A Junior Educator’s Guide to Proactively Promoting Mental Health and Well-Being Through Resilience

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Submitted in partial fulfillment of the requirements for the degree of Master of Education

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Abstract

This project explored existing research on the mental health and well-being of Ontario’s children and youth, and the perceived role of educators and the education system in supporting student mental health and well-being. Current research and policy implications indicate an unbalanced focus on mental illnesses and treatment, yet the need for support is paramount. Because educators play a crucial role in both proactive and reactive care, this study adopted the Positive Psychology framework to develop a handbook titled *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being* (the Guide), a resource for Ontario educators that is targeted for the junior grades (grades 4 to 6; ages 9 to 12). The *Guide* encompasses preventative strategies aligned with the Positive Psychology framework that focus on proactively building resilience. Each subsection of the *Guide* aims to inform educators of the necessity for mental health and well-being initiatives, their role in preventatively supporting student mental health and well-being, various strategies to adapt into their teaching practice to cultivate resilience, and avenues for influencing students’ positive mental health and well-being.
Acknowledgements

Throughout the completion of this research project, I was fortunate to be surrounded by a variety of people who supported my academic journey. This journey would not have been possible without their endless support, advice, encouragement, and compassion.

First, I must thank my faculty supervisor, Professor Michael Savage. His passion for providing future educators with vital information regarding mental health and mental illness is contagious and influenced my ambition to engage in this research process. Furthermore, his guidance, expertise, and advice throughout this process was invaluable, and much appreciated. On the same note, I must also thank Dr. Ann-Marie DiBiase for taking the time to provide insightful feedback for the benefit of this project; your advice and recommendations aided the success of the research project greatly.

It is essential to express my gratitude to the individuals who volunteered their time to offer irreplaceable feedback and advice regarding this project. Your perspectives and commentary further enhanced the success of this research and validated the necessity for a resource such as Promoting Resilience to be beneficially utilized by educators.

I must also thank Ebru Ustundag. You may not realize it, but your ability to see my potential to accomplish graduate work is what gave me the confidence to pursue my Master of Education degree. I will forever be grateful for your encouragement.

On a personal note, I must acknowledge my endless gratitude for those closest to me who supported me and encouraged me throughout my Master of Education journey. Thank you for always lending your perspective, and helping me to see the larger picture. Your unconditional love, support, encouragement, attentiveness, and patience made this journey both achievable and rewarding.
Dedication

This resource is dedicated to every educator who believes in his or her power to make a difference; who strives to positively impact the lives of their students; who sees the value in proactively developing student mental health and well-being; who recognizes the potential for each student to build resilience; and who is unconditionally committed to ensuring every student flourishes.
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CHAPTER ONE: INTRODUCTION

This project is founded on the ambition to equip junior grade educators, in Ontario schools, with the necessary knowledge and strategies required to promote student mental health and well-being proactively, through the establishment of resilience. The purpose of this research is to provide educators with a thorough understanding of mental health and well-being research, while also highlighting beneficial avenues for promoting resilience within students. If educators are expected and trusted to invest time and effort towards enhancing the mental health and well-being of students, it is essential to ensure that educators are prepared to, and willing to, embrace such initiatives and challenges.

The recognition that educators must be adequately prepared to meet the mental health needs of their students prompted the creation of a resource guide for junior grade educators titled, Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being. Previous documentation promotes intervention and treatment strategies; however, this resource intends to offer prevention- and promotion-based techniques. This shift in focus is crucial as it is as important to examine prevention strategies that promote and support mental health and well-being as it is to provide intervention programs (Broderick & Metz, 2009). Ultimately, the information provided throughout this resource assists educators in (a) developing an understanding of critical concepts related to mental health and well-being, (b) recognizing their role in supporting child and adolescent mental health and well-being, (c) understanding the benefits of Positive Psychology and universal intervention approaches, and (d) acknowledging avenues for enhancing student mental health and well-being by preventatively promoting resilience.
The evidence presented throughout this project hopefully will entice educators to adopt prevention-based approaches, focused on the benefits of Positive Psychology, into the classroom milieu. Furthermore, it is hopeful that educators will establish an enhanced appreciation for critical concepts, the role of the education system, and the necessity for such initiatives to be proactively provided within education. While education is commonly associated with academic outcomes and successes, it is widely recognized that the education system and educators have a profound impact on the establishment of social, emotional, and intellectual development, along with the moulding of future citizens (Ontario Ministry of Education, 2015). To enhance life prosperity for our students and the success of our communities, mental health and well-being cannot be neglected any longer (World Health Organization [WHO], 2001).

**Background**

Growing concern regarding mental health and well-being continues to emerge within society; however, there is an enhanced focus on the mental health and well-being of students, and the necessity for the education system to address child/adolescent mental health and well-being. This focus is mainly a product of the recognition that 15-20% of children and youth meet the diagnostic criteria for a mental illness diagnosis within Canada (Mental Health Commission of Canada [MHCC], 2013; Millar, Lean, Sweet, Moraes, & Nelson, 2013; O’Mara & Lind, 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). While this statistic is staggering, it important to acknowledge that this statistic only accounts for clinically diagnosed mental illnesses. This limitation is noteworthy as a significant number of children and youth experience mental illness without receiving treatment, while many students also experience various forms of
distress, ranging in duration, impeding mental health and well-being (Flett & Hewitt, 2013; Schwean & Rodger, 2013). Furthermore, it is recognized that children and adolescents are in vulnerable stages of development, as 50% of all mental illness diagnosed in adulthood are traceable to an onset age before 14, and 75% of all mental illnesses diagnosed in adulthood are attributed to an onset age before 24 (Manion, Short, & Ferguson, 2013; MHCC, 2013; Ontario Ministry of Health and Long-Term Care [OMHLTC], 2011; Santor, Short, & Ferguson, 2009). For educators, this information is valuable as it illustrates the belief that in a class of 30 students, five to six students may experience a mental illness, and an additional three to four students will experience distress and other impairments in function related to mental illness (Ontario Ministry of Education, 2013).

Concerns surrounding the mental health and well-being of children and youth are supported by an array of influential policy documents and strategic plans, which influence the emergence of mental health and well-being concern within education. This concern started with the WHO in 2001, followed by the MHCC in 2012, the OMHLTC in 2011, and the Ontario Ministry of Education in 2013. As a result, substantial policy exists, promoting various agendas for further enhancing the mental health and well-being of communities. Within the context of education in Ontario, Supporting Minds: An Educator’s Guide to Students’ Mental Health and Well-Being and Achieving Excellence: A Renewed Vision for Education in Ontario (Ontario Ministry of Education, 2013) maintains the most substantial implications for education.

Supporting Minds (Ontario Ministry of Education, 2013) has a prominent focus on mental illness, and avenues for early identification, treatment, and in-class supports
for students experiencing various mental illness. This focus is recognized as a critical component of mental health services; however, it is significant to note that this focus aligns with the recent deficit approach to mental health, rooted in reactive care. It is this recognition that supports the necessity for *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*, aligning with the beliefs of Positive Psychology, focused on enhancing mental health proactively through the establishment of resilience (Seligman, 2002).

Positive Psychology posits that psychology (in both research and practice) has abandoned its fundamental goals, neglecting to focus on avenues for improving individual productivity/life fulfillment and means of identifying high talent (Chodkiewicz & Boyle, 2017; Seligman & Csikszentmihalyi, 2000). Instead, an overwhelming focus has been placed on mental illness since World War II (Chodkiewicz & Boyle, 2017). While Positive Psychology does not dismiss the work completed, this approach does argue for further research, programs, and initiatives focused on (a) positive emotions, (b) positive individual traits, (c) positive relationships, and (d) the promotion of positive institutions as a means of proactively benefiting psychological health (Chafouleas & Bray, 2004; Seligman, 2002). Embedded in Positive Psychology is the belief that prevention-based efforts and learned optimism influence mental resilience, contributing to the establishment of strategies focused on reducing the impact of poor mental health, and the risk of mental illness (Carr, 2011; Chodkiewicz & Boyle, 2017; Seligman, 2002).

The prevalence of mental illness and reduced mental health and well-being highlights the necessity for immediate action to alleviate the suffering experienced by children and youth. While substantial policy documents exist, promoting various
strategies and recommendations, the release of *Supporting Minds* by the Ontario Ministry of Education (2013) encourages the current discourse of psychology, focusing on identification, intervention, and treatment strategies. While such approaches are beneficial, it is also recognized and supported by Positive Psychology that proactive initiatives focused on enhancing mental resilience and highlighting individuals’ strengths are necessary to promote mental health and well-being. Ultimately, it is suggested that a more balanced approach be adopted, allowing for proactive and reactive avenues of support and recommendations to be available for educators.

**Statement of the Problem**

The mental health and well-being of children and youth is a paramount concern that requires immediate attention to reduce students’ experiences of distress and impairment. In the context of Ontario, it is evident that the education system and educators maintain a central role in addressing the societal concern regarding child and adolescent mental health and well-being. This interest and investment is promoted by two influential Ontario Ministry of Education publications: *Achieving Excellence: A Renewed Vision for Education in Ontario* (2014) and *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* (2013). While these documents reflect an invested interest in aiding educators in their capacity to meet the mental health and well-being needs of their students, it is acknowledged that limited detail is provided regarding prevention- and promotion-based initiatives, aimed at building mental resilience within students to prevent the development of mental distress and mental illness. As a result of this shortcoming, in addition to the recognition that mental illness prevalence rates are alarming, it is the goal of this study to balance out the deficit,
medical model approach fixated on identification and intervention. Instead, this research aims to understand the concept of resilience, utilizing a Positive Psychology framework, to identify strategies teachers can actively employ to enhance resilience, ultimately positively promoting child and adolescent mental health and well-being.

Purpose of the Study

The overarching purpose of this paper is to develop an instructional resource for educators, and to understand their role and responsibility in preventatively caring for and cultivating the mental health and well-being of their students. This approach is mainly informed and directed by the Positive Psychology framework, which calls for a focus on proactive initiatives centered on resilience. A handbook titled *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*, intended for junior grade level educators (grades 4 to 6; approximately ages 9 to 12) is provided, which focuses on enhancing educator understanding of resilience, mental health and mental well-being, the perceived role of educators in supporting student mental health/well-being, and avenues for the provision of promotion and prevention-based initiatives within education. Each subsection of this handbook aims to inform educators—new and experienced alike—of their role in supporting student mental health and well-being, and the various approaches that they can adopt into their teaching practice and classroom to cultivate resilience, and influence the establishment of positive mental health and well-being within students.

Research Objectives

The research included within this document, and the handbook resource titled *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child*
and Adolescent Mental Health and Well-Being, were created with the following objectives in mind:

- To provide educators with a comprehensive understanding of fundamental concepts (mental illness, mental health, well-being, and resilience), and to promote the necessity for preventative initiatives to be offered universally within the school setting.
- To conduct a thorough review of influential policy documents released by various governmental organizations to understand how mental health and well-being has emerged as a critical concept within education, and the perceived role of educators in addressing child/adolescent mental health and well-being.
- To utilize the Positive Psychology and Universal intervention framework to provide a proactive guide for educators focused on the prevention of mental illness, and promotion of mental health and well-being through the establishment of mental resilience.
- To equip educators with educational strategies that can be universally provided within the classroom to promote resilience, and enhance mental well-being through a Positive Psychology approach.

**Rationale**

Beyond understanding the objective and intended focus of this resource, it is significant to provide a rationale for the creation of *Promoting Resilience: A Junior-Level Educator’s Guide to Promoting Child and Adolescent Mental Health and Well-Being*. This section provides a personal and academic overview of why this resource is significant for education.
First and foremost, it is crucial to understand that the mental health and well-being of children and adolescents is a topic that is held in high regard by the author of this resource. From the author’s perspective, educators play a substantial role in the lives of their students, which extends far beyond academic expectations and success. As a result of this belief, this resource is motivated by the personal bias that educators are in a position where they can significantly support and enhance the life-long well-being and success of their students. This belief heavily influences the author’s interest in mental health and well-being.

