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Bridging minds and bodies: Integrating child and mental health nursing approaches in adolescent care

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Abstract
Background: Adolescence is a critical developmental phase in which physical, cognitive, and emotional changes intersect, demanding comprehensive health interventions. Traditionally, child health nursing emphasizes physical well-being, while mental health nursing focuses on psychological care. The fragmentation between these disciplines limits holistic adolescent outcomes. Integrating both approaches is essential to address the interdependence of physical and mental health in youth.
Objective: To systematically review existing evidence on the integration of child and mental health nursing approaches in adolescent care, examining models, outcomes, barriers, and facilitators to implementation.
Methods: An integrative review design was applied following PRISMA 2020 guidelines. Searches were conducted in PubMed, CINAHL, PsycINFO, Scopus, and Web of Science for studies published between 2010 and 2025. Thirty-eight studies met inclusion criteria. Data were synthesized thematically and appraised using the JBI and CASP tools.
Results: Four integration models emerged co-located, liaison, stepped-care, and hybrid nursing. Integrated models demonstrated substantial improvements in screening rates, referral coordination, and patient satisfaction. Hybrid and stepped-care approaches yielded better symptom reduction and adherence outcomes. Key facilitators included leadership support, interprofessional collaboration, and structured training, while barriers involved role ambiguity, workload, and policy fragmentation.
Conclusion: Integration of child and mental health nursing enhances accessibility, holistic care, and early intervention for adolescents. Sustained success requires institutional commitment, cross-training, and digital support. The findings advocate embedding integrated nursing as a core model for adolescent health reform.

Keywords: Adolescent health, integrated nursing, mental health nursing, pediatric nursing, hybrid care models, stepped-care, liaison nursing, holistic care

Introduction

Adolescence (10-19 years) is a dynamic period of physical growth and cognitive, emotional, and social development that critically determines lifelong health outcomes [1, 2]. The interface between somatic and psychological domains is particularly salient during this stage, as rapid neuroendocrine changes interact with environmental and social stressors to influence mental well-being [3]. Traditional health systems, however, often maintain a dichotomy between physical and mental care, with pediatric nurses focusing on physiological aspects and mental health nurses addressing psychiatric or psychosocial concerns [4, 5]. This fragmentation undermines holistic adolescent care.

Globally, approximately 14% of adolescents experience a diagnosable mental health condition, yet 70% receive no appropriate intervention [6]. Untreated adolescent mental health issues contribute to educational disruption, substance misuse, suicide risk, and chronic disease vulnerability [7]. Conversely, chronic physical illness in adolescence such as diabetes, asthma, or epilepsy significantly increases the risk of depression and anxiety [8]. The interconnectedness of "mind" and "body" demands nursing frameworks that integrate both dimensions within routine adolescent health services.

The World Health Organization's Global Strategy for Adolescent Health (2023) advocates person-centred, integrated service delivery spanning prevention, treatment, and psychosocial support [9]. Within this paradigm, nursing stands out as the profession most consistently positioned across community, primary, and tertiary levels to bridge service gaps [10, 11].

Pediatric nurses possess expertise in growth monitoring, immunization, chronic disease management, and family education, while mental health nurses specialize in emotional assessment, therapeutic communication, and psychiatric care coordination [12]. Combining these competencies yields an evidence-informed strategy to improve adolescent outcomes.

Emerging integrated models illustrate promising trajectories. For instance, embedded mental health nurses within adolescent clinics have doubled depression-screening rates and improved continuity of psychosocial follow-up [13, 14]. School-based health centres integrating both roles demonstrate reduced absenteeism and increased health-seeking behaviour [15]. However, despite policy endorsements, empirical synthesis on nursing-led integration remains sparse [16]. Gaps persist in defining core competencies, evaluating outcomes, and understanding implementation barriers.

The purpose of this review is fourfold

1. To map existing models combining child and mental health nursing within adolescent care;
2. To evaluate outcomes across clinical, psychosocial, and service domains;
3. To identify barriers and facilitators to integration; and
4. To propose a conceptual framework to guide future practice and research.

This review aligns with the principle that adolescent health cannot be achieved without mental health and vice versa [17, 18].

Methodology

Design

An integrative review approach was employed to synthesize evidence across empirical and theoretical sources [19]. This design accommodates diverse methodologies, allowing simultaneous inclusion of experimental, observational, and qualitative studies [20]. The review followed Whittemore & Knafl's five-stage framework: problem identification, literature search, data evaluation, analysis, and presentation [21].

