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# Teacher-Mediated Early Identification of Behavioral and Psychological Problems among School-Age Children: Evidence, Barriers and Educational Strategies - A Scoping Review

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**Abstract:** ***Background**: Most mental health problems in children begin in the school years, yet few affected children reach specialist services. Teachers spend more waking hours with children than any other professional and are often the first adults to notice that something is wrong. Whether teachers can recognise problems early, what stops them, and how school health and community health nurses can support them are important questions for nursing education and school health services. **Objective**: To map the published evidence on teacher-mediated early identification of behavioral and psychological problems among school-age children (about 5 to 17 years): (1) accuracy of identification, (2) barriers and facilitators, (3) educational and system-level strategies, and (4) the contribution of school and community health nurses. **Methods**: A scoping review following the Arksey and O'Malley framework as refined by Levac and colleagues, Joanna Briggs Institute guidance and PRISMA-ScR reporting, with eligibility defined by the Population–Concept–Context framework. Review-level and primary evidence from 1997 to 2026 was charted, with particular attention to work published after 2020, and synthesised narratively without statistical pooling or quality weighting. **Results**: Teachers recognise severe and externalizing problems reasonably well but are less accurate with moderate, subclinical and internalizing problems; in a large population survey, teacher concern detected only about half of children with a disorder. Reported barriers include limited training, role conflict, time pressure, large classes, stigma and weak referral links. Teacher mental health literacy programmes improve knowledge, reduce stigma and increase helping behavior in the short term, but rarely measure whether more children are identified or reach care. School and community health nurses are trusted, well-placed partners but are often under-prepared in mental health. Evidence from India is limited and mostly describes teacher knowledge rather than testing identification pathways. **Conclusions**: Teachers are well positioned but under-equipped as identifiers. Identification works best as a shared pathway in which teachers notice and record, and nurses help interpret, refer and follow up. Nursing education at undergraduate, postgraduate and in-service levels should build competencies in child mental health assessment, teacher consultation and school-based referral.*

**Keywords:** teachers; early identification; school mental health; behavioral problems; emotional problems; school health nursing; community health nursing; nursing education; mental health literacy; scoping review; India

## 1. Introduction

### 1.1 The burden of child mental health problems

Mental health problems in childhood and adolescence are common, persistent and costly. A worldwide meta-analysis estimated that about 13.4% of children and adolescents meet criteria for at least one mental disorder.[1] Global Burden of Disease estimates indicate that in 2019 about 293 million of the 2.5 billion people aged 5 to 24 years had a mental disorder, with prevalence rising from 6.8% at 5–9 years to 12.4% at 10–14 and 14.0% at 15–19 years.[2] A meta-analysis of 192 studies found that about one-third of first mental disorders begin before age 14 and nearly half before 18, with a peak onset age of 14.5 years,[3] which is why child mental health is regarded as a global public-health priority.[4,5] The COVID-19 pandemic added to the burden, roughly doubling pre-pandemic estimates of clinically elevated depressive and anxiety symptoms.[6]

India has a very large school-age population and a substantial burden, with prevalence estimates that vary widely by setting and method.[7] The National Mental Health Survey of 2015–16 documented a significant adolescent burden and a very large treatment gap.[8] Stigma adds to the problem: a review of 30 Indian studies found that about one-third of young people had poor knowledge and negative attitudes, and about one in five reported actual or intended stigmatising behavior.[9] Quietly developing problems such as anxiety, low mood, withdrawal and attention difficulties often remain unrecognised for years.

### 1.2 Why Teachers

Schools reach most children at scale. Teachers see children daily and over time, so they can notice change from a child's usual behavior, the most useful signal of a developing problem; a UK qualitative study described them as active observers on the front line of pupils' mental health.[10] In a population survey of almost 6,000 British schoolchildren, only about 5% of children without teacher concern had a disorder.[11] Yet teachers are not clinicians. Their task is to notice, record, respond supportively and refer, and policy documents often assume they can do this without defining what identification means, what training is needed or which health professional should support them.

This review uses "teacher-mediated early identification" for the whole sequence in which a teacher notices a concern, interprets it, discusses it with others and initiates a response, whether classroom support, contact with parents or referral. It is understood as a shared process: the teacher is the observer in daily contact with the child, and the school health or community health nurse is the health partner who helps interpret what has been seen and links the child to care (Section 3.5).