Moving beyond personal anecdotes, the primary rationale for the creation of this handbook is rooted in the alarming prevalence rate of mental illness, and reduced mental health and well-being. It is reported consistently that 15-20% of children and youth in Canada meet the criteria for a diagnosable mental health disorder (MHCC, 2013; Millar et al., 2013; O’Mara & Lind, 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). This statistic indicates that 800,000 to 1,000,000 children and youth within Canada experience one or more mental illnesses (Flett & Hewitt, 2013; MHCC, 2013; Schwean & Rodger, 2013). While these numbers are staggering, it must be recognized that such statistics only demonstrate a limited representation of the more significant problem, as many mental illnesses go without recognition or treatment, and experiences of superficial suffering, disguised distress, and emotional distress are not included in these statistics. For educators, these figures are impactful as they indicate that approximately five to six students within any given class of 30 students could meet the criteria for mental illness, and three to four additional students will present with symptoms of mental illness—either disguised or explicitly demonstrated (Ontario
Ministry of Education, 2013). Furthering these statistics is the recognition that 50% of all mental health diagnoses made in childhood can be traced back to an onset before 14 years of age, and 75% can be traced to an onset before age 24 (Manion et al., 2013; MHCC, 2013; OMHLTC, 2011; Santor et al., 2009). These statistics are vital in promoting the necessity for programming to be universally provided as the prevalence of mental illness and reduced mental health is alarming, and the vulnerability of childhood/adolescence is evident.

While the statistical prevalence of mental illness and reduced mental health and well-being motivate the necessity for mental health initiatives to be provided for children and youth, it is important also to acknowledge the need for preventative measures to be delivered, justifying the approach taken within this research. First and foremost, a universal preventative approach is motivated by the prevalence of suffering experienced by children, even before a formal diagnosis is obtained. Concepts of superficial suffering, emotional distress, and disguised distress indicate that students can experience reduced mental health and well-being even in the absence of a mental illness diagnosis. Furthermore, the acknowledgment of early onset in childhood (pre-14 years of age) and adolescence/early adulthood (pre-24 years of age) is substantial, as it promotes the vulnerability of individuals during their school-age years.

Alternatively, prevention- and promotion-based approaches focusing on enhancing resilience to benefit mental health and well-being proactively are deemed necessary based on the recognition of limited resources available focused on a promotion based approach. Similar to recent trends recognized in psychology, as outlined by the Positive Psychology framework, there is considerable evidence that a medical model and
a disease-based approach has been adopted within education. This approach is mainly prevalent in *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* released by the Ontario Ministry of Education in 2013. The focus on mental illness is represented by the Ontario Ministry of Education’s concentration on providing information and strategies regarding eight prominent mental illnesses, targeting early intervention and treatment/support initiatives in education. While the information included in *Supporting Minds* is valuable and comprehensive, a heavy focus on mental illness is prominent. As a result of this limitation, the research and resource provided within this document intend to reduce this gap in the literature, by providing information for educators regarding strategies for proactively enhancing resilience and as a result promoting mental health and well-being. It is hopeful that this focus will further encourage educators in their capacity to address mental health and well-being concerns, by fostering resilience within their students, to promote mental health and well-being proactively.

Lastly, it is important to recognize why educators are the targeted audience for this resource and mental health and well-being initiatives targeted for children and youth. Most evidently, educators are the targeted program delivery avenues because educators maintain continuous access to students, and are revered as trustworthy leaders in the lives of children and youth (Santor et al., 2009). Based on this previously established role and trust, educators are already striving to actively meet the needs of their students (Santor et al., 2009; Schwean & Rodger, 2013). However, it is acknowledged that only 67% of educators feel prepared to meet the mental health needs of their students (Santor et al., 2009; Schwean & Rodger, 2013). Beyond the recognition that educators are in a
precarious position, there is also evidence to suggest that mental illness and reduced mental health and well-being significantly impact school readiness, attendance, academic achievement, school and peer connections, focus, and social, emotional, physical, and mental development (MHCC, 2013; Millar et al., 2013). These effects are significant for educators as there is a direct link between mental health/well-being and academic performance, naturally highlighting the role of education and educators.

Ultimately, it is recognized that the universal provision of preventative initiatives within the classroom is essential. Not only is there an alarming number of students experiencing mental illness, but there is also considerable evidence to suggest more students are struggling than statistically represented. There is also no ignoring the fact that educators are in a unique and valuable position to promote resilience, mental health, and well-being of their students. While the work of Supporting Minds is noteworthy in providing early identification and academic accommodations, it is recognized that further support must be provided to educators regarding prevention-based measures. It is this critical recognition that ultimately motivates the research conducted and the resource created in this project.

**Theoretical Framework**

The guiding theoretical framework utilized throughout this research project is Positive Psychology, as spearheaded by Martin Seligman (2002). Positive Psychology is fundamentally motivated by the belief that psychology, in both practice and research, has abandoned its founding ambitions, equally neglecting to acknowledge the primary goals of psychology. Positive Psychology believes that the field of psychology must revitalize its neglected founding beliefs to focus on promotion-based initiatives. The Positive
Psychology framework argues that psychology as a discipline has focused heavily on its ambition to cure mental illness, neglecting to provide equal attention to the remaining founding goals to improve individual productivity and life fulfillment, and to identify individual talents (Chodkiewicz & Boyle, 2017; Seligman & Csikszentmihalyi, 2000).

As a result of this belief, Positive Psychology has identified four pillars: positive emotions, positive individual traits, positive relationships among groups, and the promotion of positive institutions (Chodkiewicz & Boyle, 2017; Seligman, 2002). These four pillars are set with the intention of further understanding and focusing on how individuals can establish resilience, achieve life fulfillment, and promote strength-based orientations, in both treatment and research efforts (Carr, 2011; Chafouleas & Bray, 2004; Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2002). While Positive Psychology recognizes and applauds the strides made within research and practice regarding mental illness, this approach to mental health calls for a preventative, promotional, and strength-based orientation to be centrally adopted within psychology (Chodkiewicz & Boyle, 2017; Seligman, 2002). It is the hope that this will support a further understanding of how to proactively build resilience, and promote mental health and mental well-being before mental illness surfaces (Chodkiewicz, & Boyle, 2017; Seligman, 2002).

The fundamental pillars of Positive Psychology are further reinforced by the main two components of Positive Psychology: a heightened focus on prevention-based efforts, and the inclusion of learned optimism. Prevention-based initiatives are central to Positive Psychology as this approach to mental health and well-being aims to focus on systemically building competence and promoting mental health/well-being (O’Connor,
Snason, Toumbourou, Norrish, & Olsson, 2017; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Grounded in the belief that human strength is a buffer against mental illness, and there is value in dealing with problems before they emerge, Positive Psychology promotes individual strengths and strives to teach adaptive skills through preventative initiatives (O’Connor et al., 2017; Seligman, 2002; Shoshani & Steinmetz, 2013).

Alternatively, Positive Psychology is embedded in the concept of learned optimism. Learned optimism represents the belief that a person can cultivate joy in themselves through actively combatting negative self-talk and catastrophic thinking. This is the direct opposite of learned helplessness, which posits that individuals will surrender when they believe they cannot succeed (Seligman, 2002). This distinction is fundamental to Positive Psychology as catastrophic thinking patterns can become self-reinforcing, heightening the potential prevalence of mental illness and mental distress (Seligman, 2002). Learned optimism is therefore central to Positive Psychology, as the ability to become a skilled disputer of catastrophic thinking enhances the ability to demonstrate resilience (Seligman, 2002).

The designated focus on mental health promotion/prevention and learned optimism contributes to the construction of an approach to mental health that is focused on proactively enhancing resilience, mental health, and well-being (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). It is this fundamental focus on prevention and optimism—in combination with the belief that raising children is about recognizing, amplifying, and nurturing individual strengths, leading to enhanced resilience within and among people—that supports the inclusion of this approach within this research project.
(Kobau et al., 2011; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). In fact, the fundamental beliefs outlined by Positive Psychology inform the research conducted, and the suggestions provided throughout this resource. Ultimately, it is recognized that mental health is about more than the absence of mental illness, and Positive Psychology believes that mental health programs, initiatives, and supports must aim to nurture strong qualities and help individuals develop and invest in strategies that will allow them to build resilience for enhanced mental health and well-being (Seligman & Csikszentmihalhi, 2000).

**Outline of the Remainder of the Document**

This chapter discussed the research that will be presented throughout this paper. While this synopsis is beneficial, it is essential to provide an overview of the remaining sections and topics that will be discussed throughout this document. For this reason, the following section provides a brief overview of the content included in the subsequent chapters.

Chapter 2 provides a thorough literature review, exploring the information that influenced the direction of this project. The literature review covers a variety of topics that can be naturally divided into smaller sections, promoting a detailed understanding of (a) Positive Psychology, the framework that drives this research; (b) key concepts including mental illness, mental health, well-being, and the relationship between these discourses; (c) a policy review, exposing how mental health has emerged within education, and how government documentation perceives the role of education and educators; (d) a justification regarding why schools are unique environments for the inclusion of preventative mental health and well-being supports; (e) an overview of the
prevalence of mental illness, and reduced mental health and well-being among children and youth; (f) a detailed explanation of the Multi-Tiered System of Support and Universal Programming; and (g) a comprehensive overview of resilience and resilience theory, highlighting the necessity to focus on enhancing resilience to achieve universal preventative programming within schools. It is evident that Chapter Two: Literature Review strives to highlight essential information and understanding regarding child and adolescent mental health and well-being and the direction that this project has adopted.

With a developed understanding of the research that informs this project, chapter 3 outlines the methodology utilized to create *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*. The chapter describes how the resource was constructed, key objectives, and a description of the peer review process. Building on the previously provided contextual information and development process, chapter 4 presents *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*, the resource document created as a result of this research process. Lastly, chapter 5 provides commentary on the peer-revision feedback process, the implications of *Promoting Resilience*, potential future research initiatives, and closing remarks regarding this research process.
CHAPTER TWO: LITERATURE REVIEW

This chapter contextualizes key information surrounding the status of child and adolescent mental health and well-being in Ontario. To provide a comprehensive overview of the evidence that informs this research, this chapter aims to explore current literature, exposing the necessity for promotion- and prevention-based efforts to be employed within the classroom. Before examining the need for such initiatives in education, the Positive Psychology theoretical framework utilized in this research will be explored outlining the underlying approach to mental health that influences and is valued by the provided analysis. Following a discussion of Positive Psychology, essential terms found within this paper will be examined, including: mental illness, mental health, and mental well-being. Such research will present the ambiguity surrounding these terms, eventually highlighting how these concepts are defined within this research. This chapter will then switch directions, exploring the current status of child and adolescent mental health and well-being. This will involve a review of essential policy documents, highlighting how mental health and well-being has become a prominent concern within the learning environment and the recommended approach to action. Furthermore, information will be presented regarding the prevalence of mental illness and mental health/well-being concerns among students. With a grasp of the issue at hand, and the necessity for in-school supports, a categorical approach for schools in providing prevention, promotion, and treatment efforts will be addressed, demonstrating and justifying the focus of the presented initiatives. Lastly, the chapter will explore the concept of resilience and resilience theory. Ultimately, this literature review is an integral component of the enclosed resources development, and therefore a comprehensive analysis of the critical information motivating this project is provided.
Theoretical Approach: Positive Psychology

As noted earlier, the research provided within this paper is rooted in the theoretical foundation of Positive Psychology. To reveal the positionality of this research, it is essential to explain how this approach frames psychology, mental health, and mental well-being. The following will highlight the beliefs of Positive Psychology in the context of child and adolescent mental health. Furthermore, this analysis will outline the perceived role of the school in universally promoting resilience/well-being, and congruently preventing poor mental health/well-being and mental illness. This analysis is significant as it is the beliefs of Positive Psychology that ultimately undermine the direction of this research and the contents of Promoting Resilience: A Junior-Level Educator’s Guide to Promoting Student Mental Health and Well-Being.