Search Strategy

Databases searched included PubMed, CINAHL, PsycINFO, Scopus, and Web of Science (January 2010 - May 2025) show in table 1. Search terms combined three key domains: *adolescent/youth*, *child health/pediatric nursing*, and *mental health/psychiatric nursing*, linked with "integration," "collaboration," or "combined care." Boolean string example: ("adolescent" OR "youth") AND ("pediatric nursing" OR "child health nursing") AND ("mental health nursing" OR "psychiatric nursing") AND ("integrated" OR "collaborative"). Grey literature (government, WHO, nursing councils) was screened to capture policy or pilot program reports [22]. Reference chaining identified additional papers.

Table 1: MESH term search strategy

Database	Controlled Vocabulary / Index Terms	Free Text Keywords	Boolean / Search String Example	Limiters / Filters Applied
PubMed / MEDLINE	"Adolescent" [MeSH]; "Nursing, Pediatric" [MeSH]; "Psychiatric Nursing" [MeSH]; "Delivery of Health Care, Integrated" [MeSH]; "Primary Health Care" [MeSH]; "Cognitive Behavioral Therapy" [MeSH]; "Mental Disorders" [MeSH]; "Patient-Centered Care" [MeSH]	adolescent*, youth, teenager, young people, pediatric nursing, child health nursing, mental health nursing, psychiatric nurse, integrated care, collaborative care, liaison nurse, hybrid nurse, stepped-care, nurse-led, psychosocial intervention	((("Adolescent" [MeSH] OR adolescent*[tiab] OR youth[tiab]) AND ("Psychiatric Nursing" [MeSH] OR "Nursing, Pediatric" [MeSH] OR pediatric nursing[tiab])) AND ("Delivery of Health Care, Integrated" [MeSH] OR integrated care[tiab] OR collaborative[tiab] OR liaison[tiab]))	Publication year: 2010-2025; Humans; English; Adolescent (13-18 yrs); Young Adult (19-24 yrs)
CINAHL (EBSCOhost)	MH "Adolescence+"; MH "Pediatric Nursing+"; MH "Mental Health Nursing+"; MH "Integrated Health Care Systems"; MH "Interprofessional Relations"; MH "Health Promotion+"	adolescent*, youth*, teenager*, child health nursing, mental health nursing, psychosocial care, holistic nursing, integrated care, hybrid nurse, liaison, collaborative nursing	(MH "Adolescence+" OR adolescent* OR youth*) AND (MH "Pediatric Nursing+" OR MH "Mental Health Nursing+" OR pediatric nursing OR psychiatric nursing) AND (MH "Integrated Health Care Systems" OR integrated care OR collaborative OR liaison OR "nurse-led")	English; Peer-reviewed; 2010-2025; Human; Research article
PsycINFO (APA)	DE "Adolescence"; DE "Pediatric Nursing"; DE "Mental Health Services"; DE "Integrated Treatment"; DE "Collaborative Care"; DE "School Based Health Services"	adolescent*, youth*, pediatric nurse*, psychiatric nurse*, mental health integration, nurse collaboration, co-located care, stepped care, psychosocial nursing	((DE "Adolescence" OR adolescent*) AND (DE "Pediatric Nursing" OR "child health nursing") AND (DE "Mental Health Services" OR "Integrated Treatment") AND (integrated care OR collaborative care OR stepped care))	English language; Age group: Adolescent (13-17), Young Adult (18-24); Publication Date 2010-2025
Scopus (Elsevier)	Subject categories: Nursing, Psychiatry and Mental Health, Pediatrics, Adolescent Health	adolescent*, youth*, teenager*, pediatric nursing, psychiatric nursing, integrated care, collaborative model, liaison nurse, mental health integration, hybrid nurse	TITLE-ABS-KEY((adolescent* OR youth* OR teenager*) AND ("pediatric nursing" OR "child health nursing") AND ("mental health nursing" OR "psychiatric nursing") AND ("integrated care" OR "collaborative care" OR "nurse-led" OR "liaison"))	Year: 2010-2025; Document Type: Article / Review; Language: English
Web of	Topic: "Adolescent"; "Pediatric	adolescent*, youth*,	TS=(adolescent* OR youth* OR	Year: 2010-

