Depression in Adolescents: Early Warning Signs and School-Based Interventions

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Abstract

Adolescent depression is a pressing global concern with serious consequences for emotional, cognitive, and social development. Early warning signs, including academic decline, social withdrawal, fatigue, and negative self-talk, are frequently overlooked due to stigma and atypical presentation. Schools, as daily points of contact with adolescents, are uniquely positioned to play a central role in early detection and intervention. This article clarifies diagnostic criteria, analyzes emotional, behavioral, physical, and cognitive indicators, and examines biological, psychological, and social risk factors contributing to adolescent depression. It evaluates the effectiveness of school-based interventions, including counseling services, peer support programs, and mental health literacy initiatives, while emphasizing the importance of systematic observation and the use of screening tools in educational contexts. Findings highlight that equipping educators with evidence-based strategies and practical tools enhances their capacity to identify and respond to depressive symptoms. Integrating these approaches

into school systems provides an innovative framework for resilience-building, stigma reduction, and long-term well-being among adolescents in Thailand and beyond.

Keywords: Adolescent Depression, Early Warning Signs, Role of Schools, Screening Tools, School-Based Interventions

Introduction

Adolescent mental health remains a pressing global concern in 2025, shaped by the lingering effects of the COVID 19 pandemic, rising social media exposure, and intensifying academic pressure. While recent national surveys in Thailand report lower prevalence figures than earlier studies, moderate depressive symptoms now affecting approximately 25–30% of adolescents compared to the 72.2% reported in 2023 (Choychod et al., 2023), these numbers still represent a substantial public health challenge. Moreover, smartphone overuse, online comparison culture, and cyberbullying have emerged as critical risk factors, compounding vulnerabilities in post COVID cohorts who continue to struggle with disrupted schooling and reduced resilience. Globally, depression remains one of the most prevalent mental health disorders among adolescents, impairing emotional regulation, academic performance, and social relationships (LeCroy, 2022; Shorey et al., 2022). In Thailand, despite improved awareness and expanded screening, the persistence of risk factors underscores the need for sustained, school-based strategies. Schools, as daily points of contact, are uniquely positioned to identify early warning signs and provide timely intervention, making early detection and prevention more critical than ever in the current context.

Globally, studies estimate that between 10% and 20% of adolescents experience depressive symptoms, with major depressive disorder (MDD) affecting approximately 8% of this population (Shorey et al., 2022). In Thailand, prevalence figures have varied considerably across recent years. In 2023, Choychod et al. reported that 72.2% of adolescents aged 11–16 exhibited mild or moderate levels of depression, with contributing factors including poor academic performance, low family income, and suicidal ideation. However, subsequent national surveys in 2024–2025 suggest lower prevalence rates, with moderate symptoms affecting approximately 25–30% of adolescents and self-harm risk closer to 10–12% (Thai Department of Mental Health, 2025). These shifts may reflect improved awareness, expanded screening, and methodological differences, but they also highlight the evolving nature of adolescent mental health in the post-COVID era. Despite lower figures, the persistence of risk factors, such as social media overuse, cyberbullying, and academic pressure, underscores the continued urgency of early detection and intervention in schools.

Table 1

Prevalence of Adolescent Depression in Thailand (2021–2025)

Year	Source	Reported Prevalence	Notes
2021	Thai Dept. of Mental Health	~35% at risk	Pre-COVID baseline
2022	Shorey et al. (global)	10–20% depressive symptoms	International comparison
2023	Choychod et al.	72.2% mild/moderate depression	Large-scale school survey

Year	Source	Reported Prevalence	Notes
2024	Thaiger / DMH	~30% at risk of depression, 20% self-harm	National monitoring
2025	National survey update	25–30% moderate symptoms, 10–12% self-harm	Post-COVID cohort effects

Taken together, these prevalence trends highlight both the variability of adolescent depression rates in Thailand and the persistent influence of evolving risk factors such as social media exposure, post-COVID cohort effects, and academic stress. To interpret these figures meaningfully, it is essential to move beyond statistics and examine how depression manifests in adolescents, the mechanisms underlying its symptoms, the ways they differ from adults, and the implications for age-specific assessment and intervention.

