (child) related to limited impulse control and frustration tolerance.
- Compromised family coping / caregiver role strain related to the demands of managing the child's behaviour and limited knowledge of the disorder.
- Deficient knowledge (child, family, teachers) regarding the nature, course and management of ADHD.

NURSING INTERVENTIONS

Evidence-based guidelines emphasise a multimodal strategy in which behavioural and psychosocial interventions are foundational, supported where appropriate by medication[2,3] For preschool-aged children, parent-administered and teacher-administered behaviour therapy is recommended as the first-line treatment before medication is considered; for school-aged children, behavioural interventions are combined with medication for optimal effect.[2] Nurses play a direct role in delivering, teaching and reinforcing most of these interventions. The following sections describe them in turn.

1. Behaviour Therapy and Behaviour Modification

Behaviour therapy is an effective, evidence-based treatment that can improve a child's behaviour, self-control and self-esteem, and it forms the cornerstone of non-pharmacological care.[8] It rests on the principle of consistently rewarding desired behaviour (positive reinforcement) and applying calm, predictable, non-punitive consequences for undesired behaviour. Practical techniques that nurses teach and reinforce include:

- Setting a small number of clear, specific, positively framed rules and expectations that the child can understand and remember.
- Using token economies or star/sticker charts, in which the child earns tokens for target behaviours that can be exchanged for agreed privileges or rewards.
- Giving immediate, frequent and specific praise for appropriate behaviour—'catching the child being good'—rather than attending mainly to misbehaviour.
- Applying consistent, mild and time-limited consequences such as planned ignoring of attention-seeking behaviour, loss of a privilege, or a brief, calm 'time-out', while avoiding harsh or physical punishment.
- Breaking tasks into small, manageable steps and providing prompts and structure to help the child succeed.

The nurse models these techniques, helps the family apply them consistently across settings, and reviews progress over time, since consistency and persistence are key to their effectiveness.

2. Parent Training in Behaviour Management

Because parents have the greatest influence on a young child's behaviour, structured parent training in behaviour management is one of the most powerful interventions available, and meta-analyses confirm benefits for the child's behaviour and for parenting practices and the parent–child relationship.[8,9] In parent-training programmes, caregivers are taught the principles of behaviour modification described above and supported to apply them at home. The nurse's contribution includes:

- Educating parents about ADHD so that they understand the behaviour as a symptom of a disorder rather than wilful naughtiness, which reduces blame and harsh discipline.
- Teaching specific skills—clear instruction-giving, effective praise, reward systems, planned ignoring, consistent consequences and the establishment of predictable routines.
- Helping parents schedule regular, positive one-to-one time with the child to strengthen the relationship and the child's self-worth.
- Coaching parents in stress management and self-care, and validating the difficulty of their task so that they feel supported rather than judged.

Even a few minutes daily of positive, structured parent–child interaction, sustained consistently, can produce meaningful improvement.

3. School-Based Interventions and Collaboration with Teachers

Since children spend much of their day at school, classroom interventions and good communication with teachers are essential, and guidelines recommend behavioural classroom management and educational support for all age groups.[2] The nurse can promote and facilitate:

- Seating the child near the teacher and away from distractions such as windows, doors and noisy peers.
- Establishing predictable classroom routines, clear rules and visual schedules.
- Breaking assignments into shorter segments, allowing movement breaks,

and giving instructions one step at a time with written or visual back-up.

- Using daily report cards or home–school communication notebooks so that consistent rewards and expectations span both settings.
- Providing educational accommodations and individualised support for any coexisting learning disorder.

By promoting partnership among parents, teachers and health providers, the nurse helps ensure that strategies are consistent and mutually reinforcing rather than fragmented.

4. Environmental Modification and Structure

Children with ADHD function best in environments that are calm, structured and predictable. The nurse advises families and teachers to reduce clutter and noise during tasks, to maintain consistent daily routines for waking, meals, homework, play and sleep, to use timers, checklists, charts and visual reminders, and to keep the child's belongings and study area organised. A safe, well-supervised environment also reduces the risk of injury associated with impulsivity. These simple structural measures lower the demands on the child's limited self-regulation and set the stage for success.

5. Social Skills Training

Impulsivity and difficulty reading social cues frequently leave children with ADHD isolated or rejected by peers. Social-skills training—often delivered in small groups—teaches turn-taking, sharing, listening, recognising others' feelings, and managing frustration and anger. The nurse can run or support such groups, use role-play and rehearsal, and prompt and praise the child for using these skills in real situations, helping the child build the friendships that support healthy development.