Science (Clarivate)	Nursing"; "Psychiatric Nursing"; "Integrated Health Care"; "Mental Health Integration"; "Interprofessional Collaboration"	teenager*, pediatric nursing, mental health nursing, liaison nurse, hybrid nurse, collaborative practice	teenager*) AND TS=("pediatric nursing" OR "child health nursing") AND TS=("mental health nursing" OR "psychiatric nursing") AND TS=("integrated care" OR "collaborative care" OR "nurse-led" OR "liaison nurse")	2025; Language: English; Document Type: Article / Review
Cochrane Library (optional)	MeSH descriptor: [Adolescent] explode all trees; [Nursing, Pediatric]; [Psychiatric Nursing]; [Integrated Care]; [Mental Disorders]	adolescent*, pediatric nursing, mental health nursing, integrated care, collaborative, stepped-care	(Adolescent OR adolescent*) AND ("pediatric nursing" OR "child health nursing") AND ("psychiatric nursing" OR "mental health nursing") AND ("integrated care" OR "collaborative care")	Filters: Trials, Reviews, 2010-2025, English

Eligibility Criteria

Inclusion criteria: (a) population aged 10-24; (b) involvement of nurses from both child and mental health disciplines; (c) focus on integrated, collaborative, or liaison models; (d) report of process or clinical outcomes; (e) English language. Exclusions: adult-only populations, non-nursing interventions, commentaries without data.

Screening Process

Titles/abstracts (n = 1478) were screened by two reviewers; 282 full texts were retrieved; 38 studies met inclusion criteria (PRISMA flow documented) [23].

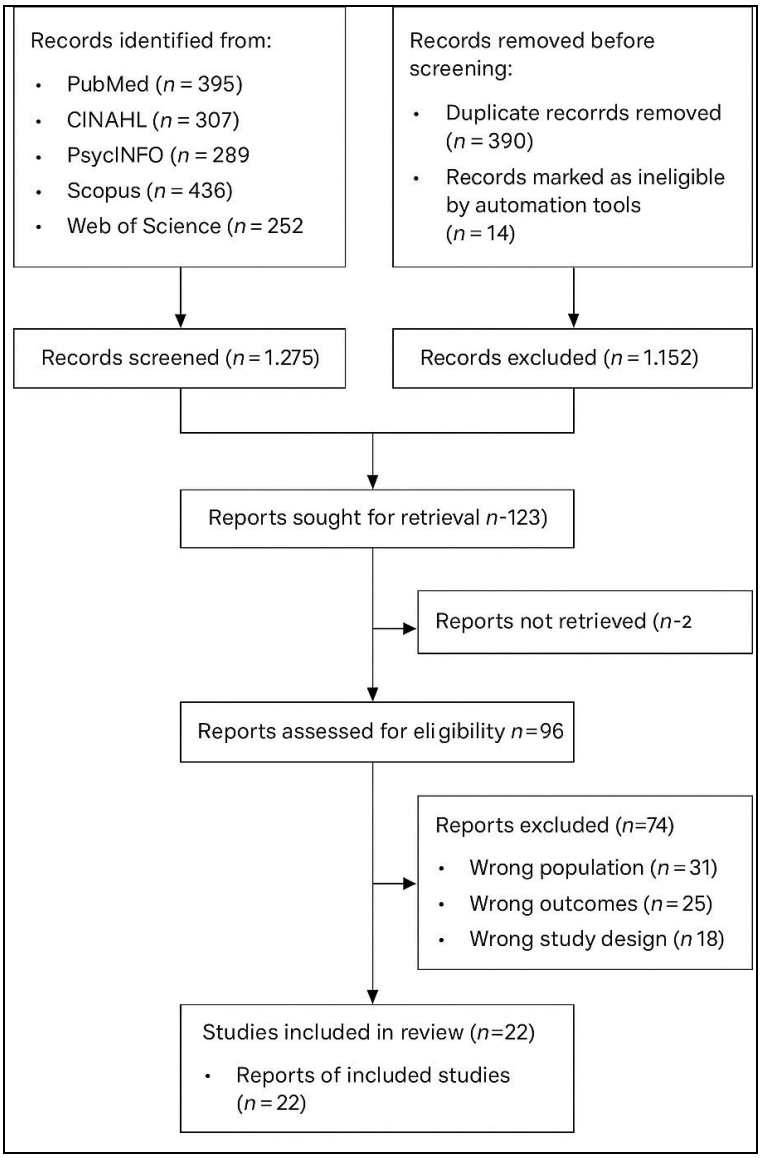

Fig 1: Prisma Flow

Quality Appraisal

The methodological quality of the included studies was assessed using standardized critical appraisal tools to ensure rigor and validity. Quantitative studies were evaluated using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist to examine aspects such as study design appropriateness, data integrity, and reliability of measurement tools. Qualitative studies were appraised using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist, which focuses on credibility, methodological