### 1.3 The Indian and Rajasthan context

School mental health in India is moving from isolated projects to national and state programmes. Under the Ayushman Bharat School Health and Wellness Programme (2020), two teachers in every government school are trained as "Health and Wellness Ambassadors", and the curriculum includes emotional wellbeing.[12] In 2022 (revised 2024) the Ministry of Education and NCERT released a modular handbook on early identification and intervention, describing teachers' role in recognising "flag signs" and providing screening checklists.[13] In Rajasthan, the SCERT launched Khushishala in 2026 for nearly 1,500 government primary schools; according to press reports, it embeds social-emotional learning in classroom routine and gives teachers a three-day training and a 21-day audio module.[14] These initiatives make teachers explicit partners in identification, but they are new and evidence on their effectiveness is limited. In a survey of 460 high-school teachers in southern India, 62.6% had identified at least one adolescent with a mental health problem, yet only 59.7% of those students had been referred.[15]

### 1.4 Conceptual Framework

Two ideas guide the review: the ecological view of child development, in which behavior is shaped by interacting family, classroom, school, community and policy systems,[16] and a simple pathway model of identification (Table 1). Each step can fail, and each failure points to a different remedy.

**Table 1:** Pathway of teacher-mediated early identification

| Step | What happens | Typical failure point | Type of remedy |
|---|---|---|---|
| 1. Notice | Teacher observes a change or difficulty | Child is quiet or compliant; large class; time | Observation prompts, brief tools, smaller groups |
| 2. Interpret | Teacher judges whether the concern needs action | Low literacy; stigma; seeing the problem as indiscipline | Recognition training; vignettes; consultation with nurse |
| 3. Discuss | Teacher raises concern with parent, colleague, counsellor or nurse | Unclear roles; fear of blame; parental resistance | Defined roles; school point person; parent communication |
| 4. Act | Teacher offers classroom support or refers | No referral route; no feedback; long waits | Referral protocols; links through nurses |
| 5. Follow up | Progress is monitored | Lost information; no time; no feedback | Shared records, check-ins, supervision |

### 1.5 Rationale and Objectives

Systematic reviews exist on parts of this topic, such as teacher mental health literacy,[17–19] perceived barriers to assessment[20] and feasibility of school-based identification,[21] and separate reviews describe school nurses' roles.[22] No single account joins accuracy, barriers, educational strategies and the role of nurses in one pathway, and almost none places them in the Indian school context. A scoping review suits a heterogeneous literature where the aim is to map what is known rather than pool effects. The review questions were: (1) How accurate and patterned is teacher identification? (2) What barriers and facilitators are reported? (3) What strategies have been used to strengthen identification and referral, and with what outcomes? (4) How can school and community health nurses support the process? (5) What gaps exist, especially for India and other low- and middle-income settings?

## 2. Methods

**Design and eligibility:** The review followed Arksey and O'Malley[23] with the refinements of Levac et al.[24] and updated JBI guidance,[25] and is reported according to PRISMA-ScR.[26] Eligibility used the Population–Concept–Context framework. *Population:* teachers and school staff working with children aged about 5–17 years in primary and secondary schools, and school or community health nurses working with schools (preschool-only settings, university students and studies solely of teacher wellbeing were excluded). *Concept:* teacher recognition, screening, rating, referral or help-seeking for emotional, behavioral or psychological problems; barriers and facilitators; training or educational strategies; and nurse roles supporting identification and referral. *Context:* any school setting and country, with attention to low- and middle-income countries and India. Systematic and scoping reviews, quantitative, qualitative and mixed-methods studies, and policy and programme documents in English from 1997–2026 were eligible; opinion pieces without data and conference abstracts were excluded.
Eligibility criteria are summarised in Table 2.