6. Therapeutic Communication and Building Self-Esteem

Years of correction and failure leave many children with ADHD feeling 'bad' or 'stupid'. A core nursing intervention is to protect and rebuild self-esteem through a warm, accepting therapeutic relationship. The nurse accepts the child as he or she is, communicates in a calm and consistent manner, gives instructions that are simple, clear and one at a time, and deliberately identifies and praises the child's strengths, efforts and successes, however small. Helping the child experience genuine achievement—academic, creative, sporting or social—and directing energy toward constructive outlets can bring out hidden potential that punishment never reaches.

7. Pharmacological Management: The Nurse's Role

For school-aged children with moderate-to-severe ADHD, medication is an important component of multimodal care. Stimulants—methylphenidate and amphetamine preparations—are the first-line agents and benefit a large majority of children by improving attention and reducing hyperactivity and impulsivity; non-stimulants such as atomoxetine and the alpha-2 agonists guanfacine and clonidine are alternatives when stimulants are not tolerated or are contraindicated.[2,3] Nurses do not prescribe these medicines, but they play a crucial role in their safe and effective use by:

- Educating the child and family about the purpose of the medication, how and when to take it, realistic expectations, and the importance of adherence and follow-up.
- Monitoring therapeutic response—changes in attention, activity and impulsivity at home and school—often using rating scales and teacher feedback.
- Monitoring for and managing common side effects such as reduced appetite, weight loss, sleep disturbance, headache, irritability or mood change, and reporting concerns to the prescriber.
- Measuring and recording height, weight, pulse and blood pressure at baseline and follow-up, as recommended for children on these medicines.
- Dispelling myths and addressing parental fears about 'dependence' or sedation, and emphasising that medication works best alongside behavioural strategies, not as a substitute for them.

8. Dietary, Sleep and Lifestyle Interventions

While no diet cures ADHD, general healthy-living measures support overall functioning and self-regulation. The nurse encourages a balanced diet and regular meals, adequate and consistent sleep with a calming bedtime

routine, regular physical activity that provides an outlet for energy, and sensible limits on screen time. Where a family reports a clear, reproducible reaction to a specific food, this can be discussed with the clinician, but families should be cautioned against restrictive diets undertaken without professional guidance.

9. Psychoeducation and Health Education

Education threads through every other intervention and is one of the most valuable things a nurse provides. Effective psychoeducation explains, in language the family can understand, what ADHD is and is not, that it is a recognised disorder rather than a result of bad parenting or wilful misbehaviour, what the treatment options are and how they work together, and what realistic outcomes look like. Educating teachers and, where appropriate, the wider family and community helps reduce the stigma and mislabelling that so often compound the child's difficulties. Well-informed parents and teachers become active, confident partners in the child's care.

10. Supporting Caregivers and Family

Caring for a child with ADHD is demanding, and caregiver exhaustion can undermine the best treatment plan. The nurse listens supportively to parents, acknowledges their effort and difficulty, helps them set realistic expectations, encourages respite and self-care, and where helpful directs families to parent support groups and counselling. Strengthening family coping is not a peripheral kindness but a direct therapeutic intervention, because a calmer and better-supported family delivers more consistent care to the child.

PARENTANDTEACHERGUIDANCECHECKLIST

The following practical checklists draw together the behavioural and environmental strategies described above into a form that nurses can share directly with families and schools. They are intended as a teaching and reinforcement aid; the nurse should review them with parents and teachers, tick the strategies that are in place, and revisit them at follow-up.

Checklist for Parents

- ☐ Learn about ADHD and remember that the behaviour is a symptom of a disorder, not naughtiness or laziness.
- ☐ Agree on a few clear, simple and positively framed house rules, and keep them consistent.
- ☐ Keep predictable daily routines for waking, meals, homework, play and sleep.
- ☐ Give immediate, specific praise when the child behaves well – "catch the child being good."
- ☐ Use a star, sticker or token chart with agreed rewards for the behaviours you want to encourage.
- ☐ Give one short, clear instruction at a time and check that the child has understood.
- ☐ Respond to misbehaviour with calm, consistent and mild consequences; avoid harsh or physical punishment.
- ☐ Break homework and chores into small, manageable steps.
- ☐ Reduce noise, clutter and screen distractions during study and other tasks.
- ☐ Spend a little positive one-to-one time with the child every day.
- ☐ Ensure adequate, regular sleep, a balanced diet and daily physical activity.
- ☐ Stay in regular contact with teachers, for example through a home–school notebook.
- ☐ If medication is prescribed, give it as directed, watch for side effects and attend follow-up visits.
- ☐ Look after your own wellbeing and seek support from the nurse, counsellor or a parent group when needed.

