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School-Based Early Detection, Mental Health Education, and Youth Mental Health Cadre Orientation for Adolescents

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ABSTRACT

Adolescent mental health problems require early identification and school-based follow-up. This community service program aimed to map self-reported symptoms of depression, anxiety, and stress and to deliver mental health education and Youth Mental Health Cadre orientation at SMK N 1 Lembah Gumanti. On May 28, 2025, 225 eleventh-grade students completed the Indonesian Depression Anxiety Stress Scales for Youth (IDASS-Y) and participated in face-to-face education, coping-skill demonstrations, and peer-support orientation. Screening data were analyzed descriptively. Symptoms above the normal category were identified for anxiety in 90 students (40.0%), depression in 56 (24.9%), and stress in 51 (22.7%). Moderate-to-extremely-severe categories were recorded in 54 students (24.0%) for anxiety, 34 (15.1%) for depression, and 28 (12.4%) for stress. The program delivered education and clarified cadres' roles as peer educators and referral connectors. However, no pre-post assessment measured changes in literacy, stigma, behavior, or cadre competence. The findings support confidential follow-up for students with elevated scores, supervised peer support, and a formal referral pathway linking the school with primary care and mental health professionals. Future programs should include pre-post and follow-up evaluation.

Keywords: adolescent mental health, early detection, IDASS-Y, mental health literacy, peer support, school-based program

INTRODUCTION

Adolescent mental health is a major public health concern because emotional difficulties arising during this developmental period can affect education, relationships, and long-term well-being. The Indonesia-National Adolescent Mental Health Survey (I-NAMHS) reported that 34.9% of Indonesian adolescents aged 10–17 years experienced a mental health problem in the preceding 12 months and 5.5% met criteria for a mental disorder. Anxiety disorders were the most prevalent diagnosed condition (3.7%), followed by major depressive disorder (1.0%) (Center for Reproductive Health et al., 2022). These nationally representative findings provide a more appropriate basis for school-based adolescent mental health programs than general adult prevalence data.

Adolescence involves rapid physical, cognitive, emotional, and social development. Academic pressure, family expectations, peer conflict, social comparison, and uncertainty about future education or employment may increase psychological distress when coping resources and supportive relationships are limited (World Health Organization [WHO], 2024; UNICEF Indonesia, 2025). In schools, depression, anxiety, and stress may be reflected in reduced concentration, absenteeism, declining participation, interpersonal difficulties, and impaired academic functioning (Andrews et al., 2020).

SMK N 1 Lembah Gumanti, Alahan Panjang, Solok, identified four service gaps: the absence of structured data on students' mental health, limited student mental health literacy, the absence of Youth Mental Health Cadres, and the lack of an integrated preventive and referral mechanism. These gaps justified a program combining screening, education, peer support orientation, and follow-up planning.

Schools are strategic settings for early identification because most adolescents spend a substantial part of their day in school and school personnel are often among the first adults able to observe changes in behavior and functioning. Indonesian adolescent health guidance also encourages integrated school-based programs that involve students, educators, families, and health services and that combine mental health literacy, screening, peer education, and referral (UNICEF Indonesia, 2025).

The Youth Mental Health Cadre component was adapted from community mental health promotion principles that emphasize participation, early detection, education, supportive communication, and referral (Keliat et al., 2011). Within the school setting, cadres were defined as peer educators and initial connectors rather than counselors. This role boundary is essential because clinical assessment, diagnosis, and therapy must remain the responsibility of qualified professionals. Previous school-based community service using IDASS-Y also demonstrated the feasibility of combining adolescent education with early mental health screening (Wenny et al., 2023).

Accordingly, the program consisted of: (1) early screening using IDASS-Y; (2) education on adolescent mental health, warning signs, help-seeking, and stigma; (3) introduction and orientation of Youth Mental Health Cadres; (4) practice of simple coping techniques, including deep breathing and progressive muscle relaxation; and (5) recommendations for confidential follow-up and referral of students requiring further assessment.

This community service program aimed to: (1) describe the distribution of depression, anxiety, and stress symptoms among participating students; (2) deliver school-based mental health education and coping-skill demonstrations; and (3) orient selected students to the Youth Mental Health Cadre role and its referral boundaries. The article reports implementation outputs and baseline screening findings; it does not evaluate intervention effectiveness because no pre-post, follow-up, or comparison-group measurements were conducted.

METHOD

Program Design and Participants

This single-day community service program was implemented at SMK N 1 Lembah Gumanti, Alahan Panjang, Solok, on May 28, 2025. The school coordinated the participation of 225 Grade XI students. The analysis included students who attended the activity and completed the IDASS-Y screening; no probability sampling, control group, or comparison group was used. Activities were delivered face to face by the community service team from the Faculty of Nursing, Universitas Andalas, in coordination with the principal, teachers, and school representatives.