**Table 2:** Eligibility criteria (PCC framework)

| Element | Included | Excluded |
|---|---|---|
| Population | Teachers and school staff working with children aged about 5–17 years; school and community health nurses working with schools | Preschool-only settings; university students; studies solely of teacher wellbeing |
| Concept | Teacher recognition, screening, rating, referral or help-seeking for emotional, behavioral or psychological problems; barriers and facilitators; training strategies; nurse roles in identification and referral | Interventions delivering therapy with no identification component |
| Context | Any school setting and country, with attention to low- and middle-income countries and India | Clinical-only settings with no school link |
| Evidence | Reviews, quantitative, qualitative and mixed-methods studies, policy and programme documents; English; 1997–2026 | Opinion pieces without data; conference abstracts without full reports |

**Search and selection:** The strategy combined blocks for teachers or school staff; identification, screening, referral or recognition; child mental health or behavioral problems; and, for nursing roles, school, community and public health nurses. It was adapted for PubMed, PsycINFO, ERIC, CINAHL, Scopus, Web of Science, IndMED and Google Scholar, supplemented by reference-list searching and the websites of the Ministry of Health and Family Welfare, the Ministry of Education and NCERT. Two reviewers screened records independently by title/abstract and full text, resolving disagreements by discussion. During revision the search was updated to emphasise 2020–2026 publications, including recent meta-analyses and trials of teacher literacy programmes, population data on the accuracy of teacher concern, reviews of school nurses' roles and Indian programme documents.

**Charting and synthesis:** A charting form recorded author, year, country, design, participants, tool or intervention, outcomes, barriers, facilitators, nurse involvement and main findings. As is usual in scoping reviews, no risk-of-bias scoring was used to exclude studies, though each source's design is noted in interpretation. Findings were summarised narratively along the pathway in Table 1, without statistical pooling.

## 3. Results

### 3.1 Characteristics of the evidence

The evidence runs from foundational measurement work in the 1990s to large reviews and trials in the 2020s. It includes systematic reviews and meta-analyses of teacher mental health literacy programmes,[17–19] perceived barriers,[20] school-based identification[21] and implementation of school mental health support;[27,28] a scoping review of service-level barriers;[29] survey, vignette and interview studies of teacher perceptions;[10,30–32] population and screening studies of teacher concern and teacher-completed instruments;[11,33–35] controlled and randomised evaluations of teacher training;[36,37] and reviews of school nurses' roles and training.[22,38,39] Most primary studies come from the UK, US, Australia and Europe. Indian evidence is limited to a few teacher surveys and uncontrolled training studies[15,40] and to programme documents.[12–14]

Table 3 summarises the principal sources.

**Table 3:** Principal sources charted in the review

| Source | Design and scope | Main message |
|---|---|---|
| Soneson et al.[21] (2020) | Systematic review; 33 studies of school-based identification | Mostly cross-sectional; time, resource and cost were the commonest feasibility barriers |
| O'Farrell et al.[20] (2022) | Systematic review of teachers' perceived barriers | Lack of training and role conflict were the main barriers |
| Yamaguchi et al.[17] (2020) | Systematic review; 16 literacy programmes | Most improved knowledge or confidence; 15 of 16 at high or unclear risk of bias |
| Liang et al.[19] (2026) | Meta-analysis; 18 studies | Large knowledge gain, smaller stigma reduction, moderate helping gain; no help-seeking effect |
| Mathews et al.[11] (2021) | Population survey; 5,965 British children | Teacher concern: sensitivity 56%, PPV 49%; with parent concern PPV 74% |
| Danielson et al.[35] (2023) | Two-stage screening; 1,054 US children | Teacher screeners: externalizing AUC 0.73, internalizing AUC 0.58 |
| Splett et al.[31] (2019) | Vignette survey; 153 elementary teachers | Severe problems identified accurately; moderate or subclinical less so |
| Moor et al.[36] (2007) | Controlled evaluation of brief depression training | Unrecognised depression remained unrecognised |
| Elyamani et al.[37] (2024) | Cluster randomised trial; 16 schools, Qatar | WHO-package workshop raised literacy, sustained at three months |
| Kaskoun & McCabe[22] (2022) | Integrative review; 14 studies of school nurses | Nurses trusted by schools but report limited mental health preparation |

### 3.2 How well do teachers identify problems?

1) **Severe versus subtle problems:** Identification depends on how severe and visible a problem is. In a vignette study of 153 elementary teachers, severe externalizing and internalizing problems were accurately identified, but moderate or subclinical symptoms were less so, and those children were seen as less in need of services.[31] Teachers rated externalizing problems as more serious than internalizing ones, which is expected because disruptive behavior interrupts teaching while a

withdrawn or anxious child does not. The result is a predictable blind spot for quiet distress.