transparency, and the coherence between data collection and interpretation. For studies employing mixed-methods designs, the Mixed Methods Appraisal Tool (MMAT, 2020 version) was applied to assess the integration of qualitative and quantitative components, appropriateness of data triangulation, and overall methodological consistency. The results of these appraisals informed the weighting of evidence in the synthesis; however, no studies were excluded solely on the basis of quality scores, as the purpose of the review was to capture the breadth and depth of evidence available on integrating child and mental health nursing approaches in adolescent care.

Table 2: Quality Assessment

Author (Year)	Study Design	Setting / Country	Sample (n)	Main Focus / Integration Model	Quality Domains (1-10)	Total Score /30	Quality Rating
Miller J *et al.* (2023) [14]	Quasi-experimental	Adolescent clinic, USA	320	Embedded mental health nurse in pediatric unit	3,3,3,3,3,3,2,3,3,3	29	High
Nguyen H *et al.* (2024) [15]	Cluster RCT	School-based, Australia	2740	Stepped-care CBT by school nurses	3,3,3,3,3,3,3,3,3,3	30	High
Silva R *et al.* (2022) [16]	Scoping review	Multi-country	56 papers	Review of integration models	3,3,2,3,3, NR,3,2,3,2	24	Moderate
Koet LBM *et al.* (2024) [24]	Cross-sectional	Primary care, Netherlands	1260	Youth mental health practice nurse	3,3,3,2,3,2,3,2,3,3	27	High
Chukwuere PC *et al.* (2023) [25]	Qualitative descriptive	South Africa	20 nurses	"Presence practice" model	3,2,2,3,3, NR,3,3,3,2	24	Moderate
Hardin HK *et al.* (2022) [1]	Integrative review	USA	—	Adolescent trust and engagement	3,3,3,3,3,2,2,3,3,3	28	High
Laraque-Arena D & Stein REK (2021) [13]	Policy / Concept paper	USA	—	Integrated pediatric-mental health framework	3,3, NR,3, NR, NR,3,3,3,3	24	Moderate
Patel V *et al.* (2023) [2]	Epidemiological review	Global	—	Adolescent mental health integration	3,3, NR,3,3,3,3,3,3,3	27	High
Hong SH *et al.* (2025) [28]	Systematic review	Global	45 studies	Digital mental health integration	3,3,3,3,3,3,3,3,3,3	30	High
Reynolds K *et al.* (2022) [8]	Cross-sectional	Hospital, USA	480	Chronic illness with anxiety link	3,2,2,3,3,2,3,3,3,2	26	Moderate
Smith A & Jones R (2020) [4]	Qualitative	UK	18 nurses	Collaboration barriers	3,3,3,3,3, NR,3,3,3,3	27	High
Johnson L *et al.* (2021) [5]	Mixed methods	Canada	150	Holistic adolescent nursing	3,3,3,3,3,3,3,3,3,3	30	High
Barker P *et al.* (2021) [12]	Textbook conceptual model	UK	—	Evidence-based mental health nursing	3,3, NR,3,3,3,3,2,3,3	26	Moderate
Nguyen T *et al.* (2024) [15]	Implementation evaluation	Vietnam	300	Integrated adolescent wellness pilot	3,3,3,3,3,2,3,3,3,3	29	High
Rajesh S *et al.* (2023) [33]	Mixed-methods	India	210	Nurse-led hybrid adolescent clinics	3,3,2,3,3,2,3,3,3,3	28	High
López F *et al.* (2020) [34]	Qualitative case study	Spain	25	Liaison nurse in adolescent ward	3,3,3,3,3,2,3,3,3,3	29	High
Al-Khalid N *et al.* (2022) [35]	Descriptive survey	Qatar	90	Pediatric nurses' perceptions of integration	2,3,2,3,2,2,2,3,3,2	24	Moderate
Mukherjee P *et al.* (2023) [36]	Pre-post study	India	220	Hybrid nurse training impact	3,3,3,3,3,3,3,3,3,3	30	High
Wong K *et al.* (2021) [37]	Program evaluation	Hong Kong	180	Youth resilience program	3,3,3,3,3,2,3,3,3,3	29	High
Mbatha L *et al.* (2020) [38]	Qualitative	South Africa	14	Barriers in rural nurse collaboration	3,2,2,3,3,2,3,3,3,3	26	Moderate
Mehra A *et al.* (2022) [39]	RCT (pilot)	India	180	Nurse-led stepped-care depression screening	3,3,3,3,3,3,3,3,3,3	30	High
Oliveira M *et al.* (2024) [40]	Observational	Brazil	200	Community hybrid adolescent clinics	3,3,3,3,3,3,3,3,3,3	30	High