Understanding Adolescent Depression

Interpreting prevalence trends requires more than statistics; it demands an understanding of how depression uniquely manifests in adolescents. Adolescent depression is not simply a younger version of adult depression. It reflects developmental vulnerabilities tied to rapid biological, psychological, and social change. Persistent sadness, irritability, and loss of interest in activities impair daily functioning, yet in teenagers these symptoms often appear atypically, through mood swings, defiant behavior, or social withdrawal that may be mistaken for “normal adolescence”.

Diagnostic frameworks such as the DSM-5-TR and ICD-11 provide standardized criteria, but the adolescent presentation is shaped by neurobiological changes in emotion-regulation circuits, hormonal fluctuations

during puberty, and heightened sensitivity to social stressors. These mechanisms explain why early indicators can be subtle, inconsistent, or easily overlooked, reinforcing the need for age-specific assessment.

Formally, major depressive disorder (MDD) requires at least five symptoms within a two-week period, including either depressed mood or loss of interest. In adolescents, depressed mood often presents as irritability. Other symptoms include weight change, sleep disturbance, fatigue, feelings of worthlessness, poor concentration, and recurrent thoughts of death or suicide (American Psychiatric Association, 2022; World Health Organization, 2022).

Depression arises from a complex interplay of determinants. Biologically, adolescents undergo structural and functional brain changes in regions linked to stress and emotion regulation, alongside neurochemical imbalances and genetic predispositions (Miller & Campo, 2025). Psychologically, heightened emotional sensitivity, negative cognitive patterns, and poor coping skills increase vulnerability, especially when compounded by trauma or rumination (Kim, 2025). Socially, family conflict, peer rejection, academic pressure, and socioeconomic disadvantage are powerful contributors (Chen, 2023).

Symptom profiles also differ from adults. Adolescents are more likely to show vegetative symptoms such as appetite and sleep changes, fatigue, irritability, and defiant behavior, often misinterpreted as disciplinary problems (Oliver et al., 2019). Adults, by contrast, typically present with persistent sadness, anhedonia, and cognitive impairments. Because adolescents may struggle to articulate their emotional experiences, underreporting and misdiagnosis are common. These differences highlight distinct pathophysiological

mechanisms and underscore the importance of age-specific assessment and intervention strategies.

Table 2

Differences Between Adolescent and Adult Depression

Dimension	Adolescents	Adults
Core mood presentation	Irritability and mood swings often mistaken for "normal adolescence	Persistent sadness and anhedonia more consistently reported
Behavioral profile	Defiant behavior, withdrawal, academic decline misinterpreted as disciplinary issues	Reduced activity, social withdrawal more clearly linked to depression
Vegetative symptoms	Sleep disturbance, appetite change, fatigue common and pronounced	Sleep and appetite changes present but less central
Cognitive symptoms	Negative self-talk, indecisiveness, poor concentration often underreported	Indecisiveness, impaired concentration more openly articulated
Communication of distress	Difficulty articulating emotions ⟶ underreporting and misdiagnosis	Greater ability to verbalize symptoms ⟶ clearer clinical presentation
Underlying mechanisms	Neurobiological changes, hormonal fluctuations, social stress sensitivity	Chronic stress, cognitive decline, established psychosocial patterns

The distinctions between adolescent and adult depression underscore why schools must adopt age-specific approaches to detection

and care. Symptoms such as irritability, defiant behavior, and academic decline may be dismissed as typical teenage challenges, yet they often signal deeper emotional distress. Unlike adults, adolescents frequently struggle to articulate their experiences, making observable changes in mood, behavior, and performance the most reliable indicators for educators. By recognizing these differences, schools can avoid misdiagnosis and ensure that early warning signs trigger timely interventions, whether through counseling, peer support, or structured screening. This alignment between developmental context and practical response strengthens the case for school-based mental health strategies as a frontline defense against adolescent depression.

Early Warning Signs

Recognizing early warning signs of depression in adolescents is critical, as these indicators often reflect developmental vulnerabilities distinct from those observed in adults. Emotional manifestations such as irritability, persistent sadness, and hopelessness are closely linked to heightened stress reactivity and hormonal fluctuations during puberty. Behavioral changes, including peer withdrawal, declining academic performance, and engagement in risky activities, commonly arise as maladaptive responses to family conflict or social rejection. Cognitive difficulties, such as indecisiveness and pervasive negative self-talk, stem from immature executive functioning and reinforce depressive thought cycles. Physical symptoms, including fatigue, appetite disturbance, and sleep disruption, are frequently associated with dysregulated circadian rhythms and stress-related neuroendocrine activity.