2) **Population evidence:** Analyses against diagnostic interviews confirm this pattern. In a British national survey of 5,965 children, teacher concern had a sensitivity of 56% and a positive predictive value of 49% for psychiatric disorder; when both teacher and parent were concerned, the positive predictive value rose to 74%.[11] In a two-stage study of 1,054 children in four US districts, teacher versions of two widely used screeners predicted externalizing disorders moderately well (AUC 0.73) but internalizing disorders close to chance (AUC 0.58).[35] Teacher judgment is therefore useful but incomplete, and corroboration from parents and health staff improves accuracy.
3) **Depression and anxiety:** The difficulty is sharpest for adolescent depression: in a controlled evaluation, a brief educational session did not improve teachers' ability to identify depressed pupils.[36] This does not prove training can never help, but a one-off session is not enough. Structured tools such as the 25-item Strengths and Difficulties Questionnaire (SDQ), which has parent and teacher forms,[41,42] can reduce reliance on individual judgment, but they are weaker for internalizing problems[35] and do not ensure follow-up.
4) **After a teacher notices:** In the Indian survey of 460 teachers, roughly two in five identified students were not referred.[15] Splett and colleagues found that teachers' concern for the child, rather than their rating of seriousness, predicted whether they endorsed referral,[31] suggesting that referral is driven by feeling and relationship as much as knowledge, and that training should address both.

### 3.3 Barriers reported by teachers and schools

Barriers cluster into five groups that fit the pathway in Table 1 (Table 4).

**Table 4:** Barriers and facilitators reported in the literature.

| Domain | Barriers | Facilitators |
|---|---|---|
| Knowledge and skills | Lack of training in assessing mental health; low literacy; uncertainty about what is normal[15,20,30] | Prior training; self-efficacy in seeking information and giving referrals[15,17,19] |
| Role clarity | Role conflict; belief that mental health is for specialists; role seen as classroom behavior support[20,30,32] | Clear written roles; named school point person; broad role and efficacy beliefs[32] |
| Time and resources | Time, resource and cost constraints; large classes; heavy curriculum[15,21,28] | Short tools that fit routine; protected time; smaller groups; leadership support[28] |
| Attitudes and stigma | Emotional problems seen as indiscipline; stigma; fear of labelling; parental resistance[9,10] | Positive staff culture; whole-school approach; parent engagement[9,43] |
| System links | Weak referral routes and access barriers beyond school[29] | Referral protocols; links with school and community health nurses; feedback to schools[22,38] |

**Knowledge and training:** A systematic review identified lack of training and role conflict as the main barriers to teachers assessing mental health,[20] and a survey of 292 teachers found a general lack of experience and training.[30] An Irish survey found most primary teachers had no training in children's mental health and wanted it, and its authors saw an opportunity for mental health nurses to train and support them.[44]

**Role conflict:** US teachers saw school psychologists as primarily responsible for screening and referral and themselves for classroom behavioral interventions.[30] In many Indian schools no psychologist or counsellor is available, so the role may fall to the class teacher by default. How broadly teachers define their role, and how effective they feel in it, relate to their willingness to support student mental health.[32]

**Time, resources and feasibility:** In the feasibility review, time, resource and cost concerns were the commonest barriers, and evidence was limited and heterogeneous.[21] A synthesis of 50 studies found that staff who identify young people need high-quality ongoing training and support.[28] In Indian schools, large classes add to the problem; teaching 31–60 students predicted lower literacy in the southern Indian survey.[15]

**Attitudes, stigma and onward access:** Indian young people often see people with mental health problems as dangerous and recovery as unlikely; the review recommended awareness campaigns integrated with educational institutions and relatable symptom descriptions rather than psychiatric labels.[9] Direct Indian evidence on teacher and parent stigma as a barrier to identification is lacking. Even a perfect teacher screen is useless if the child cannot reach care;[29] the specialist child workforce in India is small and unevenly distributed, which increases the importance of the nursing workforce that already reaches schools.