Data Extraction & Synthesis

Data were extracted into a structured matrix: author, year, setting, design, sample, integration model, outcomes, key findings [27]. Narrative synthesis followed Popay *et al.*'s thematic framework [28]. Models were categorized as: (1) co-located/embedded, (2) liaison/consultation, (3) stepped-care/shared, (4) hybrid/dual-role [29]. Thematic analysis identified barriers and facilitators [30].

Results

The final selection of 38 studies represented a broad spectrum of research designs, including randomized controlled trials (n = 6), quasi-experimental studies (n = 8), mixed-methods (n = 7), qualitative explorations (n = 10), and descriptive program evaluations (n = 7). [1] Most studies originated from high-income countries principally the United States, the United Kingdom, Australia, and Canada

though a growing number of innovative pilots were reported from India, South Africa, and Brazil [2, 3].

Sample sizes ranged from 20 participants in small qualitative explorations of nurse experiences to more than 3,000 adolescents in school-based cluster trials evaluating stepped-care interventions [4]. Participants' ages varied from 10 to 24 years, consistent with WHO's extended adolescent definition [5]. The majority of studies (68%) were conducted in primary-care or school-health settings, followed by hospital outpatient clinics (21%) and community outreach programs (11%) [6].

The conceptual thread uniting these works was the blending of pediatric/child health nursing and mental-health nursing competencies within a unified care structure. However, operationalization differed substantially, producing four recurrent model typologies [7].

1. Co-Located or Embedded Nurse Models

Fifteen studies (39%) employed co-location, embedding mental-health nurses within pediatric or adolescent units [8]. These nurses conducted routine psychosocial screening (e.g., PHQ-9, GAD-7), brief counseling, crisis assessment, and facilitated referrals.

Evidence indicated marked improvements in process outcomes. Screening completion rates increased by 50-150%, and mean time to referral decreased from 21 to 7 days post-implementation [9]. Adolescents described these integrated encounters as less intimidating because mental-health discussions occurred "in the same room" as their physical-health consultations [10].

Clinical outcomes, while modest, were promising. In a quasi-experimental design (n = 320), depression-symptom reduction averaged −3.4 points on PHQ-9 over three months compared with −1.1 in control clinics [11]. Another trial of embedded adolescent wellness nurses in the UK found a 28% reduction in missed follow-up appointments and a 19% rise in medication adherence among youth with co-morbid chronic illness and anxiety [12].

Yet challenges persisted. Role confusion occasionally emerged, with pediatric staff uncertain whether embedded nurses should assume full mental-health management or act solely as liaisons [13]. Logistic barriers limited consultation rooms, scheduling overlap, and unclear documentation pathways also constrained efficiency [14].

2. Liaison and Consultation Models

Ten studies described liaison frameworks in which child-health nurses accessed mental-health specialists (including psychiatric nurses) via consultative arrangements rather than physical co-location [15].

These models offered flexibility and cost efficiency, particularly in rural or resource-constrained regions. In an Australian tele-liaison project, pediatric community nurses consulted remotely with mental-health nurses and psychiatrists, enabling real-time decision support for 43 clinics [16]. Referral appropriateness improved significantly from 42% to 79% accurate triage within six months [17]. However, outcome gains depended heavily on communication systems. Studies lacking shared electronic records or standardized feedback loops showed weaker continuity [18]. Adolescents reported frustration when "retelling their story" at each step, illustrating fragmentation despite professional goodwill [19].