Implementation Sequence

The program followed six stages: partner coordination and preparation; participant briefing and confidentiality explanation; IDASS-Y screening; mental health education and coping-skill demonstration; Youth Mental Health Cadre orientation; and descriptive analysis, feedback, and referral planning (Figure 1). The intervention was completed within the one-day program. The duration in minutes of each component was not separately recorded in the activity documentation; future implementation should document component duration to improve reproducibility.

School-Based Community Service Program Flow

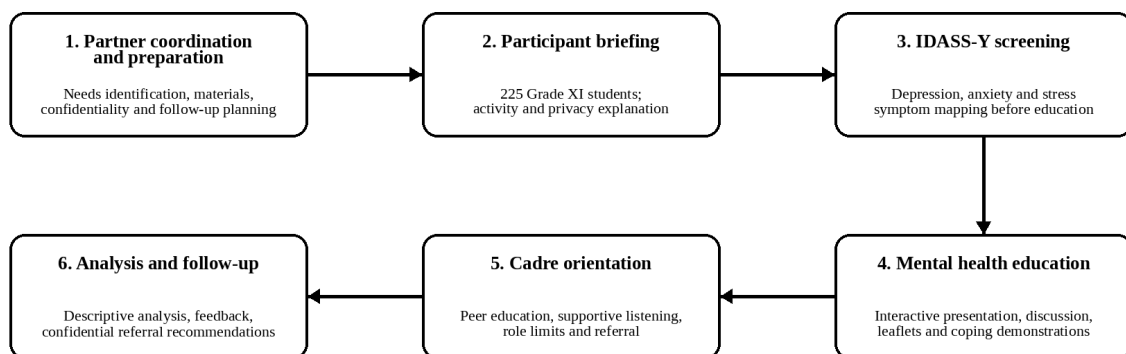


Figure 1. Flow of the school-based community service program

Screening Instrument and Administration

The Indonesian Depression Anxiety Stress Scales for Youth (IDASS-Y) is a 21-item self-report instrument comprising seven depression items, seven anxiety items, and seven stress items. Each item is rated from 0 to 3, and item scores are summed within each domain; higher scores indicate greater symptom severity. The original DASS-Y was developed specifically for children and adolescents (Szabó & Lovibond, 2022). Psychometric evaluation of the Indonesian version supported its three-factor structure and demonstrated high content validity ($S-CVI/Ave = 0.95$). Cronbach's alpha coefficients were 0.897 for depression, 0.893 for anxiety, 0.884 for stress, and 0.948 overall; McDonald's omega coefficients were 0.897, 0.894, 0.874, and 0.949, respectively (Sarfika et al., 2024). The screening was administered before the educational session using standardized instructions and confidential handling of responses. Severity categories were assigned using the validated IDASS-Y scoring guidance. The instrument was used to identify symptom levels and support needs, not to establish a clinical diagnosis.

Educational Intervention

After screening, all 225 participants received a face-to-face educational session facilitated by the community service team in coordination with school personnel. Teaching strategies included an interactive presentation, guided discussion, question-and-answer activities, leaflets and flyers, demonstrations, and guided practice. Content covered adolescent mental health, early warning signs, stigma, help-seeking, referral options, and simple coping strategies, including deep breathing, progressive muscle relaxation, five-finger hypnosis, and spiritual coping. These activities constituted information delivery and initial skill exposure; they were not evaluated with a pre-post knowledge, stigma, behavior, or coping-skill measure.

Youth Mental Health Cadre Orientation

Selected students were oriented to act as peer educators and initial connectors to adult and professional support. Selection considered participation, interest in mental health issues, communication potential, and school recommendations. Orientation covered accurate information sharing, empathetic and non-judgmental listening, confidentiality, encouragement of help-seeking, recognition of role limits, and referral to teachers, school counselors, or health professionals. Mentoring reinforced these boundaries. Cadres were not authorized to diagnose, provide therapy, promise absolute secrecy in high-risk situations, or independently manage severe symptoms. The activity record did not separately document the number of oriented cadres, and no standardized competency assessment was conducted; therefore, cadre orientation is reported as an implementation output rather than evidence of effectiveness.

Evaluation and Data Analysis

Evaluation focused on implementation reach and baseline screening results. IDASS-Y data were summarized using frequencies, percentages, means, minimum and maximum values, and standard deviations. Student participation was observed, and oral feedback from students and school partners was used to assess the clarity, relevance, and acceptability of the activities. Because no pre-post test, follow-up test, comparison group, standardized literacy measure, stigma scale, behavior measure, or cadre competency rubric was used, changes in awareness, literacy, stigma, behavior, or cadre skill cannot be inferred.