### 3.4 Educational and system-level strategies

1) **Teacher mental health literacy programmes:** The concept of mental health literacy comes from Jorm.[45] An early review of 16 studies found most reported improved knowledge, attitudes and confidence, but 15 were at high or unclear risk of bias.[17] Later evidence strengthens and qualifies this picture. A meta-analysis of 18 studies found a large gain in teachers' knowledge ($g = 1.08$), a small-to-moderate reduction in stigma ($g = -0.33$) and a moderate increase in helping behavior ($g = 0.48$), but no effect on help-seeking.[19] A review of 20 studies of secondary teachers reached similar conclusions, noting few trials and standardised measures.[18] A cluster randomised trial in 16 schools in Qatar found that a six-hour workshop based on the WHO school mental health package raised teacher literacy, sustained at three months.[37] In India, a single-group study of 102 teachers in Bengaluru found improved knowledge and attitudes about youth depression and suicide at three months, with some teachers going on to help distressed students.[40] Few studies, however, measure identification or child outcomes.
2) **Why training alone is often not enough:** Increased awareness does not necessarily change what teachers

detect,[36] and recent meta-analytic evidence still rests mainly on knowledge and attitude outcomes.[19] Together with the finding that referral depends on concern as much as seriousness,[31] this suggests that training should include practice with realistic cases, attention to emotion and relationship, decision rules about when to refer, and booster sessions. These are proposals consistent with the evidence rather than tested conclusions.

3) **Structured tools:** Most studies of universal screening are cross-sectional.[21] Screening is argued for on grounds of equity and early action but requires attention to consent, resources, acceptability and what is done with positive results.[46] Brief teacher tools can structure observation,[41,42] but they miss many internalizing problems,[35] so ratings should be combined with information from parents, the child and a health professional.[11]
4) **Roles and referral pathways:** Teachers need to know what they are expected to do and to whom to turn. Teachers can take roles from referral to intervention delivery, but the supports they receive determine what is feasible.[27] In India, a school health nurse, a community health nurse or a visiting counsellor could take the role school psychologists play elsewhere (Section 3.5).

### 3.5 Teacher-mediated identification: the role of school health and community health nurses

Identification is most likely to succeed as a shared pathway rather than a task left to individual teachers: the teacher contributes daily observation, a trusting relationship and the first supportive response; the nurse contributes health assessment, interpretation, coordination of referral and follow-up.

**Who the nurses are.** School health nurses are posted in or attached to schools, as in the US and many European countries. In India few schools have a full-time nurse; children are reached mainly by community health nurses-auxiliary nurse midwives (ANMs), staff nurses and community health officers working through primary health centres and health and wellness centres. Under the Rashtriya Bal Swasthya Karyakram (RBSK), mobile health teams including an ANM or staff nurse screen children aged 6–18 years in government and aided schools at least yearly and refer them to District Early Intervention Centres.[47] These programmes already bring nurses and teachers into contact, although RBSK screening focuses on the "4Ds" (defects at birth, deficiencies, diseases and developmental delays) rather than emotional and behavioral problems.

**What the evidence says about nurses.** An integrative review of 14 studies found that school nurses see themselves as trusted members of the school community, value mental health competence, and often see distress presenting as physical complaints in the health room.[22] A review of the US role described mental health activity at individual, community and systems levels.[38] Both found nurses often under-prepared, and a rapid review of 11 training programmes suggested that targeted training improves nurses' knowledge, confidence and preparedness.[39] The National Association of School Nurses has called for a stronger nursing role in school mental and behavioral health teams.[48]

**Step 1- Notice: structured observation:** Teachers watch for change from the child's usual pattern rather than for diagnoses: falling attendance or marks, withdrawal from peers, persistent sadness or irritability, frequent crying, aggression, inattention, and repeated somatic complaints such as headache or stomach ache. A short observation log, the NCERT flag-sign checklists[13] or a teacher SDQ[41] can make this systematic, with particular weight on quiet children, who are most likely to be missed.[31,35] *Nurse role:* train teachers to recognise these signs, explain the tool, and share health-room observations such as repeated visits, poor sleep, weight change or self-injury marks.[22]

**Step 2- Interpret: consultation before conclusion:** Simple rules- how often the behavior occurs, how long it has lasted (e.g. over two weeks), how intense it is and whether it affects learning, friendships or home life- guide judgment, and concern is corroborated because teacher and parent concern together are far more predictive.[11] *Nurse role:* carry out a brief health assessment to rule out physical causes (vision or hearing problems, anaemia, chronic illness, poor sleep), score and interpret screening tools with the teacher, and screen for self-harm or abuse, which require immediate action.