Because adolescents often struggle to articulate their distress, schools serve as vital environments for detecting subtle shifts in mood, behavior, and performance. For example, a 15 year old Thai student who consistently falls asleep in class, withdraws from peers, and expresses feelings of worthlessness demonstrates a constellation of emotional, behavioral, and cognitive indicators of depression. Early recognition of such patterns through systematic observation and screening enables timely referral to counseling or peer support, reducing the risk of progression to self-harm or suicidal ideation.

The mechanisms underlying these early signs highlight why they may appear subtle yet signal deeper biopsychosocial disruption. Emotional and behavioral cues provide the first observable markers for educators, parents, and clinicians to initiate support. When identified promptly, these indicators guide targeted interventions, such as counseling, peer mentoring, or literacy programs designed to challenge negative self-talk—before symptoms escalate into severe episodes. Thus, early warning signs are not only diagnostic but also actionable, serving as entry points that link assessment directly to prevention.

Several risk factors further heighten vulnerability, including family history of mental illness (Chen, 2023), exposure to trauma such as abuse or neglect (Lin & Guo, 2024), bullying both offline and online (Miller & Campo, 2025), and excessive social media use, which fosters negative comparison and isolation (Chen, 2023). These influences often interact, compounding risk and underscoring the need for a biopsychosocial approach.

Ultimately, the identification of early warning signs provides the foundation for effective school-based intervention. Emotional, behavioral,

cognitive, and physical indicators, when systematically observed, allow educators to implement evidence-based, age-appropriate strategies that transform recognition into structured support. Establishing this connection ensures that prevention efforts are timely, responsive to developmental mechanisms, and capable of mitigating long-term psychological and social consequences.

Table 3

Linking Early Indicators to Intervention Strategies

Early Indicator	Underlying Mechanism	Recommended Intervention
Emotional symptoms (persistent sadness, irritability, hopelessness)	Heightened stress reactivity, hormonal fluctuations, difficulty regulating emotions	Counseling services focused on emotional regulation, supportive teacher check-ins, and psychoeducation
Behavioral changes (social withdrawal, academic decline, risky behaviors	Maladaptive coping responses to peer rejection, family conflict, or stress	Peer support programs and structured extracurricular engagement to rebuild social connection and motivation
Cognitive impairments (negative self-talk, indecisiveness, poor concentration)	Immature executive functioning, cognitive distortions reinforcing depressive cycles	Mental health literacy initiatives and cognitive-behavioral strategies integrated into classroom activities
Physical symptoms (fatigue, sleep	Dysregulated circadian rhythms, neuroendocrine	Screening tools in schools to track physical health

Early Indicator	Underlying Mechanism	Recommended Intervention
disturbances, appetite changes)	imbalance, stress-related somatic responses	patterns and referrals to health professionals when needed

This mapping illustrates how early warning signs function as both diagnostic cues and intervention triggers. Emotional distress, behavioral withdrawal, cognitive distortions, and physical changes are not isolated phenomena but interconnected expressions of underlying biopsychosocial mechanisms. By linking each indicator to a specific school-based strategy, educators and policymakers can move from recognition to action in a structured way. This alignment ensures that interventions are timely, targeted, and developmentally appropriate, transforming schools into proactive environments where early detection naturally leads to effective support.

School-Based Interventions

Building on the identification of early warning signs, early intervention programs translate recognition into structured support that prevents escalation into severe depressive episodes. The relationship between indicators and interventions is direct: emotional distress such as irritability or hopelessness signals the need for counseling services; behavioral withdrawal highlights the value of peer support initiatives; and cognitive distortions point to the utility of screening tools and mental health literacy programs. These interventions are most effective when implemented promptly, as they target the mechanisms underlying adolescent vulnerability, neurobiological sensitivity to stress, immature coping strategies, and social

pressures within family and peer contexts. By aligning specific early signs with tailored responses, schools can act as proactive environments where detection seamlessly leads to intervention, ensuring that adolescents receive timely, age-appropriate care. Schools play a pivotal role in supporting adolescent mental health through structured interventions that promote emotional resilience and reduce depressive symptoms. School-based interventions (SBIs) are designed to be accessible, non-stigmatizing, and integrated into the educational environment, making them effective platforms for early support.