Ethical Safeguards and Referral

Students' identities and individual screening results were protected from public disclosure and labeling. Screening results were used to identify support needs, not to diagnose disorders. Students in moderate, severe, or extremely severe categories were recommended for confidential follow-up by school counselors, designated teachers, parents or caregivers where appropriate, and qualified health professionals. Any indication of immediate safety risk required urgent escalation through the school's safeguarding and referral procedures.

RESULTS AND DISCUSSION

Respondent Characteristics

This community service program involved 225 eleventh-grade students at SMK N 1 Lembah Gumanti. Based on gender, most participants were female, accounting for 157 students (69.8%), while 68 students (30.2%) were male. All participants were from grade XI.

The distribution of participants across study programs was relatively balanced. A total of 62 students (27.6%) were from Office Management and Business Services, 61 students (27.1%) from Fashion Design, 52 students (23.1%) from Hospitality, and 50 students (22.2%) from Culinary Arts. This distribution indicates that the program reached students from different vocational backgrounds, allowing the screening results to provide an initial overview of adolescent mental health conditions in the school setting.

Table 1. Frequency distribution of respondent characteristics at SMK N 1 Lembah Gumanti

Respondent Characteristics	Frequency	Percentage (%)
Sex		
Male	68	30.2

Respondent Characteristics	Frequency	Percentage (%)
Female	157	69.8
Grade		
XI	225	100
Major		
Office Management and Business Services	62	27.6
Culinary Arts	50	22.2
Hospitality	52	23.1
Fashion Design	61	27.1

The involvement of students from different study programs is important because mental health promotion in schools should not be limited to certain academic groups. Adolescents across vocational programs may experience similar developmental and psychological challenges, although the sources of stress may vary depending on academic workload, social environment, family expectations, peer relationships, and future career concerns. The relatively balanced distribution of participants also supports the relevance of school-wide mental health promotion, rather than interventions targeted only at selected classes or majors.

Implementation of the School-Based Mental Health Program

On May 28, 2025, the program followed the six stages presented in Figure 1. Screening and education reached 225 Grade XI students. Figure 2 documents coordination between the community service team and school partner, while Figure 3 documents the face-to-face mental health education session.



Figure 2. Community service team and school partners at SMK N 1 Lembah Gumanti

IDASS-Y was administered before the educational activity to obtain baseline symptom data. The results were used to map depression, anxiety, and stress categories and to identify students who might require confidential follow-up. They were not used as clinical diagnoses or as evidence of educational effectiveness.

All participants then received education on adolescent mental health, common warning signs, stigma, help-seeking, and referral. The interactive presentation was supported by discussion, question-and-answer activities, flyers, leaflets, and practical demonstrations.



Figure 3. Delivery of adolescent mental health education as part of the school-based mental health education program

The coping demonstrations included deep breathing, progressive muscle relaxation, five-finger hypnosis, and spiritual coping. These techniques were presented as introductory self-management strategies and not as substitutes for professional assessment or treatment. No standardized skill assessment was conducted after the demonstrations.

Selected students received Youth Mental Health Cadre orientation on peer education, supportive listening, confidentiality, role limits, and referral. The documented output was the delivery of orientation and mentoring; cadre competence, peer-level outcomes, and changes in help-seeking behavior were not measured.

Documented Program Outputs and Evaluation Boundaries

The program documented reach and activity delivery rather than measured changes in knowledge, attitudes, behavior, or cadre competence. Table 2 distinguishes the outputs that were recorded from outcomes that were not evaluated.

Table 2. Documented program outputs and evaluation status

Program component	Documented output	Evaluation status
Mental health screening	225 Grade XI students completed IDASS-Y	Descriptive symptom scores and categories
Mental health education	225 students received education and coping demonstrations	Participation observation and oral feedback; no pre-post measure
Youth Mental Health Cadre orientation	Selected students received role and referral orientation	No cadre count or standardized competency assessment documented
Referral planning	Students with elevated categories were recommended for confidential follow-up	Referral completion and longer-term outcomes were not tracked

Descriptive Results of Depression, Anxiety, and Stress Scores

The descriptive analysis showed the highest mean score in the anxiety domain. Depression scores ranged from 0 to 17 (mean 1.476; SD 0.955), anxiety scores from 0 to 16

(mean 1.720; SD 1.025), and stress scores from 0 to 19 (mean 1.396; SD 0.839). The ranges indicate heterogeneity in reported symptoms; they should be interpreted as screening results rather than clinical diagnoses.