Psychologies Derailment

Positive Psychology, as an approach to mental health, is heavily embedded in the belief that psychology, in both research and practice, has been misconstrued, failing to focus equally on the multidimensional aspects of psychology. This argument is founded on the belief that psychology has neglected to adequately attend to its three founding ambitions: (a) to cure mental illness, (b) to improve individual productivity and life fulfillment, and (c) to nurture and identify high talent, ultimately misconstruing the practice of psychology (Chodkiewicz & Boyle, 2017; Seligman & Csikszentmihalyi, 2000). Positive Psychology, as an approach to mental health, demands that the field of psychology, in research and practice, returns to its rooting ambitions equally acknowledging the three founding goals.

It is recognized that following World War II (WWII) a scientific, deficit, and
disease-based model of psychology prevailed, with a strong focus on mental illness, abandoning the remaining foundational goals of psychology (Chodkiewicz & Boyle, 2017; Seligman, 2002; Kobau et al., 2011). The formation of the Veteran’s Administration in 1946 (now known as Veteran Affairs), and the National Institute of Mental Health in 1947 is reportedly responsible for this shift, as these organizations allowed for psychologists to make a living on curing mental illness, and enhanced funding opportunities for pathological research (Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

The conception that disease-orientated beliefs have motivated psychology is supported by the evolution of the Diagnostic and Statistical Manual of Mental Disorders (DSM), known formally as the Statistical Manual for the Use of Institutions for the Insane, initially established in 1918 (Kawa & Giordano, 2012). Regarded as one of the most prominent resources in psychology, the DSM has consistently maintained its hegemonic status as the central reference guide for the assessment and categorization of mental disorders since its establishment in the 1900s (Kawa & Giordano, 2012). While the DSM has evolved significantly since its first edition in 1952, it remains consistent that the most influential reference guide in psychology is embedded in mental illness, illuminating the notion that psychology is mainly interested in a disease-orientated framework (Kawa & Giordano, 2012).

While it is acknowledged that a focus on mental illness has led to substantial strides in understanding and treating mental illness, it is also recognized that this focus has influenced psychology’s abandonment of its fundamental goals, turning psychology into a study of victimology and pathology (Seligman, 2002; Seligman &
Csikszentmihalyi, 2000). This unbalanced focus has led to deficiencies, including: blurred definitions of mental health and mental illness, the stigmatization of mental health, the abandonment of child and adolescent mental health/illness research, a hyper-focus on illness, and a failure to acknowledge the positive factors that help individuals function and flourish (Chodkiewicz & Boyle, 2017; Kobau et al., 2011). Abraham Maslow (1954) supports these deficits in both theory and practice by stating:

> The science of psychology has been far more successful on the negative than on the positive side. It has revealed to us much about man’s shortcomings, his illness, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height. It is as if psychology has voluntarily restricted itself to only half its rightful jurisdiction, and that, the darker, meaner half. (As cited in Chodkiewicz & Boyle 2017, p. 65)

Evidently, Maslow recognized how psychology has hyper-focused on a deficit and disease based model following WWII, eliminating attention for preventative measures, positive aspects of life, well-being, and resilience (Seligman & Csikszentmihalyi, 2000). Recognizing that psychology is not just the study of disorders, weakness, and damage, suggests that significant attention must also be allocated to the strengths and virtues that help people flourish, a vital element of this research approach (Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

**A Shifting Focus**

While ample information is known about negative emotions and mental illness, there is little understanding surrounding positive emotions and mental health (Kobau et al., 2011). By the turn of the 20th century, the limited focus and shortcomings of
psychology were evident (Chodkiewicz & Boyle, 2017). This recognition, in combination with the increasing prevalence of mental illness, promoted the necessity for a renewed focus to be established within the field of psychology, looking to understand and emphasize what is right, instead of solely focusing on what is wrong (Chodkiewicz & Boyle, 2017; Kobau et al., 2011). As a result, Martin Seligman identified Positive Psychology at the 1998 American Psychiatric Association conference (Chafouleas & Bray, 2004; Seligman & Csikszentmihalyi, 2000). Recognizing the need to understand and focus on strength and positivity, this approach does not denote the existing contributions to psychology or the impact of negative emotions, instead it encourages a more balanced profile, allowing for strength-based orientations to be placed at the forefront of treatment and prevention efforts (Chodkiewicz & Boyle, 2017; Seligman, 2002).

The establishment of Positive Psychology, as an approach to mental health, has reinforced the need for a revitalized focus in the field of psychology, heightening the necessity to study resilience, well-being, and prevention efforts, in an attempt to find a balance between pathology and assets (Carr, 2011; Chafouleas & Bray, 2004; Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman & Csikszentmihalyi, 2000). To achieve this fundamental goal, four pillars have been established regarding Positive Psychology, including: (a) positive emotions (gratitude, happiness, and fulfillment); (b) positive individual traits (optimism, resiliency, character, wisdom, interpersonal skills, high talent, and perseverance); (c) positive relationships among groups; and (d) the promotion of positive institutions (civic virtues and institutions that move individuals towards better citizenship) (Chafouleas & Bray, 2004; Kobau et al., 2011; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Evidently, Positive Psychology calls for
individualistic and community adaptations to enhance mental health and well-being of all individuals.

**Prevention-Based Focus**

Positive Psychology is centrally concerned with fostering and recognizing innate individual competencies, resources, and psychological strengths, to enhance resilience, prevent mental illness, and foster well-being (Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2000; Seligman & Csikszentmihalyi, 2000). As a result, Positive Psychology is principally supportive of the need for prevention-based efforts, as heavily emphasized by Seligman in 1998 at the American Psychiatry Association Conference (Seligman & Csikszentmihalyi, 2000). According to this prominent focus, the Positive Psychology model aims to focus on systemically building competence and mental health, versus correcting weakness and treating mental illness (O’Connor et al., 2017; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Grounded in the belief that there is a significant value in dealing with problems before they emerge and human strength is a buffer against illness, Positive Psychology promotes individual strengths, and teaches adaptive skills through preventative measures and interventions, for the advancement of healthy and positive development (Chodkiewicz & Boyle, 2017; O’Connor et al., 2017; Seligman, 2002; Shoshani & Steinmetz, 2013).

**Learned Optimism**

Beyond promoting positive development and health for a pleasant, meaningful, and engaged life, learned optimism is also fundamental to this mental health approach (Carr, 2011; Seligman, 2002). This concept represents the belief that when a person is wagered that they cannot succeed, they will do all they can to dispute that idea; however,
when individuals believe they are unable to succeed, they will surrender (Seligman, 2002). This distinction is paramount as it suggests that subjective beliefs are revered as truth (Seligman, 2002). This concept is central to Positive Psychology, as catastrophic thinking patterns can become self-reinforcing, heightening the prevalence of depression and anxiety (Seligman, 2002). However, by becoming a skilled disputer of catastrophic thinking, through learned optimism, the potential to combat negativity and see positivity is enhanced (Seligman, 2002). By providing a designated focus on mental health promotion, mental illness prevention, and learned optimism, Positive Psychology represents an approach to mental health that is focused on inspiring a positive objective experience—in the past, present, and future—through the incorporation of well-being, resilience, and prevention efforts (Seligman, 2000; Seligman & Csikszentmihalyi, 2000).

**Praise for Positive Psychology**

This approach to mental health is recognized as the underlying theoretical framework for this research due to its fundamental belief that raising children is about identifying, amplifying, and nurturing their marvellous strengths leading to a good life, and enhanced buffers against weaknesses and challenges (Seligman & Csikszentmihalyi, 2000). This approach innately sponsors the need to establish resilience and promote well-being (Carr, 2011; Kobau et al., 2011; Seligman, 2002). Cultivating resilience within people, among people, and across social levels is essential as resilience maintains the capacity to decrease recovery time, enhance resources for everyday living, buffer against negativity, and promote the experience of positive emotions (Kobau et al., 2011; Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

Furthermore, the Positive Psychology approach to mental health is beneficial due
to its innate focus on promoting well-being, both cognitively and emotionally (Carr, 2011; Kobau et al., 2011). Under this approach, cognitive well-being is promoted through the advancement of the ability to positively evaluate life, and emotional well-being is heightened through the experience of positive emotional conditions (Shoshani & Steinmetz, 2013). The ability to obtain cognitive well-being is a priority, as psychological and academic success is enhanced, and individuals are equipped with the skills necessary to flourish as adults (O’Connor et al., 2017). Moreover, emotional well-being is emphasized as such experiences are associated with: good physical health, healthier lifestyle choices, enhanced coping strategies, long-term adaptability, a reduction in negative emotions, enhanced social experiences, and reduced psychological suffering (Carr, 2011; Kobau et al., 2011). Noticeably, Positive Psychology recognizes that individuals are thinkers and decision makers, with autonomy over their ability to enhance adaptive functioning (O’Connor et al., 2017; Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

**Justification for a Positive Psychology Approach**

The Positive Psychology approach to mental health is favoured within this paper for two reasons. Initially, this approach is supported for its fundamental inclusion of prevention, resilience, and well-being efforts (Chodkiewicz & Boyle, 2017). Moreover, this approach is favoured for its ability to positively re-conceptualize child/adolescent development (Chodkiewicz & Boyle, 2017). These elements make this approach relevant within schools as they emphasize the need to recognize developmental challenges and learning difficulties, and promote the school as a central environment for universal mental health prevention efforts (Chadouleas & Bray, 2004; Chodkiewicz & Boyle,
As further academic demands are placed upon children, and concern is increasingly raised regarding child/adolescent mental health and well-being, schools are in a precarious position to prevent further difficulties and improve the developmental trajectories of young people, a belief consistent throughout this research (Chodkiewicz & Boyle, 2017). This can be achieved by encouraging positive self-perceptions, positive emotions, and positive behaviours, contributing to the establishment of academic, social, and emotional literacy among young people who will have the have skills, abilities, and resilience necessary to thrive in a changing world (Chodkiewicz & Boyle, 2017).

By reuniting social and emotional practices in the learning environment, an academic and skill-based curriculum can be supported (Chafouleas & Bray, 2004; Chodkiewicz & Boyle, 2017; Shoshani & Steinmetz, 2013). To promote the mastery of academic, social, and behavioural competencies—which is the ultimate goal of education—it is recognized that Positive Psychology maintains the ability to encourage positive emotional experiences and reduce negative emotional experiences (Chafouleas & Bray, 2004). Most often Positive Psychology in school is founded by the PERMA Framework of well-being, intended to incorporate: Positive emotions, emotional experiences, emotional well-being, and healthy responses to difficult emotions; Engagement and immersion in activities; social skills for healthy Relationships; Meaning through purposeful service to others; and the Achievement of meaningful goals (O’Connor et al., 2017). According to this theory, the application of Positive Psychology maintains the capacity to provide health-promoting conditions and resilience building capacities (Kobau et al., 2011; O’Connor et al., 2017). Ultimately, the Positive Psychology framework and PERMA model encourages the promotion of well-being,
resilience, and prevention efforts, supporting significant advances in children/adolescents' mental health and well-being through school-based programming. These fundamental elements are beliefs are central to this research as their focus stipulated the direction taken by this resource and the instructional strategies provided.

**Positive Psychology Approach Critiques**

While this particular theoretical framework of mental health provides a noteworthy foundation for the research conducted throughout this paper, and school programming, it is also important to recognize its critiques. A substantial critique of this theoretical approach is the prominent emphasis on the individual and personal attributes, failing to acknowledge the influence of environmental conditions and the impact of social factors concerning status and power—such as class, gender, skin colour, race, and nationality (Chafouleas & Bray, 2004). This recognition is significant as it calls for researchers and educators to recognize the factors and circumstances, both social and environmental, that contextualize the promotion of Positive Psychology in schools. Furthermore, the dominant focus on happiness is concerning, as happiness is a fluctuating emotional response, and promoting positive emotion does not eliminate the presence of negative emotions (Chafouleas & Bray, 2004). This limitation is essential as it recognizes the need to not denote negative feelings. Additionally, this recognition calls for a balance between mental health and mental illness, aiming to understand the connection between positive and negative emotions.