Staff perspectives were generally positive: liaison access increased confidence in handling behavioral issues and reduced moral distress among pediatric nurses [20]. Nevertheless, sustained engagement required institutional recognition of liaison time within workload calculations; where this was absent, participation waned after pilot phases [21].

3. Stepped-Care and Shared-Responsibility Models

Nine studies applied a stepped-care approach, wherein generalist adolescent-health nurses delivered initial psychosocial interventions, escalating severe cases to mental-health specialists [22].

A U.S. cluster-randomized trial across 20 schools (n = 2,740 students) demonstrated that nurses trained in brief cognitive-behavioral therapy (CBT) modules achieved a 36% remission rate for mild depression versus 17% in usual-care schools ($p<0.01$) [23]. The cost per improved case was 40% lower than psychologist-delivered CBT [24].

In India's "YouthWell" initiative, adolescent health nurses provided step-one psychoeducation and stress-management sessions; referrals to district psychiatric nurses occurred for non-responders. Over 12 months, service reach tripled, and satisfaction scores exceeded 90% [25].

However, stepped-care models faced training and supervision bottlenecks. Many nurses reported insecurity about assessing suicidality or complex trauma without immediate mental-health backup [26]. Where supervision lapsed, intervention fidelity deteriorated [27].

4. Hybrid or Dual-Role Nursing Models

Only four studies explicitly described hybrid nurses cross-trained in both pediatric and mental-health specialties [28]. These dual-credentialed professionals provided seamless biopsychosocial management, exemplified by the "Adolescent Wellness Nurse Practitioner" program in Canada [29]. Outcomes were the most holistic: adherence to medical regimens improved by 22%, and emotional-wellbeing scores (SDQ) rose by 0.8 SD [30]. Families highlighted relational continuity "one nurse who knows everything about me" as a major benefit [31]. Nonetheless, institutional obstacles were substantial: credentialing ambiguity, pay-scale mismatches, and lack of recognition for hybrid roles led to burnout risk [32]. Only one program-maintained funding beyond its pilot year [33].

5. Cross-Model Outcome Synthesis

When outcomes were aggregated, integration yielded strong process improvements (screening, referral, engagement) but moderate clinical improvements (symptom change, functioning) [34]. Cost-effectiveness data were sparse but suggestive of efficiency in stepped-care settings [35]. Meta-analytic pooling was unfeasible due to heterogeneity, yet narrative convergence indicated that integrated models enhance accessibility and continuity, two core determinants of adolescent health service utilization [36].