Table 3. Mean scores of depressions, anxiety, and stress among adolescents at SMK N 1 Lembah Gumanti

Variable	Mean	Min–Max	Std. Deviation
Depression	1.476	0–17	0.955
Anxiety	1.720	0–16	1.025
Stress	1.396	0–19	0.839

Although group means were relatively low, the broad score ranges show that a subgroup of students reported substantially higher symptoms. This finding supports confidential individual follow-up rather than reliance on classroom observation or average scores alone (Andrews et al., 2020).

Distribution of Depression, Anxiety, and Stress Categories

Most students were classified in the normal category for all three IDASS-Y domains. Symptoms above the normal category were identified in 56 students for depression (24.9%), 90 for anxiety (40.0%), and 51 for stress (22.7%). Moderate-to-extremely-severe categories were recorded for 34 students in depression (15.1%), 54 in anxiety (24.0%), and 28 in stress (12.4%). These domain-specific counts may overlap because the same student could report symptoms in more than one domain; they must not be summed as a count of unique students.

Table 4. Frequency distribution of depression, anxiety, and stress among adolescents at SMK N 1 Lembah Gumanti

Variable	Frequency	Percentage (%)
Depression		
Normal	169	75.1
Mild	22	9.8
Moderate	23	10.2
Severe	5	2.2
Extremely severe	6	2.7
Anxiety		
Normal	135	60.0
Mild	36	16.0
Moderate	41	18.2
Severe	8	3.6
Extremely severe	5	2.2
Stress		
Normal	174	77.3
Mild	23	10.2
Moderate	22	9.8
Severe	2	0.9
Extremely severe	4	1.8

For depression, 169 students (75.1%) were in the normal category, while 22 (9.8%) were mild, 23 (10.2%) moderate, 5 (2.2%) severe, and 6 (2.7%) extremely severe. Thus, 56 students (24.9%), not 22.7%, reported depression symptoms above the normal category.

Students in the moderate to extremely severe groups require confidential assessment and follow-up rather than interpretation based solely on the screening category.

For anxiety, 135 students (60.0%) were in the normal category, while 36 (16.0%) were mild, 41 (18.2%) moderate, 8 (3.6%) severe, and 5 (2.2%) extremely severe. Anxiety was therefore the most frequently identified symptom domain, affecting 90 students (40.0%).

For stress, 174 students (77.3%) were in the normal category, while 23 (10.2%) were mild, 22 (9.8%) moderate, 2 (0.9%) severe, and 4 (1.8%) extremely severe. Overall, 51 students (22.7%) reported stress symptoms above the normal category.

The predominance of anxiety is consistent with I-NAMHS, which identified anxiety as the most common mental disorder among Indonesian adolescents, although direct numerical comparison is inappropriate because I-NAMHS used a diagnostic interview whereas this program used a self-report symptom scale (Center for Reproductive Health et al., 2022).

Interpretation of the Main Findings

The central finding was that anxiety symptoms were more frequent than depression and stress symptoms. This pattern is consistent with national evidence identifying anxiety as the most common diagnosed mental disorder among Indonesian adolescents (Center for Reproductive Health et al., 2022). However, the 40.0% obtained in this program should not be compared directly with the 3.7% national diagnostic prevalence because the instruments, thresholds, sampling methods, and intended interpretations differ.

The program did not measure causal or contextual determinants of these symptoms. Nevertheless, anxiety in a vocational-school population may plausibly relate to academic assessment, practical competency demands, peer relationships, family expectations, and uncertainty regarding employment or further education. These factors should be treated as hypotheses for subsequent qualitative or analytic assessment, not as causes established by the present program (World Health Organization, 2024; UNICEF Indonesia, 2025).

Depression symptoms above the normal category were reported by 24.9% of students and stress symptoms by 22.7%. The presence of moderate to extremely severe categories is programmatically important because psychological difficulties may interfere with learning, attendance, interpersonal functioning, and help-seeking even when most students remain in the normal category (Andrews et al., 2020; WHO, 2024). The results therefore justify a tiered response rather than a uniform intervention for all students.

At the universal level, all students may benefit from accurate mental health information, stigma-sensitive communication, and basic coping education. At the indicated level, students with elevated screening results need confidential review and referral according to symptom severity, functional impairment, and safety risk. IDASS-Y results must remain one component of assessment because the instrument measures symptoms and does not provide a clinical diagnosis (Sarfika et al., 2024).