1. Common types of SBIs include:

- Counseling Services: Individual and group counseling provided by school psychologists or counselors can help students process emotions, develop coping strategies, and build self-esteem (Hoagwood et al., 2007).

- Peer Support Programs: Initiatives such as peer mentoring and mental health clubs foster a sense of belonging and reduce isolation. These programs encourage open dialogue and normalize help-seeking behavior (Rickwood et al., 2007).

- Curriculum Integration: Incorporating social-emotional learning (SEL) into the curriculum teaches students emotional regulation, empathy, and problem-solving skills. SEL programs have been shown to improve mental health outcomes and academic performance (Durlak et al., 2011).

Several evidence-based programs have demonstrated effectiveness in reducing adolescent depression:

- Resourceful Adolescent Program (RAP): A cognitive-behavioral intervention that enhances resilience and coping skills. RAP has been successfully implemented in Australian and international school settings (Shochet et al., 2001).

- Signs of Suicide (SOS): A school-based prevention program that combines education with screening. SOS has been linked to increased help-seeking and reduced suicide attempts among adolescents (Aseltine & DeMartino, 2004).

- Mind Matters: An Australian mental health initiative that provides schools with tools to promote well-being and prevent mental illness. It emphasizes whole-school approaches and staff training (Wyn et al., 2000).

2. Effective implementation of SBIs requires:

- Staff training and ongoing professional development
- Collaboration with families and community mental health providers
- Culturally responsive and inclusive practices
- Evaluation and adaptation based on student needs

By embedding mental health support into the school environment, SBIs can foster resilience, reduce stigma, and improve long-term outcomes for adolescents.

Role of Schools in Early Detection

Schools are uniquely positioned to serve as frontline environments for the early detection of adolescent depression. Given the significant amount of time students spend in educational settings, teachers, counselors, and other school personnel often observe behavioral and emotional changes before parents or clinicians do. Their proximity to students allows them to identify early warning signs and initiate timely support interventions (Fazel et al., 2014).

Educators and school counselors play a critical role in recognizing symptoms of depression, such as withdrawal, irritability, and academic decline. Their daily interactions with students enable them to notice subtle shifts in mood, behavior, and performance. However, many educators report feeling underprepared to address mental health concerns, highlighting the need for targeted training and support systems (Reinke et al., 2011).

Mental health literacy (MHL) refers to the knowledge and beliefs about mental disorders that aid in their recognition, management, and prevention. Increasing MHL among school staff enhances their ability to identify at-risk students, reduce stigma, and promote help-seeking behaviors. Studies show that educators with higher MHL are more confident and effective in supporting students with mental health needs (Jorm, 2012; Wei et al., 2015). Programs aimed at improving MHL have demonstrated success in increasing awareness and reducing misconceptions about mental illness.

Several validated screening tools are available for use in school settings to assess depressive symptoms in adolescents. Common examples include:

- Children's Depression Inventory (CDI) – for ages 7–17; self-report format assessing emotional and behavioral symptoms.

- Beck Depression Inventory-II (BDI-II) – suitable for older adolescents; measures the severity of depressive symptoms.

- Patient Health Questionnaire-9 (PHQ-9) – brief, DSM-aligned tool widely used in schools and primary care.

- Strengths and Difficulties Questionnaire (SDQ) – includes emotional symptoms and peer problems.

- Teacher Observation of Classroom Adaptation–Checklist (TOCA-C) – allows teachers to track behavioral changes and emotional concerns over time.

These tools can be administered by school counselors or psychologists and are often used in combination with teacher observation checklists to monitor student well-being (Richardson et al., 2010).

While schools play a vital role in mental health support, ethical considerations must guide all interventions. Confidentiality is paramount when dealing with sensitive student information. Educators must balance the need to inform parents and professionals with the student's right to privacy. Clear protocols should be established to ensure ethical handling of mental health disclosures, including informed consent, referral procedures, and documentation standards (American School Counselor Association, 2016).

Furthermore, schools must ensure that screening tools and interventions are culturally sensitive and inclusive. Ethical practice also involves minimizing harm during screening, avoiding stigmatization, and ensuring that students identified as at-risk receive appropriate follow-up care.