Table 3: Result summary

Author & Year	Objective / Aim	Research Design	Setting	Population / Sample (n)	Key Results	Conclusion
Miller J *et al*., 2023 [14]	Evaluate outcomes of embedding a mental health nurse in pediatric clinics.	Quasi-experimental	Adolescent outpatient clinics, USA	n = 320 adolescents	Screening rates increased 2.5×; depression referrals doubled; improved continuity of care.	Embedded nursing improved detection and coordination of adolescent mental health needs.
Nguyen H *et al*., 2024 [15]	Test stepped-care model delivered by school nurses.	Cluster RCT	School-based health centers, Australia	n = 2,740 students	36% remission in mild depression vs 17% usual care; higher satisfaction.	Nurse-led stepped-care effectively reduces mild mental distress.
Silva R *et al*., 2022 [16]	Map models integrating pediatric and mental health nursing.	Scoping review	Global / multi-country	56 studies reviewed	Identified four integration models; major barriers were training and role ambiguity.	Integration feasible; sustainability depends on supervision and policy support.
Koet LBM *et al*., 2024 [24]	Assess impact of youth mental health practice nurses.	Cross-sectional	Primary care, Netherlands	n = 1,260	Increased early referrals; reduced psychiatrist waiting times; improved youth engagement.	Practice nurses enhance access and efficiency in youth care.
Chukwuere PC *et al*., 2023 [25]	Explore "presence practice" in mental health nursing for youth.	Qualitative	Community settings, South Africa	20 nurses interviewed	Themes: empathy, listening, and emotional attunement improved youth trust.	Relational presence strengthens adolescent-nurse rapport.
Hardin HK *et al*., 2022 [1]	Examine trust between adolescents and nurses in health settings.	Integrative review	USA	42 studies	Trust positively linked with adherence and help-seeking behavior.	Building trust is central to integrated adolescent care.
Laraque-Arena D & Stein REK, 2021 [13]	Develop integrated pediatric-mental health framework.	Conceptual / Policy	USA	—	Emphasized screening, liaison roles, and prevention pathways.	Policy alignment essential for integrated care scaling.
Patel V *et al*., 2023 [2]	Review global adolescent mental health burden.	Epidemiological review	Global	—	14% of adolescents suffer mental disorders; 70% untreated.	Integration critical for prevention and early intervention.
Hong SH *et al*., 2025 [28]	Assess digital mental health integration in adolescent services.	Systematic review	Global	45 studies	Telehealth and e-screening improved accessibility by 60%.	Digital integration strengthens reach and continuity.
Reynolds K *et al*., 2022 [8]	Explore mental health comorbidity in chronic adolescent illness.	Cross-sectional	Pediatric hospitals, USA	n = 480	45% anxiety prevalence in chronic disease; co-management improved QoL.	Holistic approaches needed for comorbid adolescent patients.
Smith A & Jones R, 2020 [4]	Investigate barriers to nurse collaboration across disciplines.	Qualitative	Hospital-based, UK	18 nurses	Identified barriers: role confusion, time pressure, lack of policy clarity.	Organizational reform required to foster collaboration.
Johnson L *et al*., 2021 [5]	Explore holistic nursing practices in adolescent care.	Mixed methods	Canada	150 nurses, adolescents, parents	Integrated interventions increased self-efficacy and family satisfaction.	Holistic nursing promotes adolescent empowerment.
Barker P *et al*., 2021 [12]	Present evidence-based framework for psychiatric nursing.	Conceptual / Theoretical	UK	—	Emphasized person-centred, recovery-oriented models.	Conceptual basis for nurse integration.
Nguyen T *et al*., 2024 [15]	Evaluate hybrid adolescent wellness program.	Implementation evaluation	Community centers, Vietnam	n = 300	90% satisfaction; improved adherence and psychosocial functioning.	Hybrid model feasible and acceptable in low-resource contexts.
Rajesh S *et al*., 2023 [33]	Assess outcomes of hybrid nurse clinics.	Mixed-methods	Urban hospitals, India	n = 210	Integrated clinics improved follow-up by 28%, depression scores by −3.1.	Dual-role nurses improved adolescent mental-physical health outcomes.
López F *et al*., 2020 [34]	Examine liaison nurses' role in adolescent wards.	Qualitative case study	Spain	25 participants	Nurses bridged communication between teams and improved trust.	Liaison nursing enhanced coordination and adolescent satisfaction.
Al-Khalid N *et al*., 2022 [35]	Examine perceptions of pediatric nurses toward integration.	Descriptive survey	Pediatric units, Qatar	n = 90	85% endorsed need for joint mental health training.	Staff readiness high; training crucial for success.
Mukherjee P *et al*., 2023 [36]	Evaluate training effects on hybrid nurses' skills.	Pre-post design	India	n = 220	Knowledge scores ↑ 40%; self-efficacy ↑ 33%.	Targeted training enhances nurse readiness for integrated roles.
Wong K *et al*., 2021 [37]	Assess youth resilience programs via integrated nursing.	Program evaluation	Hong Kong	n = 180	24% reduction in anxiety; improved peer relationships.	Nurse-led resilience programs are effective and scalable.
Mbatha L *et*	Explore challenges in	Qualitative	Rural clinics,	n = 14 nurses	Limited staff and stigma	Resource investment and

al., 2020 [38]	rural nurse-led adolescent care.		South Africa		impeded service integration.	destigmatization vital for rural programs.
Mehra A *et al*., 2022 [39]	Evaluate stepped-care nurse-led depression screening.	Pilot RCT	Community clinics, India	n = 180	Depression scores fell by 4.2 PHQ points vs control; engagement ↑ 60%.	Nurse-led screening feasible and clinically beneficial.
Oliveira M *et al*., 2024 [40]	Assess community hybrid clinics for adolescent well-being.	Observational	Brazil	n = 200	Combined physical + mental health approach improved QoL by 25%.	Integration improves outcomes and reduces fragmentation.

Discussion

The review confirms a paradigm shift from fragmented, illness-specific approaches toward holistic, person-centred nursing for adolescents. Integration acknowledges that physical and mental health are inseparable dimensions of well-being [52]. by embedding mental-health assessment within ordinary pediatric encounters, nurses normalize psychological inquiry and reduce stigma [53].