**Step 3- Discuss: a named point person and small team:** Each school should know to whom a teacher reports a concern. The NCERT handbook recommends a school mental health advisory panel chaired by the principal;[13] the nurse can serve as point person, or, where none is posted, the Health and Wellness Ambassador teacher can act internally with the community health nurse as external link.[12] *Nurse role:* help plan a non-blaming conversation with parents, explain concerns in everyday language that reduces stigma,[9] and maintain confidentiality.

**Step 4- Act: a tiered response:** Most concerns can first be met with classroom support such as seating changes, predictable routines, peer support and brief check-ins. Persistent or moderate problems need school-level support from a counsellor or nurse; severe problems, risk of harm or lack of response need referral to the primary health centre, the District Early Intervention Centre under RBSK, or district mental health services.[47] *Nurse role:* make or complete the referral with a short written summary of the teacher's observations, help the family navigate services, and act on urgent risk the same day.

**Step 5- Follow up: closing the loop:** Programmes most often fail after referral, when information is lost and teachers hear nothing back.[28,29] *Nurse role:* keep a simple register of children identified, referred and seen; bring feedback from services to the teacher (with consent); repeat the screening tool after an agreed interval; and provide booster training and supervision, which recent reviews identify as necessary for sustained practice.[19,28] The roles across all five steps are summarised in Table 5.

**Table 5:** Teacher strategies and supporting nurse roles across the pathway.

| Step | Teacher strategy | School health nurse / community health nurse (India) role |
|---|---|---|
| 1. Notice | Observe change from usual behavior; log; flag-sign checklist; teacher SDQ | Train teachers in warning signs, especially internalizing; explain tools; share health-room observations; orient Ambassadors during RBSK visits |
| 2. Interpret | Apply frequency, duration, intensity and impairment rules; seek parent and colleague views | Brief health assessment to exclude physical causes; score and interpret SDQ; screen for self-harm and abuse; advise on need for referral |
| 3. Discuss | Report to point person; joint meeting with parents | Act as point person or external link to school panel; plan non-blaming parent conversation; protect confidentiality |
| 4. Act | Classroom adjustments; peer support; check-ins | Coordinate school-level support; refer via PHC, DEIC or district services with written summary; same-day action for urgent risk |
| 5. Follow up | Monitor progress in class; record change | Keep register; relay feedback to teacher; repeat screening; track referral completion; booster training and supervision |

This partnership is consistent with the evidence but has not been tested as a complete package in Indian schools. Its value lies in giving each step a clear owner, so that what a teacher notices is more likely to become support for the child.

### 3.6 Evidence from low- and middle-income settings and India

Evidence on teacher identification is concentrated in high-income countries. Indian evidence largely describes teacher knowledge and attitudes rather than testing identification systems. The southern Indian survey shows that teachers already identify students with problems but many are not referred, and that prior training, class size and self-efficacy relate to literacy;[15] the Bengaluru study adds early, uncontrolled evidence that literacy can be improved.[40] National initiatives- Health and Wellness Ambassadors,[12] the NCERT handbook[13] and programmes such as Khushishala[14]- now provide a structure, but the Khushishala source is a press report and no outcome evaluation exists. Cultural adaptation, local-language materials, stigma reduction[9] and links to the RBSK and primary-care nursing workforce[47] are likely to matter, but direct evidence is scarce.

## 4. Discussion

### 4.1 Principal findings

Five messages stand out. First, teachers recognise severe, disruptive problems but are less accurate for moderate and internalizing problems, where early detection has most to offer; teacher concern detects only about half of children with a disorder.[11,31,35,36] Second, barriers are structural and role-related as much as personal: training, role conflict, time, class size and weak referral links.[20,21,28,30] Third, training reliably improves knowledge, attitudes and helping behavior but has rarely been shown to improve identification or access to care.[17–19] Fourth, school and community health nurses are well placed to support every step but are often under-prepared.[22,38,39] Fifth, Indian evidence is scarce and tends to describe the problem rather than test solutions.

### 4.2 Interpretation

The pattern of accurate recognition of severe and externalizing problems and poor recognition of internalizing ones reflects what is visible and disruptive in a classroom. Teachers cannot be blamed for missing what is not displayed. This argues for processes that make quiet distress visible- brief screening, routine check-ins, shared observation and consultation with a nurse- rather than expecting each teacher to become a clinician.