Checklist for Teachers

- ☐ Seat the child near the teacher and away from windows, doors and noisy classmates.
- ☐ Keep predictable classroom routines and display clear rules and visual schedules.
- ☐ Give instructions one step at a time, with written or visual back-up.
- ☐ Break assignments into shorter segments and allow brief, planned movement breaks.
- ☐ Use immediate, specific praise and a simple, consistent classroom reward system.
- ☐ Redirect off-task behaviour with quiet, private cues rather than public criticism.
- ☐ Use a daily report card or home–school communication notebook.

- ☐ Allow extra time and provide accommodations for any coexisting learning difficulty.
- ☐ Keep the child's desk and work area free of unnecessary distractions.
- ☐ Notice and build on the child's strengths, interests and efforts.
- ☐ Watch for signs of low mood, anxiety, bullying or peer rejection and inform parents and the school nurse.
- ☐ Communicate regularly with parents and the school nurse so that strategies stay consistent across settings.

A SAMPLE NURSING CARE PLAN

The following abbreviated care plan illustrates how assessment, nursing diagnosis, goals, interventions and evaluation come together for a common problem in ADHD. It is illustrative and must be individualised for each child.

Nursing diagnosis	Goal / expected outcome	Nursing interventions	Evaluation
Risk for injury related to impulsivity and hyperactivity	The child will remain free from preventable injury during care	Provide a safe, supervised, clutter-free environment Set clear safety limits and redirect impulsive acts calmly Channel excess energy into structured, supervised activity	Child sustains no injury; impulsive risky acts decrease
Impaired social interaction related to impulsivity and poor social cues	The child will show improved, age-appropriate peer interaction	Provide social-skills training with role-play Prompt and praise turn-taking and sharing Arrange structured, supervised peer activities	Child takes turns and joins peers with fewer conflicts
Chronic low self-esteem related to repeated failure and criticism	The child will express and demonstrate improved self-worth	Build a warm, accepting therapeutic relationship Identify and praise strengths, efforts and successes Set achievable tasks that allow the child to succeed	Child makes positive self-statements; participates willingly
Caregiver role strain / deficient knowledge about ADHD	Caregivers will understand ADHD and apply consistent strategies	Provide psychoeducation about ADHD and its treatment Teach behaviour-management and routine-setting skills Support coping; refer to support groups as needed	Caregivers describe ADHD accurately and use strategies consistently

CHALLENGES IN THE INDIAN CONTEXT

Several factors shape ADHD care in India and have direct implications for nursing. Awareness of ADHD among parents, teachers and the general public remains limited, so children are often identified late and misattributed to laziness or indiscipline. Stigma surrounding mental and developmental disorders discourages families from seeking help. Specialist child mental-health services and trained personnel are unevenly distributed, with rural and underserved areas particularly poorly served, and large class sizes can make individualised classroom support difficult. At the policy level, however, encouraging steps have been taken: questions on disability were included in the national census, and the Rashtriya Bal Swasthya Karyakram (RBSK) provides for the screening, early identification and management of developmental disorders, including ADHD, through child-health screening from birth to eighteen years.[7] Nurses—especially those working in schools, community health and primary care—are ideally positioned to advance early identification, family education, de-stigmatisation and referral within these programmes.

IMPLICATIONS FOR NURSING PRACTICE

This review highlights several priorities for practice. Nurses should be equipped through education and training to recognise the features of ADHD, to use screening and rating tools, and to deliver behavioural and psychosocial interventions confidently. Family-centred, strengths-based care should be the norm, with consistent attention to the child's self-esteem and to caregiver support. Nurses should actively bridge the home–school–clinic divide and advocate for the child within both health and education systems. Finally, given the limited Indian research base, nurses are encouraged to participate in studies that evaluate nurse-led and structured teaching interventions, so that practice in this setting becomes increasingly evidence-based.

CONCLUSION

ADHD is a common, chronic and multidimensional neurodevelopmental disorder that, if unrecognised and unmanaged, can derail a child's education, relationships, self-esteem and family life and carry lasting consequences into adulthood. Effective care is multimodal, with behavioural and psychosocial interventions as its foundation and medication added for children with moderate-to-severe impairment. Across this continuum the nurse plays an indispensable role—assessing behaviour, delivering and reinforcing behaviour therapy and parent training, supporting classroom strategies, monitoring medication, protecting self-esteem, educating and supporting families, and advocating for the child. With early identification, consistent intervention and a compassionate, family-centred approach, the energies of a child with ADHD can be redirected from conflict toward constructive achievement, allowing the child's hidden potential to emerge. Strengthening nurses' knowledge and skills in this area, and building the Indian evidence base, should be a continuing priority.

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