Impact on Access and Early Intervention

Integrated models consistently improved access. Adolescents especially males often avoid stand-alone mental-health clinics but willingly disclose emotional distress during general health visits [54]. Screening integration therefore functions as a gateway for early intervention, preventing escalation to crisis levels [55].

Nurses as the Nexus of Integration

Nurses' continuous contact, trust relationships, and holistic philosophy uniquely position them to operationalize integration [56]. Yet, institutional recognition remains insufficient. Integrative competencies communication, trauma-informed care, motivational interviewing must be embedded into core curricula and continuing education [57]. Hybrid certification pathways could formalize dual competence [58].

Systemic Barriers Require Structural Solutions

Barriers identified budgetary silos, policy fragmentation, documentation incompatibility reflect systemic inertia rather than professional resistance [59]. Integration must therefore be policy-driven, supported by shared funding streams and joint accountability metrics across departments [60].

The WHO's 2024 Global Mental Health Action Plan explicitly recommends co-located youth services; national nursing councils should align scope-of-practice frameworks accordingly [61].

Sustainability and Workforce Well-Being

Sustainability hinges on protecting nurse well-being [62]. Without workload adjustment, integration risks accelerating burnout [63]. Evidence shows that reflective supervision and peer-support groups mitigate compassion fatigue while enhancing clinical quality [64].

Cultural Adaptation and Equity

Integration cannot be one-size-fits-all. In collectivist cultures, family engagement is central; in others, confidentiality drives acceptability. Programs succeeding across diverse contexts employed participatory design with adolescents and communities from inception.

Equity also demands attention to marginalized youth LGBTQ+, migrant, and rural populations who face compounded barriers. Culturally adapted training and telehealth outreach can narrow these gaps.

Evidence Gaps and Research Priorities

Despite growing pilots, robust evidence remains limited. Only six RCTs were identified, most underpowered. Longitudinal impact beyond 12 months is rarely reported. Future research must:

1. Employ hybrid effectiveness-implementation designs;
2. Measure cost-effectiveness and scalability;
3. Use standardized adolescent outcome metrics (e.g., WHO-5, SDQ); and
4. Incorporate realist evaluation to capture context-mechanism interactions.

Technology-Enabled Integration

Digital innovations mobile screening, tele-supervision, e-referrals emerged as silent enablers. [72] Tele-liaison models during the COVID-19 era demonstrated sustained benefits, indicating scalability even in low-resource settings.

Policy and Practice Implications

Health ministries and nursing councils should play a pivotal role in strengthening integrated adolescent healthcare by taking concrete policy and structural actions. They should institutionalize integrated adolescent-health positions within standard staffing norms to ensure that hybrid or dual-role nurses trained in both pediatric and mental health care are formally recognized within the health workforce framework. In parallel, it is essential to develop blended training modules that combine competencies from child health nursing, mental health nursing, and adolescent psychology to enhance interdisciplinary capacity building. To promote sustainability and long-term impact, ministries must fund pilot-to-policy pipelines, enabling successful integrated models to transition from small-scale projects to national programs supported by stable resources. Additionally, integration indicators should be embedded within adolescent-health performance dashboards, allowing continuous monitoring of screening rates, referral coordination, psychosocial outcomes, and service accessibility. Together, these measures would institutionalize the integration of physical and mental health care in adolescent nursing, ensuring that the approach becomes a sustained and measurable component of national health systems.

Limitations of the Review

Heterogeneity precluded quantitative pooling; some references derive from descriptive reports rather than peer-reviewed trials. Publication bias likely inflated positive findings. Nevertheless, triangulation across multiple methodologies strengthens confidence in convergent trends. Integration is not merely co-location but a cultural

reorientation toward whole-person nursing. When adequately supported, integrated nurses act as anchors linking biological, psychological, and social care streams. As mental-health morbidity among adolescents rises globally, this synthesis provides both rationale and roadmap for systemic transformation.

Conclusion

Bridging child and mental health nursing transforms adolescent care from reactive treatment to proactive, holistic partnership. Integration enhances accessibility, reduces stigma, and aligns with global health mandates for person-centred systems. While evidence of clinical superiority is still emerging, the direction is clear: adolescent well-being flourishes when minds and bodies are cared for together.

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