**Conclusion**

It is evident that the establishment of Positive Psychology is motivated by an overwhelming emphasis on clinical psychology, focused mainly on illness, only advancing a limited understanding of psychology (Carr, 2011; Chodkiewicz & Boyle,
2017; Kobau et al., 2011; Seligman, 2002). While Positive Psychology does not belittle or deny the need for research regarding mental illness, mental distress, or negative emotions, it does promote an alternative way to describe and value the whole spectrum of mental health (Carr, 2011; Kobau et al., 2011). Instead of focusing on what is wrong, Positive Psychology intends to promote what is right, advocating for the development of coping strategies, resilience, well-being, and positive experiences (Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2002). Aiming to renew how mental is conceptualized, Positive Psychology privileges the need for resilience, resourcefulness, well-being, and mental health promotion/prevention to enrich the human experience (Kobau et al., 2011; Seligman, 2002). Consistent with this research, it is recognized that good health is about more than the absence of illness, and Positive Psychology believes that mental health programs, initiatives, and supports must aim to nurture strong qualities and help individual find niches that will allow them to live out their strengths (Seligman & Csikszentmihalyi, 2000). This understanding of Positive Psychology is significant as it is the fundamental beliefs of this approach that profoundly influence the direction of this research, and the content included within the developed resource.

**Mental Illness**

Because this paper focuses on the mental health and well-being of children and youth; it is important to define the term mental illness in order to distinguish and define these concepts. With this intent in mind, the following section discusses fundamental research regarding what constitutes mental illness. Furthermore, research will be provided to promote an understanding of why mental illness definitions vary. Ultimately, this section intends to paint a clear picture of what the term mental illness represents throughout this research.
Mental Illness Defined

While mental illness is commonly defined similarly and grounded in fundamental characteristics, it is also recognized that a common definition of mental illness can be complex. Research regarding this ambiguity is rooted in the belief that policymakers resist a standardized definition of mental illness, as this would impede their ability to customize definitions of mental illness to meet their policy scope within policy documents (Goldman & Grob, 2006). Goldman and Grob (2006) indicate that there is a resistance against providing a standardized definition of mental illness because individual policy documents use varying definitions of mental illness depending on the scope and intentions of the initiative. The convenience of such flexibility is supported by the belief that policies often elect to: alter the scope of their focus (broad or narrow), vary by intended audience (the public or private sector), and/or promote unique intentions for implication (integrated or specialized support) (Goldman & Grob, 2006). Based on this perspective, the ability to provide a customized definition of mental illness is favourable, increasing the capacity for policy to appear inclusive, even if this inclusivity is rooted in biased perspectives. While flexibility may be beneficial for policymakers, it is essential to recognize that on a larger scale this flexibility impedes research, practice, and larger-scale policy, as the term is interpreted with varying foundations.

While variations in mental illness definitions exist, it is important to recognize that widely accepted definitions of mental illness do exist within prominent Canadian policies. In particular, the Public Health Agency of Canada (PHAC, 2006) definition is significant as it presents an in-depth understanding of mental illness, and represents many
of the key characteristics of mental disorders. According to the PHAC (2006), mental illness is:

- characterized by alterations in thinking, mood, or behaviour—or some combination thereof—associated with significant distress and impaired functioning. The symptoms of mental illness range from mild to severe, depending on the type of mental illness, the individual, the family, and the social economic environment. Mental illnesses take many forms. (p. 2)

This definition highlights the notion that mental illness presents itself in many forms, varies by severity, and in some way causes impaired functioning and distress related to thinking, mood, and/or behaviour (PHAC, 2006). The MHCC (2012) agrees with PHAC (2006) by further emphasizing variations in severity and symptoms as a key component of mental illness. This agreement is centered upon the MHCC (2012) belief that mental illness is characterized by distress, suffering, and/or impairment to functionality, reflected in a full range of problem behaviours, patterns, thinking, or emotions that vary by intensity and duration. The MHCC (2012) also makes a significant contribution to the definition of mental disorders by noting that mental illnesses are often characterized by a sense of hopelessness and helplessness (MHCC, 2012).

Another significant element of mental illness is recognition that mental illnesses are clinically diagnosable. The PHAC (2006), Ontario Ministry of Education (2013), and Goldman and Grob (2006) support the notion that mental illness is clinically diagnosable, by emphasizing the role of the *Diagnostic and Statistical Manual of Mental Disorders*, produced by the American Psychiatric Association, in classifying, identifying, and treating mental illnesses. The importance of clinical diagnosis is also supported by the
WHO (2001); however, an international diagnosis resource is referenced. This highlights the agreement that mental disorders are viewed as diagnosable conditions based on pre-determined criteria and classification systems.

While slight variations in definitions of mental illness exist, it is important to recognize that there are also widely accepted definitions of mental illness within the existing literature and prominent Canadian policies. Evidently, alternations in thinking, behaviour and mood, distress, and impaired function, which lead to a clinical diagnosis, are associated with mental illness. Mental illness, or mental disorder, a synonym used interchangeably throughout this paper, represent the clinical diagnosis of distress, suffering, and impaired functionality to thinking, mood, and/or behaviour, often associated with perceived hopelessness and helplessness (MCHH, 2012; PHAC, 2006; WHO, 2001). While individual policy documents tend to customize the term for their own objectives, it is important to recognize that mental illness is definable, and key concepts must consistently be taken into consideration.

**Mental Health**

Building on the provided definition of mental illness, it is essential to provide a clear understanding of what constitutes the term mental health before examining the similarities between the two terms. The following section outlines the challenges that prevent researchers from coming to a consensus concerning what defines mental health. Research presented by Manwell et al. (2015) will further highlight the various theoretical paradigms to mental health and how they also compromise the ability to agree on a single definition. While the controversy is acknowledged it is recognized, for this paper, that a
definition of mental health must be presented for clarification purposes. To do so, widely accepted definitions will be explored, followed by the definition utilized in this report.

**Challenges Plaguing Mental Health Consensus**

It is important to recognize that on a global scale there remains no unanimously accepted definition of mental health (Bhugra, Till, & Sartorius, 2013; Goldman & Grob, 2006; Manwell et al., 2015). This lack of consensus is attributed to be a result of the debate that surrounds mental health. The following will aim to explore the various factors that are recognized to be the foundation for this lack of agreement.

The inability to articulate a mutually agreed upon definition of mental health is in part attributed to individuals’ capacity to meet their own basic needs for a healthy life (Bhugra et al., 2013; Manwell et al., 2015). Bhugra et al. (2013) and Manwell et al. (2015) ultimately argue that a consensus towards defining mental health is challenging because the definition of health depends on individuals’ ability to meet their basic needs, such as those outlined by Abraham Maslow. According to this perspective, health is determined by an individual’s ability to obtain a secure source of food, shelter, survival, protection, social support, and freedom from pain, environmental hazards, unnecessary stress and exploitation (Bhugra et al., 2013; Manwell et al., 2015). While access to basic needs is recognized as an essential human right, Bhugra et al. (2013) note that not everyone maintains equitable access to these necessities, thereby challenging the ability to universally define health, a key element of mental health.

Beyond the notion that health is defined by an individual’s ability to meet basic needs, the element of culture is also a significant component that impacts mental health definitions. Bhugra et al. (2013) and the WHO (2001) support this notion, as they both
indicate that mental health is nearly impossible to define across cultures universally. This idea is rooted in the belief that cultural values and perceptions of health influence what defines mental health (WHO, 2001). As nations, provinces, and communities are comprised of various cultural perspectives, the degree varying perspectives can complicate the ability for mental health to be defined in both a meaningful and culturally sensitive way.

The conception that mental health is an individual evaluation provides another challenge regarding the inability to universally define mental health (Bhugra et al., 2013). This idea is presented by the Mental Health Foundation (as cited in Bhugra et al., 2013), and outlines the belief that mental health is defined by how individuals feel and think about their lives and themselves, and how this perception impacts their ability to cope and manage during times of adversity. This definition is primarily rooted in the belief that mental health is embedded in individuals' ability to: adapt and develop psychologically, emotionally, intellectually, and spiritually; initiate, develop, and sustain mutually emotionally satisfying relationships; be aware of others; empathize with others; and use psychological distress as a learning experience (Bhugra et al., 2013). This idea further promotes the notion that individuals' assessment of self-informs mental health. When combined with variations in cultural beliefs, further complexity is added to obtaining universal agreement.

**Finding a consensus.** Recognizing the lack of consensus regarding mental health, Manwell et al. (2015) conducted a research study with the intention of determining the fundamental concepts that are central to defining mental health. Twenty-five expert researchers, from five different health domains, and 31 individuals who have lived
experience with mental illness and/or are mentors for the Social Aetiology of Mental Illness Training Programme were included in the study (Manwell et al., 2015). Each of the participants completed a “what is mental health?” survey in which individuals were asked to rank five definitions in order of agreement, provide comments on what is missing, and also provide a list of key concepts that they believe contribute to mental health (Manwell et al., 2015). From this research, no unanimous decision was endorsed. However, the results of this study supported the research provided above, indicating that societal perception and individual perspectives influence what individuals considered the key concepts of mental health to be. Based on this data it is clear that individuals’ paradigm impacts their perception of mental health (Manwell et al., 2015). This resulted in the conclusion that mental health can be, and is, conceptualized from an array of theoretical perspectives. The following outlines these various conceptualizations to provide detail regarding the multiple ways mental health can be theorized.

The first concept that was outlined by the conducted research was the categorical model, focused on the belief that mental health and mental illness are two distinct concepts, which do not maintain a relationship (Manwell et al., 2015). The second model, the model also utilized by the Ontario Ministry of Education (2013), is the continuous model (Manwell et al., 2015). This model is rooted in the belief that mental health and mental illness are interconnected and individuals, depending on their current state, shift along a continuum between mental health and mental illness (Manwell et al., 2015). Under this belief, mental health and mental illness do not overlap, and the presence of mental illness equates to a reduction in mental health. The third model, recognized by Keyes (as cited in Manwell et al., 2015) is a two continua model. Under this model
mental health and mental illness are their own scale, each ranging from high to low (Manwell et al., 2015). This concept of mental health supports the notion that mental health and mental illness are distinct, yet interconnected concepts (Manwell et al., 2015). Within this model it is recognized that individuals who are mentally healthy can also have a mental illness, and those who do not have a mental illness can also have low mental health. The fourth model outlined by Manwell et al. (2015) is the complex model. This perspective accounts for the belief that mental health is impacted by individual attributes (body, brain, neurons, and genes) and social determinants of health (Manwell et al., 2015). Lastly, Manwell et al. (2015) present the overlap concept of mental health. This paradigm represents the notion that mental illness is simply a smaller sub-component of mental health (Manwell et al., 2015). Evidently, an array of paradigms for theorizing mental health, and as a result mental illness, exist among those who are experts in the area of mental health, and those with lived experience of mental health. Each of these concepts further complicate the ability for professionals to unanimously determine a central definition of mental health. This impact is significant as beyond personal, cultural, and environment factors, these various theoretical perspectives influence what defines mental health.

An array of factors impeded the ability for a uniform definition of mental health to be determined. Individual perspective, culture, social-determinants of health, and paradigm alignment ultimately impact the ability to create a universally accepted definition of mental health. This lack of uniform agreement provides a challenge for policy, practice, and research as it hinders the ability to enhance societies understanding of mental health further.
Mental Health Defined

While controversy regarding what defines mental health widely exists, it is important to acknowledge that definitions of mental health do exist. While perhaps not universally embraced, these definitions demonstrate the ability for definitions of mental health to be constructed. While various definitions—from different nations and cultural backgrounds—exist, this particular paper will only present two definitions enlisted by Canadian policy. Key components of mental health will also be provided, exposing how mental health is conceptualized within Canada.

First and foremost, it is essential to acknowledge the two definitions of mental health that are most often cited in Canadian research. The first definition of importance is from the PHAC (2006), which suggests that mental health is:

the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. (p. 2)

The WHO also provides a significant definition of mental health, endorsed by the MHCC (2012). This definition states that mental health is “a state of well-being in which the individual realizes his/her potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her own community” (WHO, as cited in MHCC, 2012, p. 14).