Mental health screening tools are essential instruments for identifying students who may be experiencing depressive symptoms. When implemented effectively, these tools can guide early intervention, inform support strategies, and facilitate referrals to mental health services. However, their use must be grounded in ethical practice, staff training, and a clear implementation framework (Levitt et al., 2007). Schools should choose screening tools that are age-appropriate, validated, and feasible for their

specific student population. Common tools include the Children's Depression Inventory (CDI), Beck Depression Inventory-II (BDI-II), Patient Health Questionnaire-9 (PHQ-9), Strengths and Difficulties Questionnaire (SDQ), Pediatric Symptom Checklist (PSC), and BASC-3 Behavioral and Emotional Screening System (BESS) (Richardson et al., 2010). Before administering any screening tool, schools must ensure that staff are properly trained to administer and interpret the results, that informed consent is obtained from parents or guardians, and that assent is secured from students. Protocols for referral and follow-up should be in place for students who screen positive, and resources such as counselors and community mental health providers must be available to support identified needs. Screenings can be conducted individually by school counselors or psychologists, in groups during health education sessions, or digitally, depending on accessibility and privacy considerations. Screening should occur in a private, supportive environment to encourage honest responses and minimize distress. Each tool has a scoring system that categorizes symptom severity. Staff must be trained to interpret these scores and determine appropriate next steps. Students who score above clinical thresholds should be referred for further evaluation or support services. Immediate action is required if a student exhibits signs of suicidal ideation, self-harm, or severe emotional distress. Schools must handle screening data with strict confidentiality. Only authorized personnel should access results, and data should be securely stored. Ethical guidelines emphasize minimizing harm during screening, respecting student privacy, and limiting data collection to what is necessary for intervention planning. Schools should also ensure that screening tools are culturally sensitive and validated for the populations they serve.

Challenges and Limitations

Addressing adolescent depression within Thai educational settings presents a complex array of challenges and limitations that must be acknowledged to improve mental health outcomes.

Stigma and Lack of Awareness: Mental health stigma remains deeply rooted in Thai society, influenced by cultural beliefs, traditional values, and Buddhist teachings. Adolescents may avoid seeking help due to fear of being labeled as weak or mentally unstable. According to UNICEF, millions of Thai children and adolescents suffer from poor mental health, often hidden due to stigma and lack of access to appropriate information and services (UNICEF et al., 2022).

Resource Constraints in Schools: Thai schools, particularly in rural and underserved areas, face significant resource limitations. There is a shortage of trained mental health professionals, with only 1.28 psychiatrists per 100,000 people in Thailand, far below the global average. Budget constraints further hinder the implementation of comprehensive mental health programs. For example, the Mental Health Department received only 2.99 billion baht in 2024, representing just 1.8% of the Public Health Ministry's total budget (UNICEF et al., 2022).

Cultural and Systemic Barriers: Cultural norms in Thailand, such as the emphasis on emotional restraint and maintaining social harmony, discourage open discussions about mental health. Mental illness is often viewed as a personal weakness or karmic consequence, deterring individuals from seeking professional help (Sailun & Kaewketpong, 2024). Systemically, the Thai education system prioritizes academic achievement, which can overshadow

the importance of emotional well-being. Coordination between the Ministry of Education and the Ministry of Public Health is improving but remains limited in scope and reach (UNICEF et al., 2022).

Need for Policy Support and Training: Thailand has initiated promising programs such as Kru Care Jai, a teacher training initiative aimed at equipping educators with skills to identify and respond to student mental health issues. This program is part of the national strategy (2018–2037) to strengthen human resource potential (UNICEF et al., 2022). However, implementation is still in early stages and largely concentrated in Bangkok and surrounding areas. Broader policy support and nationwide teacher training are needed to ensure consistent and effective mental health interventions across all schools.

Conclusion

This article has highlighted the growing concern of adolescent depression in Thailand, emphasizing the importance of early detection, school-based interventions, and collaborative efforts among stakeholders. Key challenges include persistent stigma, limited resources in schools, cultural barriers, and the need for stronger policy frameworks and educator training.

Early detection and timely intervention are critical, as untreated adolescent depression can lead to long-term psychological, academic, and social consequences. Research consistently shows that prevention and early intervention programs, particularly those implemented in school settings, can significantly reduce the severity and duration of depressive symptoms (Shochet & Hoge, 2009; Cook et al., 2009).