The findings also support attention to co-occurring emotional distress. Depression, anxiety, and stress are related constructs, and elevated symptoms may overlap within the same student. Consequently, follow-up should assess the student's broader psychosocial context, including academic pressures, peer and family support, functioning, and safety, rather than treating each score as an isolated condition (Sarfika et al., 2025).

Program Contribution and Educational Boundaries

The screening results provided a needs-based rationale for mental health education and referral planning. Education addressed symptom recognition, help-seeking, stigma, and simple coping strategies, which are core components of mental health literacy and school-based prevention (Iswanto & Ayubi, 2023; UNICEF Indonesia, 2025). Flyers and

leaflets may reinforce message retention after the session, but their effect was not measured.

Because this program did not use pre-post tests or standardized outcome instruments, the article should not state that student knowledge increased, stigma decreased, or behavior changed. The defensible conclusion is that education and coping demonstrations were delivered and accepted as components of the program. Future implementation should measure baseline and post-intervention knowledge, help-seeking intentions, stigma, self-efficacy, and retention at follow-up.

Youth Mental Health Cadres and Referral

Youth Mental Health Cadres were introduced to extend basic information and encourage timely help-seeking. Peer-based approaches are relevant because adolescents may disclose difficulties to peers before approaching adults, and structured peer education can support resilience and health-promoting behavior (Tang et al., 2022). Nevertheless, this program did not measure cadre competence or peer-level outcomes; therefore, conclusions are limited to feasibility and role introduction.

Cadre activities must remain within clear safeguards: providing basic information, listening without judgment, encouraging access to trusted adults, and activating referral when needed. Cadres should not diagnose, conduct therapy, or manage high-risk situations independently. Sustainable implementation requires supervision by school counselors or designated teachers and linkage with primary health care or mental health professionals (UNICEF Indonesia, 2025).

A recent school-based mental health cadre training program in Padang used a structured pre-post assessment and reported measurable improvement in cadre screening skills (Wenny et al., 2025). In contrast, the present program did not administer a standardized competency assessment; therefore, its contribution is limited to the delivery of orientation, clarification of role boundaries, and referral preparation.

Ethical and Practical Implications

Screening minors creates an obligation to protect privacy and provide proportionate follow-up. The moderate-to-extremely-severe categories involved 54 anxiety scores, 34 depression scores, and 28 stress scores; because categories may overlap, follow-up should be organized by individual student rather than by summed domain counts. Individual results should not be announced, used for labeling, or shared beyond personnel directly responsible for support. Immediate safety concerns require urgent referral according to school safeguarding procedures.

The practical implication is the need for a written pathway linking students, cadres, homeroom teachers, school counselors, parents or caregivers, primary health care services, and mental health professionals. Periodic screening may be integrated with school health and counseling activities only when consent, confidentiality, data protection, staff capacity, and referral resources are assured (UNICEF Indonesia, 2025).

Program Limitations

The results represent one school and one time point and therefore cannot establish clinical prevalence, causality, or generalizability to other settings. The program had no pre-post measurement, comparison group, standardized assessment of mental health literacy, behavior, stigma, coping skill, or cadre competence, and no long-term follow-up. The activity record also did not separately document the duration in minutes of each component or the number of students completing cadre orientation. Oral feedback and participation observations cannot substitute for validated outcome measures.

Future programs should record the duration and facilitator allocation for every component, document the number and characteristics of cadres, use pre-post and follow-up measurements, assess cadre competency with a structured rubric, and monitor referral completion while protecting confidentiality. Qualitative feedback from students, counselors, teachers, and parents would also clarify contextual factors, acceptability, safety, and sustainability.

CONCLUSION

Screening of 225 eleventh-grade students identified symptoms above the normal category in 90 students for anxiety (40.0%), 56 for depression (24.9%), and 51 for stress (22.7%). Moderate-to-extremely-severe categories were recorded in 54 anxiety scores, 34 depression scores, and 28 stress scores. These domain-specific counts may overlap and represent screening findings rather than clinical diagnoses. The results support confidential individual follow-up and an operational school referral pathway.

The program delivered face-to-face mental health education, coping-skill demonstrations, and Youth Mental Health Cadre orientation. Cadres were positioned as peer educators and referral connectors under adult supervision, not as clinical counselors. Because the program did not use pre-post or follow-up measures, it cannot claim improvements in mental health literacy, stigma, behavior, coping competence, or cadre effectiveness.

Based on the screening findings, the school should prioritize confidential assessment of students with elevated scores, formalize referral links with primary health care and mental health professionals, supervise peer cadres, protect screening data, and integrate mental health education into counseling and school health activities. Future implementation should include documented session duration, cadre numbers, pre-post evaluation, referral monitoring, and longer-term follow-up.

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