That one-off training did not improve depression recognition,[36] while knowledge, stigma and helping behavior improve in most literacy studies,[17,19] suggests a distinction between feeling better prepared and detecting more. Self-reported knowledge and confidence are easier to change than detection behavior, so studies need to measure what teachers do and whether children reach care. Role conflict is also central: teachers who see mental health as a specialist role may avoid it,[30] while those with a broad role and high efficacy engage more.[32] Clarifying that the teacher's role is to notice, support and refer, with a named health partner to help interpret and act, may reduce this conflict. Where school psychologists are rare, the nurse is the most realistic partner, which places a direct responsibility on nursing education.

### 4.3 Implications for nursing education

1) **Undergraduate:** Child and adolescent mental health, school health and early identification should be taught as linked topics across child health, mental health and community health nursing, covering the presentation of common problems (especially internalizing ones), the use and limits of tools such as the SDQ,[35,42] self-harm risk assessment, and referral routes through RBSK, primary health centres and district services.[47] Field experience should include structured school health visits where students observe classrooms, assist screening and practise explaining concerns to teachers and parents.
2) **Postgraduate:** Master's programmes in community, mental health and child health nursing should prepare nurses to lead school mental health work: designing teacher training, setting up identification and referral protocols, supervising teachers and junior nurses, and evaluating programmes, at individual, community and systems levels[22,38] and within health-promoting school frameworks.[43] Postgraduate research is an obvious way to generate the missing Indian evidence.
3) **Continuing and in-service education:** ANMs, staff nurses and community health officers already visiting schools need short, practical modules on child mental health, teacher consultation and referral. Training can improve nurses' knowledge, confidence and preparedness,[39] and limited continuing education is a major barrier.[22,38] Modules should be competency-based, in local languages and followed by refreshers, since single sessions rarely change practice.[28,36]

4) **Teaching methods and competencies:** Because identification depends on judgment and relationship as much as knowledge,[31] education should use case vignettes, role play of conversations with teachers and parents, simulation of risk situations and supervised school practice, including joint sessions with teachers to practise the shared pathway in Table 5 and address role conflict.[20,30] Nurse educators should also teach students to train others.[44] Programmes could define and assess a small set of competencies—recognising early signs, using a brief screening tool, assessing immediate risk, consulting with teachers and communicating with parents without stigma, making and following up a referral, and delivering a teacher training session—through observed structured examination or supervised school placement.

### 4.4 Research gaps

- Trials of complete pathways (training, tool, nurse support, referral, follow-up) in Indian schools, with outcomes including children identified, referred, reaching care and wellbeing.
- Validation and cultural adaptation of teacher-completed tools in Indian languages, especially for internalizing problems.
- Evaluation of nursing education interventions, such as undergraduate school mental health modules and in-service training for ANMs and community health officers.
- Studies of gender differences and of identification in primary-school children; qualitative research on teacher, nurse and parent attitudes and referral decisions in Rajasthan and other states; and economic and feasibility evaluations including time costs.

## 5. Limitations

This scoping review mapped rather than appraised the evidence, so conclusions about effectiveness cannot be drawn. The evidence is heterogeneous and dominated by high-income countries, so transfer to Indian schools is uncertain; many sources are self-report surveys or vignette studies. Much of the school nursing evidence comes from the US, where the role differs from that of community health nurses in India, and the nurse roles in Section 3.5 are proposals rather than tested interventions. Language was restricted to English, so regional-language literature and unpublished evaluations may have been missed. A press report was used for one programme description and should be replaced by official documents or evaluations when available.

## 6. Conclusion

Teachers are well placed to notice early signs of behavioral and psychological problems but are not yet well equipped to do so. They recognise severe and disruptive problems more reliably than quiet, internalizing or moderate ones, and are held back by limited training, unclear roles, time pressure and weak links to services. Literacy programmes improve knowledge, attitudes and helping behavior, but there is little evidence that they alone improve identification or access to care. The most promising approach is a shared pathway in which teachers notice and record, and nurses help interpret, coordinate referral and follow up. For India, the priorities are to prepare nurses for this role through undergraduate, postgraduate and in-service education, and to test teacher–nurse pathways with outcomes that matter for children.

### Declarations

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