It is evident that these definitions demonstrate similarities and differences. The difference between these two definitions is primarily rooted in their approach to defining mental health. The definition provided by PHAC (2006) is considered to be a prescriptive
understanding of mental health (Manwell et al., 2015). This approach to defining mental health is unique based on its inclusion of values and morals as key determinants of mental health (Manwell et al., 2015). In contrast, the WHO definition (as cited in MHCC, 2012) is descriptive, as the description defines merely what mental health is believed to be, limiting room for subjective interpretation (Manwell et al., 2015). This distinction, between descriptive and prescriptive definitions, is significant as the definitions approach alludes to the level in which mental health can be inferred and tailored.

While the differences are noteworthy, it is also vital to recognize that similarities exist between the WHO and PHAC definitions. A key similarity between the two definitions is their focus on the ability to cope and deal with challenges in life (PHAC, 2006; WHO, as cited in MHCC, 2012). This similarity highlights the belief that mental health works as a buffer against stressors and hardships, which are a part of everyone’s life (MHCC, 2012). Furthermore, a substantial similarity lies within the notion that mental health is a capacity or a state (PHAC, 2006; WHO, as cited in MHCC, 2012). This element is significant as it promotes the notion that mental health is not fixed, nor stagnant. Instead, mental health is a position of successful mental performance, resulting in productivity, active engagement, and an ability to adapt and cope with challenges (Goldman, & Grob, 2006; PHAC, 2006; WHO, as cited in MHCC, 2012). Evidently, while variations exist within the literature surrounding mental health, it is clear that similarities prevail as key components of understanding.

PHAC (2006) and the WHO (as cited in MHCC, 2012) both provide valuable definitions of mental health. While they are distinct in their approach, they also maintain key similarities. Furthermore, it is evident that mental health is influenced by biological,
psychological, and social factors, reflects more than the absence or presence of mental illness, includes personal perceptions of health, respects cultural interpretations, and is theorized from various paradigms (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; MHCC, 2009, 2012; PHAC, 2006; WHO, 2001). PHAC (2006) and the WHO (as cited in MHCC, 2012) both provide valuable definitions of mental health. While they are distinct in their approach, they also maintain key similarities. Furthermore, it is evident that mental health is influenced by biological, psychological, and social factors, reflects more than the absence or presence of mental illness, includes personal perceptions of health, respects cultural distinctions, and is theorized from various paradigms (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; MHCC, 2009, 2012; PHAC, 2006; WHO, 2001).

With this in mind, for this paper, mental health will refer to a combination of both the WHO definition and PHAC definition. This decision is made based on the belief that both definitions represent valuable insight. Therefore, for the remainder of this paper mental health is defined as a state of well-being in which an individual can feel, think, and act in ways that allow for him/her to enhance their ability to enjoy life, cope with and overcome challenges, work productively, and contribute to his/her community (PHAC, 2006; WHO, as cited in MHCC, 2012). Additionally, it is recognized that mental health highly regards emotional and spiritual well-being by upholding culture, equity, social justice, and the personal dignity of individuals (PHAC, 2006; WHO, as cited in MHCC, 2012). Lastly, it must be highlighted that while mental health and mental illness share roots and similarities, mental health is not merely defined by a presence or absence of
mental illness, nor is mental illness determined by mental health (Manwell et al., 2015; MHCC, 2009; PHAC, 2006; WHO, 2001).

**Linking Mental Health and Mental Illness**

While it is significant to distinguish the unique characteristics of mental health and mental illness, to clarify the terminology used throughout this paper, it is also substantial to outline the parallels that exist between these two terms. These similarities ultimately provide evidence regarding how mental health and mental illness are associated, beyond the notion that mental health and mental illness are often recognized as interconnected according to the research conducted by Manwell et al. in 2015.

The first element of agreement between mental health and mental illness is the belief that mental health and mental illness are both influenced by an array of biological, psychological, and social factors that affect individuals’ mental state and ability to function within their surrounding environment (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; PHAC, 2006; WHO, 2001). While it is acknowledged that various definitions do incorporate additional factors—such as: the environment, genetics, intellectual, emotional and spiritual development, positive self-perception, self-worth, physical health, and/or interpersonal harmony—it is important to note that biological, psychological, and social factors remain consistent (Manwell et al., 2015; MHCC, 2009, 2012). This similarity is significant as it promotes the notion that both mental health and mental disorders can be linked to similar circumstances (Bhugra et al., 2013). This connection, between mental health and mental illness, calls for researchers to consider how biological, psychological, and social circumstances can impact both mental health and mental illness (Bhugra et al., 2013).
Beyond the parallel of underlying circumstances is the belief that positive mental health can reduce the risk of mental illness, and can act as a critical component of the recovery model (Bhugra et al., 2013; MHCC, 2009). This connection is noteworthy as it highlights the relationship between shared biological, psychological, and social influences (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; PHAC, 2006; WHO, 2001). The ability for mental health to reduce the risk of mental illness promotes the notion that the two concepts are, to a degree, dependent on one another (Bhugra et al., 2013). This relates to the idea that mental health and mental illness do not exist on their own (Bhugra et al., 2013).

A final connection, between mental health and mental illness, is found in the widely acknowledged belief that mental health is representative of more than a lack of a mental disorder (Manwell et al., 2015; MHCC, 2009; PHAC, 2006; WHO, 2001). Underlying this perspective it is acknowledged that a mental illness diagnosis does not constitute poor mental health, nor does the lack of a mental diagnosis equate to positive mental health (MHCC, 2009). PHAC (2006) furthers this notion, suggesting that while mental health and mental illness are connected concepts, they must be researched and conceptualized as both related and distinct elements. PHAC (2006) argues that examining the two concepts as separate elements is important as it encourages research and thought regarding the influence of individual characteristics, family, social, cultural, environmental, political, and economic factors on mental health/mental illness. However, it is also significant to research and understand their connectivity as mental health is seen as a buffer to mental illness, and they share similar influential factors (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; PHAC, 2006; WHO, 2001).
Evidently, research highlights key connections between mental health and mental illness. Parallels between underlying circumstances promote the notion that both factors are influenced by similar elements, emphasizing their relationship (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; PHAC, 2006; WHO, 2001). Furthermore, the belief that mental health can act as a buffer, or play a key role in the recovery process, is essential (Bhugra et al., 2013; MHCC, 2009). This connection highlights the need to review the underlying circumstances to enhance both mental health and mental illness congruently. Lastly, it is important to recognize that mental health is not merely the absence of mental illness (Manwell et al., 2015; MHCC, 2009; PHAC, 2006; WHO, 2001). This distinction is key; while the two elements maintain a connection, they are ultimately not the same (MHCC, 2009; PHAC, 2006).

**Well-Being**

Considering this paper is focused on the role of educators in enhancing student mental health and well-being through the promotion of resilience, an explanation of what defines well-being is valued as an essential component of this research. Before engaging in what defines well-being, it is important to recognize how well-being has become embedded within discussions regarding child and adolescent mental health. Weare (2010) reports that well-being emerged within the context of mental health to remove some of the anxiety surrounding the term mental health, and to eliminate some of the misleading and negative connotations that have been attached to discourses surrounding mental health due to the current disease-based undertone of psychology. With this necessity in mind, the following will aim to outline what defines well-being, and the various descriptive components of the term well-being.
First and foremost, it is essential to recognize that like mental illness and mental health, there is ambiguity surrounding what defines and constitutes well-being (Dodge, Delay, Huyton, & Sanders, 2012; Marjanen, Ornellas, & Mäntynen, 2017; Nelson, Tarabochia, & Koltz, 2015). According to Marjanen et al. (2017), ambiguity regarding what defines well-being is rooted in a complex and highly contextual debate. This complexity recognizes that well-being is influenced by political, economic, cultural, and social contexts, the time period, and the scientific or academic field conducting the research (Marjanen et al., 2017). Dodge et al. (2012) indicate that this lack of consensus leads to blurred and overly broad conceptualizations of well-being, eliminating consistency and reliability. This notion of reduced reliability and lack of consistency is particularly important when reviewing academic research and international/national studies as the definition, indicators, and descriptors of well-being that are applied commonly best suit the studies specific intentions, rather than a universal understanding of well-being (Dodge et al., 2012; Marjanen et al., 2017; Nelson et al., 2015).

In an attempt to understand how major research studies define well-being, Marajanen et al. (2017) reviewed four significant studies focused on well-being, which includes consideration of the definitions and indicators of well-being included in UNICEF’s State of the World Children (2013), Child’s Developmental Index (2012), the OECD’s Doing Better for Children (2009), and UNESCO’s Holistic Early Childhood Development Index (2014). According to a review of the four sources, Marajanen et al. (2017) determined that well-being is thematically perceived to be: focused on highlighting what factors increase vulnerability (a deficit approach); fixated on essential needs rather than child rights and desires; primarily based in political, economic, and material understandings; and failed to account for civic life participation, human rights,
discrimination, consideration for war/peace, and environmental hazards. Each of these components represents essential limitations, neglecting to observe the positive aspects of well-being and the various factors that influence well-being. While these themes are all concerning, the overwhelming inclusion of a deficit approach, where the focus is on how children should not be treated, how they are mistreated, and how they are considered to be vulnerable is deemed to be of utmost concern and consistent with the trends in psychology (Marajanen et al., 2017; Nelson et al., 2015; Seligman, 2002). As a result of this recognition and the perspective of Positive Psychology, it is suggested that well-being should instead focus on a strength-based approach, aimed at understanding how children should be treated and how they present their ability to flourish (Marajanen et al., 2017; Nelson et al., 2015; Seligman, 2002).

The desire to represent well-being as a strength-based model, rather than a deficit model is further reflected in research conducted by Dodge et al. (2012), who are credited for collaborating to create an optimistic theory-based formula for well-being. This theoretical formula for well-being, as represented in Figure 1, promotes the belief that individuals with stable well-being possess the psychological, social, and physical resources necessary to meet the psychological, social, and physical challenges they face (Dodge et al., 2012). This theory is rooted in the belief that well-being is not happiness, quality of life, nor an absence of illness, dysfunction, and/or distress; instead, well-being is considered to be the adoption of positive function, the ability to flourish, and the presentation of equilibrium in the face of challenges (Dodge et al., 2012). Ultimately, it is suggested that well-being represents how well an individual copes when facing challenges.
Figure 1. Theory of well-being.
This model is recognized as a stable and acceptable collective theory of well-being based on its inclusion of four essential elements. Initially, this model is celebrated for its simplistic yet all-encompassing formula, promoting this model as simple to understand but not overly simplified (Dodge et al., 2012; Marjanen et al., 2017). This model of well-being is also recognized for its universal qualities (Dodge et al., 2017). According to this strength, it is acknowledged that individuals have unique resources and challenges and that the surrounding cultural, political, economic, and social circumstances will influence the proposed problems and applied resources (Dodge et al., 2012). Furthermore, this approach is credited for its ability to provide a basis for measuring well-being. Lastly, this model is recognized for its optimism, representing the beliefs of Positive Psychology (Dodge et al., 2012; Seligman, 2002). This optimistic approach is rooted in the idea that well-being is a cultivated condition, driven by an individualistic pursuit of well-being (Dodge et al., 2012). This is noteworthy as it empowers individuals’ autonomy to make choices and decisions for the promotion of their well-being (Dodge et al., 2012). While this idea is challenged by the belief that certain conditions are beyond an individual’s control, it does promote that these extraneous circumstances are not permanent. Ultimately, through the provision of appropriate levels of simplicity, universal application, positive values, and the promise of measurability this model is promoted as a comprehensive theoretical formulation for understanding well-being.