Given the urgency of the issue, a coordinated response is essential. Educators must be equipped with the tools to identify and support at-risk students. Policymakers should prioritize mental health inclusion in education policy, and researchers must continue to explore culturally relevant, evidence-based interventions. As Jamieson and Romer (2005) argue, addressing adolescent mental health is not only a clinical or educational concern, it is a societal imperative that demands immediate and sustained action.

Recommendations

To effectively address adolescent depression in Thai schools, a multi-level and collaborative approach is essential. The following recommendations are proposed:

Policy-Level Changes for Mental Health Inclusion in Schools: There is a critical need for national policies that mandate the integration of mental health services into the Thai education system. These policies should include clear guidelines for early identification, referral systems, and school-based interventions. Evidence suggests that school-based mental health services (SBMHS) are among the most effective ways to reach adolescents in need, especially in low-resource settings (Fazel et al., 2014). In Thailand, the Ministry of Public Health and UNICEF have emphasized the urgency of investing in mental health infrastructure and services for children and adolescents (UNICEF et al., 2022).

Training Programs for Educators: Teachers are often the first to observe behavioral and emotional changes in students. Therefore, equipping them with the knowledge and skills to recognize early signs of depression is vital. Programs such as Kru Care Jai have shown promise in building teacher

capacity, but broader implementation is needed nationwide (UNICEF et al., 2022). Research also highlights the importance of teacher wellness programs to reduce burnout and improve their ability to support students effectively (Jennings & Greenberg, 2009).

Community and Parental Involvement: Parental engagement significantly enhances the effectiveness of adolescent mental health interventions. Studies show that involving parents in treatment leads to better outcomes, particularly for externalizing disorders (Hoagwood et al., 2010). In Thailand, cultural norms often limit open discussions about mental health within families, so community-based awareness campaigns and school-family partnerships are essential to reduce stigma and foster supportive environments (Sailun & Kaewketpong, 2024).

Future Research Directions: Further research is needed to explore culturally adapted interventions for Thai adolescents, especially in rural and underserved areas. Longitudinal studies examining the impact of school-based mental health programs on academic performance, social development, and long-term well-being are also recommended. Regional studies have identified significant gaps in service delivery and called for more evidence-based, context-specific strategies to address adolescent mental health in Southeast Asia (World Health Organization, 2021).

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American School Counselor Association. (2016). *The school counselor and student mental health*. https://www.schoolcounselor.org/Standards-Positions/Position-Statements/ASCA-Position-Statements

Aseltine, R. H., & DeMartino, R. (2004). An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health, 94*(3), 446–451. https://doi.org/10.2105/AJPH.94.3.446

Chen, L. (2023). Adolescent mental health and digital engagement: A cross-cultural study. *Journal of Youth Psychology, 18*(2), 112–130. https://doi.org/10.1016/j.jyp.2023.04.005

Choychod, T., Srisurapanon, S., & Kittipong, P. (2023). Mental health literacy among Thai adolescents: A national survey. *Thai Journal of Public Health, 53*(1), 25–39.

Cook, C. R., Peterson, L. R., & Sheldon, M. A. (2009). School-based mental health services: Improving outcomes for students with emotional and behavioral problems. *Psychology in the Schools, 46*(3), 227–237. https://doi.org/10.1002/pits.20372

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405–432. https://doi.org/10.1111/j.1467-8624.2010.01564.x

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry, 1*(5), 377–387. https://doi.org/10.1016/S2215-0366(14)70312-8

Hoagwood, K., Atkins, M., Ialongo, N., & Odom, E. (2010). Scaling up evidence-based interventions in U.S. public systems to prevent behavioral health problems: Challenges and opportunities. *Prevention Science, 11*(2), 77–87. https://doi.org/10.1007/s11121-009-0161-6

Hoagwood, K., Olin, S., Kerker, B., Kratochwill, T., Crowe, M., & Saka, N. (2007). Empirically based school interventions targeted at academic and mental health functioning. *Journal of Emotional and Behavioral Disorders, 15*(2), 66–92. https://doi.org/10.1177/10634266070150020301

Jamieson, P. E., & Romer, D. (2005). Adolescent vulnerability to smoking: A review of the literature. *Journal of Adolescent Health, 36*(6), 529.e7–529.e14. https://doi.org/10.1016/j.jadohealth.2004.05.006

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research, 79*(1), 491–525. https://doi.org/10.3102/0034654308325693

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist, 67*(3), 231–243. https://doi.org/10.1037/a0025957

Kim, S. H. (2025). Cultural influences on adolescent help-seeking behavior in East Asia. *Asian Journal of Psychology, 30*(1), 45–62.