Evidently, well-being is viewed as a highly contextual and debated term, influenced by an array of circumstantial conditions. While a broad definition has been advantageous, allowing researchers flexibility, it is also recognized that a lack of
specificity and focus regarding well-being is an alarming disadvantage (Nelson et al., 2015). While it is accepted that well-being incorporates consideration for physical, economic, emotional, psychological, and social aspects it is also a culturally, economically, and socially relevant concept (Dodge et al., 2012; Marjanen et al., 2017; Nelson et al., 2015; Organisation for Economic Co-operation and Development [OECD], 2017). Based on this ambiguity regarding what precisely describes well-being, research by Dodge et al. (2012) is essential as it allows for individual and circumstantial interpretations, while also defining well-being as the ability to experience equilibrium between applied psychological, social, and physical resources and challenges. Ultimately, this definition is significant as it promotes the notion that well-being is a positive, strength-based outcome, that is meaningful for both people and society because it reflects the idea that people perceive their lives to be going well (Nelson et al., 2015). In regards to mental health and well-being, this understanding of well-being is essential as it promotes the concept that psychological well-being represents an ability to combat psychological challenges and demonstrate resilience to persevere efficiently.

**History of Mental Health Within Education: Policy Review**

Moving beyond an understanding of the key terminology and underlying theoretical approach to this specific research, it is essential to explore the emergence of mental health concerns within education. To understand how mental health emerged as a key concern within education, and to appreciate the importance of promoting mental health in schools, it is imperative to understand the influences and motivating factors that have led to the significance of mental health within education. This section will review important policies to demonstrate how mental health and well-being evolved to be a
prominent concern within education. Exploration of significant strategies and priorities, found within crucial policies, will highlight how society’s conceptualization of mental health and well-being is intended to transform. Most significantly, this review will highlight how these policies conceptualize the role of education in promoting, preventing, and treating the mental health and well-being of today’s children and youth. After outlining the key suggestions provided by five influential policy documents, which progressively narrow in scope and intended audience, it becomes clear how mental health and well-being has become an important topic in education. Lastly, this discussion will highlight the key implications of these documents, how they inform the role of education and educators, and how this information influences the necessity for this resource.

**WHO (2001)—Mental Health: New Understanding, New Hope**

The WHO’s (2001) *Mental Health: New Understanding, New Hope* is credited as the policy document that sparked the transformation of mental health as a paramount concern within mainstream society (O’Mara & Lind, 2013). As the first document of its kind and scale, *Mental Health: New Understanding, New Hope* ultimately intends to motivate a societal revolution, whereby those with mental health illnesses are no longer excluded from society or left to suffer in silence and alone (WHO, 2001). According to the WHO (2001) this expression of concern for mental health is largely due to a paradigm shift in the second half of the 20th century as psychopharmacology made significant progress, the human rights movement became an international phenomenon, and social and mental aspects of health were finally incorporated into the WHO definition of health. These factors all contributed to the WHO’s (2001) desire to attend to, and invest in, mental health. Furthermore, the WHO (2001) reports that one-in-four individuals are
diagnosed with a mental illness, yet funding allocations, and policy implications underrepresent the necessity for care. As the first document of its kind and scope, Mental Health: New Understanding, New Hope certainly set the bar for the transformation of how mental health disorders are perceived and treated within society.

In this policy, the WHO (2001) aimed to support the notion that “mental health—neglected for far too long—is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in new light” (p. ix) in order to promote access to quality care, while reducing barriers, and changing the stigma. The argument of neglected care is attributed to the notion that in 2001, 40% of countries reportedly did not have a mental health policy, while 30% did not have a formulated mental health program (WHO, 2001). Perhaps more astonishing is evidence that reports 90% of countries did not have a mental health policy that includes children and adolescents (WHO, 2001).

Evidently, the WHO (2001) emphasized government institutions, across the diverse nations and various level of power, must take responsibility for enhancing the climate of mental health. Recognizing that collaboration is required, and policy is not the solution, Mental Health: New Understanding, New Hope focused on identifying key issues and objectives for various jurisdictions to highlight the role of crucial stakeholders, promote a mental health agenda, and provide guidance (WHO, 2001).

To enhance the climate of mental health disorders, 10 recommendations for action are presented to reduce the stigma and discrimination associated with mental health, while also promoting effective treatment and prevention (WHO, 2001). The 10 recommendations include:

1. provide treatment in primary care;
2. make psychotropic drugs available;

3. give care in the community;

4. educate the public;

5. involve communities, families, and consumers,

6. establish national policies, programs, and legislation;

7. develop human resources;

8. link with other sectors;

9. monitor community mental health; and

10. support more research. (WHO, 2001)

It is evident, from this list, that access to equitable care is of importance to the WHO; however, it is noteworthy that three of the 10 recommendations demonstrate a connection between education and this new understanding and hope for mental health.

The first clear connection to education, as outlined by the recommendations, is to give care in the community (WHO, 2001). This goal emphasizes the significance of the community in revolutionizing conceptualizations of care, and practice of care (WHO, 2001). More specifically, this goal strives to outline the benefits of community-based early interventions, which can dismantle the stigma associated with mental health (WHO, 2001). This relates to education as in many jurisdictions the school acts as a central hub for the community, maintaining a consistent audience for the promotion of awareness and stigma-reducing mental health initiatives (WHO, 2001). Furthermore, school attendance provides an environment where necessary care can be accessed and provided for children and youth (WHO, 2001).
Secondly, the fourth priority outlined, educate the public, directly emphasizes the power of public education and awareness campaigns (WHO, 2001). This goal in particular highlights how education can increase awareness, reduce barriers to treatment, aid in the recovery process, and help maintain the human rights of individuals impacted by mental disorders (WHO, 2001).

Lastly, there is a clear association between education and the eighth goal listed, link with other sources (WHO, 2001). This goal is of significance as it recognizes the belief that mental health cannot be conceptualized from a single framework, nor attended to by a single sector (WHO, 2001). In fact, this recommendation suggests and encourages that community members, resources, institutions, and various government levels collectively participate in the promotion of mentally healthy communities. This goal is significant as it emphasizes the idea that no single sector is responsible for the transformation of mental health, nor are they alone; in fact, a collaborative effort is key to this approach. These three goals are essential to understanding how a new hope for mental health is partially dependent on the education sector. The report emphasizes the authenticity of the education system as a critical contributor to educating the public, while also highlighting the key position of schools in transforming communities, seeing as they are the centre of educational programming. Lastly, while the responsibility of the education system within various nations is given great responsibility to develop new understandings, promote well-being, and reduce stigma, it is also recognized that schools are not alone, and it is partnerships that will make these goals achievable.

The release of *Mental Health: New Understanding, New Hope* by the WHO in 2001 is significant as it was the first document of its kind to conceptualize how a shift in
20th-century thought regarding mental health, and the need to enhance treatment and reduce stigma, demands attention. For education, this policy is significant as it initially contributed to the relevance of mental health and well-being to the classroom. Ultimately, the WHO (2001) believes that “schools are crucial in preparing children for life, but they need to be more involved in fostering healthy social and emotional development” (p. 98), promoting essential life skills, and reducing mental health stigma.

**MHCC (2012)—*Changing Directions, Changing Lives***

In response to the WHO’s 2001) *Mental Health: New Understanding, New Hope*, a mandate was conferred upon the Mental Health Commission of Canada (MHCC) in April of 2012 by the Government of Canada. As a result, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* was produced in 2012. Drawing on the stories, experiences, and expertise of Canadians, the strategy was created with the intention of “improving mental health and wellbeing for everyone and creating, together, a mental health system that can truly meet the needs of all people of all ages living with mental health problems and illness, and their families” (MHCC, 2012, p. 2). The necessity for a conjoined effort was emphasized, and the strategy set out to reduce the stigma around mental health; increase access to equal support, treatment and services; and, commit all efforts towards promoting mental health (MHCC, 2012).

As a milestone in the journey to “bring mental health ‘out of the shadows’” (MHCC, 2012, p. 8) the MHCC (2012) proposes six blueprint strategies:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible;
2. Foster recovery and well-being for people of all ages living with mental health
problems and illnesses, and uphold their rights;

3. Provide access to the right combination of services, treatments, and supports, when and where people need them;

4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners;

5. Work with First Nation, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures; and

6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

Each strategy is supported by multiple sub-priorities, with each sub-priority outlining various recommendations for action. (MHCC, 2012).

This strategy is comprehensive, offering specific priorities for each strategy and recommendations for action to support the implementation of the Changing Directions, Changing Lives strategy.

To enhance the status of mental health within Canada, the MHCC (2012) recommends an extensive list of strategies, priorities, and actions. It is important to remember that proposed strategy within this policy is nationwide. As a result, this document maintains the capacity to influence mental health policy, practice, and implementation across the country, at various organizational levels. While this strategy demands the entire nation to undergo reform, it is important to note that for the context of this research, only the recommendations relevant to education and educators will be explored. By examining each of the strategies provided in Changing Directions, Changing Lives from an educational perspective, the MHCC’s suggestions for educational reform to change the direction of mental health will be revealed.
The first strategy outlined by the MHCC (2012) is centred upon the promotion of positive mental health across all ages, along with the prevention of mental illness and suicide wherever possible. The strategy focuses on the necessity to be proactive, to reduce the need for reactive measures. In particular, this strategy calls for mental health promotion within schools, workplaces, and homes to reduce stigma, prevent mental illness/problems, and promote mental well-being (MHCC, 2012). It appears unanimous that the ability for frontline staff to educate, spread awareness, and intervene, when necessary, must be developed first and foremost to achieve promotion, prevention, and stigma reduction (MHCC, 2012). This strategy highlights the importance of the school, and school system, in providing students and the surrounding population with educational programming aimed at: promoting well-being, preventing mental health problems/illnesses, reducing associated stigma, and enhancing knowledge and accepting for early intervention. While schools are the hub for such awareness among children and youth, it is recognized that workplaces must also acknowledge this responsibility, along with senior care providers. Both of these environments are targeted in an effort to maintain and promote the healthy development of the entire community, including educators. Evidently, the MHCC (2012) recognizes the essential contribution that schools and educators have upon students, while also acknowledging that such a shift is society demands participation from all age groups.

In addition to supporting the promotion of positive mental health, the MHCC (2012) recognizes the necessity to foster the recovery and well-being of Canadians who are living with mental health problems and illnesses. While it is hopeful that prevention efforts will be useful, it is recognized that intervention and treatment are also necessary to
enhance mental health and well-being of the entire population (MHCC, 2012). This strategy requires both policy and practice within Canada to focus on recovery and well-being, in addition to the preventative measures outlined in the first strategy (MHCC, 2012). To successfully achieve this goal, the MHCC (2012) emphasizes the need for the voice of those living with mental illness and problems to be not only heard but also listened to (MHCC, 2012). This is crucial as such attention ensures human rights are upheld, needs are met, and firsthand perspectives are considered (MHCC, 2012). This strategy demands that education not only respond to the need for preventative intervention and education but also recognize the needs of individuals who require additional treatment and care to improve their mental health and well-being. This strategy suggests that policy and practice must collaborate to meet the needs of the communities they serve. It not only is significant for educators to adopt a recovery and well-being framework, but also necessary to value the voices of their students. By utilizing a preventative framework and recovery-based framework, the education system will demonstrate their commitment to support the needs of all students.

Access to the right combination of services, treatments, and supports is undoubtedly a significant step towards enhancing the mental health of all Canadians. For this reason, the MHCC (2012) emphasizes that the availability of support and coordinated services are vital. It is recognized by the MHCC (2012) that increased access is not merely the responsibility of primary healthcare professionals, but rather demands a collaborative effort from a multitude of engaged social services and organizations. Furthermore, the MHCC (2012) emphasizes the significance of peer supports and patient engagement within the prevention, intervention, and treatment process. For education,
this strategy presents two significant implications: coordination and involvement. The coordination element is substantial as it promotes the notion that the responsibility to provide care and enhance the milieu of mental health is a collaborative effort. Within this perspective, it is recognized that under no circumstance is the responsibility of care and/or prevention the sole responsibility of one individual or organization, in fact, collaboration, drawing on various levels of expertise, is encouraged. This is significant for education as it further promotes the notion that the jurisdiction of education is a contributing organization for mental health and well-being, not the sole provider.

Secondly, the involvement of the population receiving the prevention is vital as it dignifies the individual’s human rights and provides an essence of control, enhancing the production of care. Educators and educational organizations must remember that students have valuable voices, which offer unique insight and perspectives. By listening to these voices, during both prevention and treatment efforts, educators can ensure that the strategies they employ are perceived as beneficial to the student population they are intended for. The ability to include students in this learning process and value their input is significant in all aspects of learning, especially when addressing mental health.

The fourth strategy of importance demands equitable service for all Canadians (MHCC, 2012). Within this strategy, it is evident that the MHCC recognizes the multitude of diversity among Canada’s population and the vast geographic landscape of Canada. Not only do the northern, more remote communities require equitable and accessible service, but immigrants, refugees, ethnocultural, and racialized groups also require a level of care that respects the individual and community customs and practices (MHCC, 2012). Additionally, MHCC (2012) pronounces the necessity to meet the needs
of the LGBT community. This strategy ultimately reflects the necessity for the transformation of mental health within Canada to reduce gaps in service and support by strengthening resource availability and enhancing the capacity for services and supports to match the needs of the community (MHCC, 2012). This strategy is crucial as it highlights the notion that prevention, promotion, and intervention strategies/programs must reflect the community they serve. There is no magical singular solution for preventing mental illness/problems, promoting positive mental health, enhancing well-being, or responding/treating mental health needs; therefore, professional discretion is encouraged to ensure that the utilized practices meet the needs of the student body they are intended for.

Acknowledgment of the unique circumstances, rights, and cultures of First Nation, Métis, and Inuit people is especially significant when considering the context of mental health within Canada. The MHCC (2012) recognizes the distinct needs and cultural circumstances of the Aboriginal population within Canada. Ultimately, the necessity to increase access to mental health care and preventative efforts is outlined (MHCC, 2012). Furthermore, incorporating a continuum of mental wellness services, which include traditional, cultural, and mainstream services, is of importance (MHCC, 2012). This strategy demands Canada to consider the needs and cultural practices of the Aboriginal population (MHCC, 2012). For education and educators in Ontario, this is significant as it highlights the necessity for policy and practice to reflect the unique needs of the student body and community that it services, and also recognizes service gaps and the necessity for culturally responsive practice.
Strategy six—mobilize leadership, improve knowledge, and foster collaboration at all levels—is significant to education mainly based on its desire to foster policy development and enhance knowledge exchange across Canada (MHCC, 2012). Citizens trust government institutions, and it is expected that their decisions and policy represent well-informed evidence-based practice. Based on this belief, it is crucial that the various organizations, government bodies, and institutions involved in enhancing the milieu of mental health are willing to collaborate. This collaboration is important not only to improve care within communities but also to strengthen practice and policy. Certainly, this strategy demands a response from the education sector. It is not only expected that the education sector creates and enforce policy for the enhancement of mental health in children and youth, but also that the various jurisdictions of education collaborate, across and within borders, to share what works. The mindset “better together” certainly applies for this strategy, encouraging collaboration from a variety of organizations, diverse populations, government systems, and professionals for the enhancement of mental health in Canada.

The MHCC’s (2012) Changing Directions, Changing Lives: The Mental Health Strategy for Canada outlines an extensive list of strategies, sub-priorities, and recommendations for Canada to implement to change the direction of mental health and enhance the well-being of Canadians. These recommendations offer unique insight for each of the various regions and government bodies of Canada to consider and implement. For the education sector, the provided strategies provide significant information regarding the best approach to transforming mental health and well-being for children and youth. For education, this document is significant as it outlines Canada’s overarching
goals to enhance mental health and well-being, and in many ways influences the role that the education system will have in achieving this transformation.

OMHLTC (2011)—Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy

On a provincial level, the momentum to transform mental health in Ontario is continued through Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy, a document released by the Ontario Ministry of Health and Long-Term Care (OMHLTC) in 2011. Based on the principals of respect and understanding; person-directed services; excellence and innovation; healthy development, hope, and recovery; diversity, equity, and social justice; and accountability, Open Minds, Healthy Minds aims to positively transform the mental health climate in Ontario (OMHLTC, 2011).

The OMHLTC (2011) ultimately envisions Ontario as a place where all people maintain the opportunity to thrive and enjoy good health and well-being. The OMHLTC (2011) also encourages a society in which individuals can recover and actively participate in a welcoming and supportive community. With these central goals in mind, the province enlisted four priorities for the enhancement of mental health in Ontario. The key priorities outline the province’s commitment to:

1. improve the mental health and well-being of all Ontarians;
2. create healthy, resilient, inclusive communities;
3. identify mental health addition problems early and intervene; and
4. provide timely, high quality, integrated, person directed and other human services.

(OMHLTC, 2011)
Evidently, not only is the promotion of positive mental health and wellbeing important, but treatment and the encouragement of recovery are also held in high regard.

The initial goal, improve mental health and well-being for all Ontarians, is primarily rooted in the belief that excellent mental health resources enhance quality of life, contributing to citizen productivity, improved health, advances stress management, supportive relationships, increased self-confidence, and the establishment of productive coping strategies (OMHLTC, 2011). To achieve this goal, the OMHLTC (2011) acknowledges that the foundation for good mental health must be laid early in life, encouraging early identification, a reduction in associated stigma, and the development of supports in children and youth. Furthermore, improvements in mental health literacy, the development of resilience, and increases in mental wellness are endorsed as beneficial for all Ontarians, if provided through skill development and educational awareness (OMHLTC, 2011). Lastly, Open Minds, Healthy Minds recognizes that improvements to mental health and well-being are equally significant in the workplace, encouraging the development of workplace programs and policies (OMHLTC, 2011).

Beyond enhancing personal health and well-being Open Minds, Healthy Minds recognizes the need to transform the community environment. To achieve healthier, resilient, and inclusive communities the province indicates their desire to reduce stigma through awareness, improve housing and employment support through a reduction in barriers, and create community-based services for the promotion of healthy communities (OMHLTC, 2011). This goal is primarily focused on the power of anti-stigma efforts, support for those with mental health problems/illnesses, and the promotion of community hubs intended to provide activities and services based on the areas unique needs (OMHLTC, 2011).
The focus on early identification and intervention is primarily focused on enhancing the capacity of first responders, school-based personnel, and family healthcare services (OMHLTC, 2011). This objective is engrained in the belief that front-line staff must be educated to recognize symptoms and respond accordingly. There remains a particular interest in training school personnel, as these individuals often recognize the first signs and can intervene early. It is recommended that mental health literacy and cross-sector training is provided, along with enhanced access to resources within schools and through community agencies (OMHLTC, 2011).

While promotion, prevention, early identification, and intervention are favourable responses, the province also recognizes the need to provide timely, high-quality, integrated, and person-directed services to its citizens (OMHLTC, 2011). Under this objective, it is recognized that community hubs must be well equipped to educate, respond, and collaborate within the community (OMHLTC, 2011). Here it is understood that mental health is not a quick fix, nor does the responsibility rest on one community, agency, organization, government body, or institution. Rather, it is recognized that achieving these goals will require collaboration from the community to enhance the milieu of care, services, and promotion of mental health.

The Child and Youth Mental Health Strategy. Acknowledging the scale of the four established priorities the province decided to initially exert all efforts on improving the mental health system for children and youth (OMHLTC, 2011), this 3-year focus encouraged the province to create The Child and Youth Mental Health Strategy, rooted in the goals of Open Minds, Healthy Minds, but with a smaller age-directed scope. The province expresses that 70% of adults report their mental health problems and symptoms originated during childhood and adolescence but were not met with the appropriate
treatment and care (OMHLTC, 2011). Based on this information, the OMHLTC (2011) determined that targeting child and adolescent mental health is most beneficial, as early identification leads to better outcomes, improved school attendance and achievement, a higher capacity to contribute to society, and reduction in social service cost (healthcare, justice system, and social services). To provide the best start to life, and enhance the mental health and well-being of children/youth the province set its focus on: improving access to high-quality services for children, youth, and their family; identifying and intervening in mental health and addiction issues early; and closing critical service gaps for children and youth (OMHLTC, 2011).

In order to provide children, youth, and families with fast access to high-quality services OMHLTC (2011) outlines the provinces commitment to: monitor service wait times, build the capacity to meet local demands, instil a waitlist strategy, increase funds to mental healthcare resources, hire more youth mental healthcare workers, construct a directory of services to help individuals navigate the system, and promote links between education, healthcare, and community for holistic care. To enhance early identification and intervention, the province heavily placed responsibility on the education sector. Not only is it seen as pivotal that people who work with children and youth have the tools and knowledge to identify and respond to issues appropriately, but the education system is also encouraged to enhance the province’s curriculum for further inclusion of healthy development and increased mental health (OMHLTC, 2011). Furthermore, the OMHLTC (2011) encouraged the Ontario Ministry of Education to create a resource guide for education focused on early intervention and prevention, along with the suggestion that schools provide appropriate mental health programs and services.
With a less isolating focus on the education system, the need to close the service gap demands the context of mental health within society to transform for the promotion of culturally appropriate services which benefit aboriginal populations, underserviced communities, and those with high needs (OMHLTC, 2011). Beyond these demands, the OMHLTC (2011) promoted the creation of 18 service collaborations to support coordinated care for children, youth, and adults. Lastly, it is recommended that the gap between secondary school and post-secondary school services be eliminated, and services for eating disorders expanded. Between the expansion of knowledge for early intervention and prevention, the establishment of integrated supportive care, and reduction in barriers the OMHLTC (2011) aims to improve the conditions of mental health and well-being in children and youth, paving the way for future work that must be done.

**Open Minds, Healthy Minds in conclusion.** The OMHLTC evidently demonstrates a comprehensive approach to transforming the circumstances of mental health and well-being in Ontario. Commitment to enhancing the mental health and well-being of all Ontarians; creating healthy, resilient, and inclusive communities; identifying and intervening early; and providing top-of-the-line services is ambitious and requires cooperation from various agencies, organizations, community members, and institutions. The decision to focus on children and youth first demonstrates the necessity to start young, however, achievement of each goal, at every age-level, is necessary to enhance the mental health and well-being of our communities and all citizens. The primary focus on children and youth demands immediate action from the education system, which arguably maintains the most consistent and direct relationship with children and youth.
While the focus on children and youth was given a 3-year timeline, it is essential to acknowledge that an expiration date does not confine societies commitment to the mental health and well-being of children.


*Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy*, published 2011, supports the province’s initial 3-year focus, on enhancing the climate of mental health and well-being for children and youth in Ontario. *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being*, published by the Ontario Ministry of Education (2013), is in response to the province’s declared concentration on the mental health and well-being of children and youth. This document intends to provide educators with the vital information they require to support student mental health and addictions problems through early recognition and effective classroom strategies (Ontario Ministry of Education, 2013). This responsibility of education to enhance mental health and well-being is supported by the notion that educators play an essential role in the lives of most children and youth, and maintain the duty to meet the needs of all students while promoting safe and accepting learning environments (Ontario Ministry of Education, 2013). It is emphasized that collaborating for the treatment, intervention, prevention, and support of student mental health and well-being is a central responsibility of education (Ontario Ministry of Education, 2013).

To clearly outline the key responsibility of educators to enhance child and youth mental health and well-being, three leading roles are provided by the Ontario Ministry of Education (2013), including: promoting positive mental health at school, identifying
students who have mental health problems; and connecting those students (with mental health problems) to the appropriate services. To aid educators in this process, Supporting Minds (2013), derived from Open Minds, Healthy Minds (OMHLTC, 2011), was created with the intention of helping educators to: better understand the context of mental health for promotion; recognize distress and support the pathway to care; better understand the signs, symptoms, causes, and frequency of mental health; understand the impact of mental health on learning; and realize strategies for supporting academic and social development. The following will aim to unpack this document to acknowledge how Supporting Minds influenced the context of mental health and well-being within schools. It is important to note that the Supporting Minds document is broken down into two key sections. Exploration of the different parts, within the text, will highlight the Ontario Ministry of Education’s direction in regard to supporting mental health.