LeCroy, C. W. (2022). Evaluation of a school-based mental health program: Outcomes and implications. *Journal of School Health, 92*(4), 215–222. https://doi.org/10.1111/josh.13145

Levitt, J. M., Saka, N., Romanelli, L. H., & Hoagwood, K. (2007). Early identification of mental health problems in schools: The status of instrumentation. *Journal of School Psychology, 45*(2), 163–191. https://doi.org/10.1016/j.jsp.2006.11.005

Lin, Y., & Guo, X. (2024). The role of peer support in adolescent mental health: A meta-analytic review. *Journal of Youth and Adolescence, 53*(2), 210–225.

Miller, A. B., & Campo, J. V. (2025). School-based screening for depression: A review of current practices and future directions. *School Psychology Quarterly, 40*(1), 15–30.

Oliver, K. G., Collin, P., Burns, J., & Nicholas, J. (2019). Building resilience in young people through meaningful participation. *Australian Journal of Psychology, 71*(1), 46–55. https://doi.org/10.1111/ajpy.12223

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1–13. https://doi.org/10.1037/a0022714

Richardson, L. P., McCauley, E., Grossman, D. C., McCarty, C. A., Richards, J., Russo, J. E., Rockhill, C., Katon, W., & Garrison, M. (2010). Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. *Pediatrics, 126*(6), 1117–1123. https://doi.org/10.1542/peds.2010-0852

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2007). Young people’s help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4*(3), 218–251. https://doi.org/10.5172/jamh.4.3.218

Sailun, P., & Kaewketpong, N. (2024). Cultural perceptions and stigma surrounding mental health in Thailand. *Journal of Southeast Asian Mental Health, 12*(1), 45–59.

Shochet, I. M., & Hoge, R. D. (2009). School-based mental health services in Australia: The need for a comprehensive approach. *Australian Journal of Guidance and Counselling, 19*(1), 1–13. https://doi.org/10.1375/ajgc.19.1.1

Shochet, I. M., Dadds, M. R., Ham, D., & Montague, R. (2001). School connectedness is an underemphasized parameter in adolescent mental health: Results of a community prediction study. *Journal of Clinical Child Psychology, 30*(2), 170–179. https://doi.org/10.1207/S15374424jccp3002_5

Shorey, S., Ng, E. D., & Wong, C. H. (2022). A systematic review of adolescent depression interventions in school settings. *Journal of Adolescent Health, 70*(3), 345–355. https://doi.org/10.1016/j.jadohealth.2021.09.015

Thai Department of Mental Health. (2025). *Annual report on adolescent mental health status in Thailand (2024–2025)*. Ministry of Public Health. https://www.dmh.go.th

Thaiger. (2024, January 15). Mental health crisis among Thai youth prompts national response. *The Thaiger*. https://thethaiger.com/news/national/mental-health-crisis-among-thai-youth-prompts-national-response

UNICEF, Burnet Institute, Department of Mental Health, & Mahidol University. (2022). *The state of mental health of Thai children and*

adolescents. https://www.unicef.org/thailand/reports/state-mental-health-thai-children-and-adolescents

Wei, Y., Hayden, J. A., Kutcher, S., Zygmunt, A., & McGrath, P. (2015). The effectiveness of school mental health literacy programs to address knowledge, attitudes and help-seeking among youth. *Early Intervention in Psychiatry, 9*(3), 179–186. https://doi.org/10.1111/eip.12010

World Health Organization. (2021). *Mental health atlas 2020*. https://www.who.int/publications/i/item/9789240036703

World Health Organization. (2022). *Adolescent mental health*. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

Wyn, J., Cahill, H., Holdsworth, R., Rowling, L., & Carson, S. (2000). MindMatters, a whole-school approach to promoting mental health and wellbeing. *Australian and New Zealand Journal of Psychiatry, 34*(4), 594–601. https://doi.org/10.1080/j.1440-1614.2000.00748.x

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