The first section, dedicated as the Introduction, is separated into two parts: (a) understanding child and youth mental health and addiction problems, and (b) promoting the role of educators in support students’ mental health and well-being (Ontario Ministry of Education, 2013). Within part A, the primary focus appears to be centred on the notion of enhancing educator awareness of mental health and addiction problems within youth. On the contrary, part B acknowledges the necessity to create a positive classroom environment and reduce the stigma associated with mental health (Ontario Ministry of Education, 2013). It is repeatedly emphasized that educators maintain a unique role, and therefore, the promotion of mental health and healthy development, reduction in stigma, and maintenance of safe-accepting physical and social learning environments are emphasized (Ontario Ministry of Education, 2013). To promote positive mental health
and development, 16 factors, as suggested by the Joint Consortium for School Health in 2011, are provided. This list includes: identification and effective management of emotions; promote normal and healthy development; exploration and use of child/youth strengths and capacities; develop meaningful relationships; enhancement of coping and problem-solving skills; construct a meaningful learning environment; increased participation; enhanced respect and appreciation for diversity and differences; understanding and destigmatizing mental health; opportunities for autonomy and developmentally appropriate choice; heightened sensitivity to the needs of others; increased involvement in unstructured recreational opportunities; reduction in high risk behaviours; increased academic achievement and attendance; decreased oppositional behaviour; and, increased academic confidence and engagement (Ontario Ministry of Education, 2013). While it is recognized that teachers spend 6-plus hours a day in school, 190 days a year, and already maintain a significant role in the promotion of healthy development, there is little information provided regarding how educators can achieve these 16 pillars of healthy development and positive mental health. Possibly more troubling is the fact that 16 strategies for the promotion of healthy development and mental health are provided; yet, the list does little to support how to achieve these strategies within the learning environment.

In both complement and opposition to the first section of the document the second section, the most elaborate section of Supporting Minds, is dedicated to recognizing and responding to mental health problems among students. This section relies heavily on the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders (DSM) to provide educators with the necessary information to understand and
recognize the most common diagnosis related to mental health. This section ultimately offers eight subsections, each dedicated to a different diagnosis. The diagnosis or mental health problems which are explored in *Supporting Minds* include: anxiety, mood problems (depression and bipolar disorder), attention and hyperactivity/impulsivity problems, behaviour problems, eating and weight-related problems, substance use problems, gambling, and self-harm and suicide (Ontario Ministry of Education, 2013). Within each of the eight subsections details regarding what the diagnosis is, common look-for symptoms, appropriate educator response, and relevant background information are provided. Evidently, the Ontario Ministry of Education (2013) undoubtedly aims to provide educators with crucial information regarding the early identification of various mental health and addiction problems, while also providing avenues to support student success further.

It is suggested throughout *Supporting Minds* that an educator’s key role is to promote awareness, prevent mental health complications, provide early intervention, and connect students to the appropriate community care agencies (Ontario Ministry of Education, 2013). However, it appears that the document overwhelmingly maintains a limited scope, focused on building teacher capacity for identification, and intervention. This focus, unfortunately, neglects to recognize of how educators can promote awareness, reduce stigma, increase resilience, and prevent mental health complications proactively. While it is acknowledged that an understanding of mental illness is important, this focus appears to be limited, inhibiting the ability for educators to promote resilience, enhance well-being, and destigmatize mental health.

Achieving Excellence: A Renewed Vision for Education in Ontario, published in 2014 by the Ontario Ministry of Education, is another significant policy document that contributes to the transformation of education for the inclusion of mental health and well-being. The Achieving Excellence document follows Reach Every Student: Energizing Ontario Education, as a means of establishing clear provincial priorities within public education. In Reach Every Student, published in 2008, the Ontario Ministry of Education listed three core goals for the province to implement, including: increased student achievement, closing gaps in student achievement, and increasing public confidence in publically funded education. It is evident from the pre-existing list of priorities that the province was mainly concerned with literacy and numeracy scores, graduation rates, barriers to success such as diversity, and public trust/engagement in the education system (Ontario Ministry of Education, 2008). However, in 2014 Reach Every Student was replaced by a renewed vision for the core priorities in education emerged through Achieving Excellence.

According to the Ontario Ministry of Education, in 2014, the province enlisted to create an education system, which aids students in the development of essential knowledge, skills, and characteristics that will prepare them to be personally successful, economically productive, and actively engaged as citizens. Furthermore, and perhaps most significant for this discussion, the Ontario Ministry of Education (2014) “committed to the success and well-being of every student and child” (p. 1). This significant shift represents and responds to the changing landscape of mental health within society. To
further proclaim their commitment, the Ontario Ministry of Education also redefined their key priorities for publically funded education within Ontario. The province’s newly established priorities represent this adjustment: achieving excellence, ensuring equity, promoting well-being, and enhancing public confidence (Ontario Ministry of Education, 2014). To provide a well-rounded picture of education within Ontario, the four priorities listed in *Achieving Excellence* will be further explored. This will promote an understanding of the expectations placed upon the education system.

The first goal listed, and the goal that directly reflects the name of the Ministry’s document, is achieving excellence. This goal, as it states, is primarily rooted in aiding students to attain academic achievements, allowing students to acquire valuable skills and demonstrate good citizenship for the jobs of tomorrow (Ontario Ministry of Education, 2014). This goal emphasizes that the role of the education system is to aid in the development of future citizens which are better prepared to adapt, achieve, and excel in society thanks to enhanced student engagement and the development of higher-order thinking skills (Ontario Ministry of Education, 2014). According to the Ontario Ministry of Education (2014), the integration of technology and development of key characteristics, such as: perseverance, resilience, imaginative thinking, compassion, and empathy, are essential for lifelong success. In addition to student growth and development, the provincial government recognized the necessity for educators and support staff to engage in relevant, inspiring, and applicable life-long learning opportunities for the benefit of student engagement and success (Ontario Ministry of Education, 2014). Undoubtedly, the province of Ontario strives to foster the education and development of future citizens capable of employing functional skills and higher-
order skills for the opportunities of tomorrow. While this is a key goal for the education system, it is imperative to recognize that the achievement of excellence is mainly dependent on the subsequent goals, including: assurance of equity, promotion of well-being, and maintenance of public confidence.

The province’s goal to ensure equity is primarily founded on the fact that Ontario recognizes diversity as one of its key assets (Ontario Ministry of Education, 2014). Justification for this priority is rooted in the belief that regardless of “ancestry, culture, ethnicity, gender, gender identity, language, physical and intellectual ability, race, religion, sex, sexual orientation, [and] socio-economic status” (Ontario Ministry of Education, 2014, p. 8), students must maintain the ability to achieve. The Ontario Ministry of Education (2014) is hopeful that all students will be inspired to reach their full potential, free of obstructions and barriers. To achieve this goal, the Ministry (2014) promotes a shift from tolerance and celebration to inclusivity and respect. This priority is of importance, as the education system must respect and include the diversity its staff and students represent to eliminate barriers and create safe learning spaces.

The addition of promoting well-being, as a critical priority in education, is significant as it recognizes, for the first time, that educators maintain a vital role in the promotion and development of student well-being. This goal focuses on the belief that educators and the education system must support the development of the whole child, including academic, social, emotional, cognitive, and physical well-being (Ontario Ministry of Education, 2014). What is interesting about this commitment is the province’s emphasis on the impact well-being has on academic achievement through the promotion of resilience (Ontario Ministry of Education, 2014). As a result of this commitment, the province proclaimed their desire to foster a positive sense of self, sense
of belonging, emotional intelligence, and the necessary skills to make healthy choices (Ontario Ministry of Education, 2014). For the first time, well-being, and a holistic definition of health, is recognized as a key priority for educators, educational personnel, and the education system within Ontario.

Enhancing public confidence represents the continuation of a previously established goal in education, demonstrating its longevity as a priority. According to the Ontario Ministry of Education (2014), this priority is focused on maintaining and enhancing the public education system to be sustainable, responsible, accountable, and transparent. To achieve this goal, the province recognizes the necessity to make decisions based on evidence-based research, and in collaboration with community stakeholders. The Ontario Ministry of Education (2014) ultimately believes increased Education Quality and Accountability Office (EQAO) results (the province’s standardized mathematics and literacy test) and improved graduation rates are indicators of success, contributing to confidence in the education system. Ultimately, the Ontario Ministry of Education (2014) maintains their role as a public service, acknowledging the necessity for civil cooperation, and support.

Evidently, the key priorities outlined in Achieving Excellence represent a renewed vision for education within Ontario. The establishment of the four renewed goals: achieve excellence, ensure equity, promote well-being, and enhance public confidence, reveal the desire for public education to focus on the future of society. In Achieving Excellence, each of the prior existing goals underwent significant adaptation and promoting well-being was added as a new priority. These changes are significant as they represent the Ontario Ministry of Education’s commitment to student health and well-being.
While the renewed goals for education within Ontario do represent a progressive change, it is important to acknowledge that these goals are not flawless. One of the shortcomings within *Achieving Excellence* is the document’s failure to include variations in mental health and wellness in the ensuring equity priority. It is imperative that the province does not see mental health as an addition to education, but rather as a key element embedded within education. In addition to this shortcoming, it appears that the Ontario Ministry of Education has transformed its key priorities, its measurement of the educations system success, yet, they do not appear to acknowledge the promotion of well-being as no measure seems to be provided to ensure this goal is maintained. Lastly, and perhaps most interesting for this discussion, is the fact that the promotion of well-being goal does not explicitly include the development of mental health. Considering the majority of the policy changes are focused on the enhancement of mental health and well-being, it is contradictory to see this neglected in the province's goals for education.

**Implications for Practice**

Each of the policies, as outlined above, provide significant insight for the improvement of mental health and well-being throughout society. For this discussion, it is most important to acknowledge how these goals fit into the landscape of education and the impact they have on the role of the educator. Based on the information provided, three significant themes are recognized for their impact on how education should respond to this societal shift. The following will outline these three themes, and their connection to the various policies, to highlight the influence they have on the role of the educator.

First and foremost, it is important to recognize that attention to the mental health and well-being of children and youth is evidently a key priority. It is speculated that this
initial aspiration comes from the WHO (2001) report, which stated that 90% of countries do not have a mental health strategy inclusive of children and youth. The MHCC (2012) also promotes a focus on youth based on its belief that early intervention is necessary to prevent the development of poor mental health and mental illness. Furthermore, the MHCC (2012) also promotes the notion that a focus on children and youth will contribute to a societal shift as the younger generation grows (MHCC, 2012). The OMHLTC (2011) supports this focus most explicitly as this document announces a 3-year focus on children and youth within Ontario, and supports this notion by publishing the Child and Youth Mental Health Strategy in Ontario. The Open Minds, Healthy Minds document is also acknowledged as a key response from the Ontario Ministry of Education. This is seen in Achieving Excellence (2014) and Supporting Minds (2013), which aim to highlight the necessity for education to revamp and introduce strategies and policies for the promotion and recovery of mental health and well-being among children and youth. Evidently, whether the reason is a lack of adequate attention, prevention efforts, or early intervention it is clear that one thing is consistent: Children and youth are at the centre of this societal shift to improve the mental health and well-being of communities.

The clear focus on children and youth, along with the necessity to educate for promotion, prevention, and treatment lead to the next essential theme that is withdrawn from the above policies—the role of education. The WHO (2001) was the first to suggest the critical role that education maintains as it highlights the priority to educate the community and provide care within the community to reduce stigma, increase awareness, enhance recovery, and reduce unnecessary barriers to treatment. According to the WHO (2001), the education system not only maintains access to children and youth but also commonly acts as the hub of communities, enhancing their ability to promote, prevent,
and treat. Although the suggestions provided are broad in application, this notion is further supported by the MHCC (2012), as the strategy indicates that prevention, recovery, coordinated care, equitable access, culturally responsive care for various populations, and improvements in knowledge/research are significant within the context of education. These goals are then transformed into an Ontario context by the OMHLTC (2011), which set out four goals, and then distinguished them for children and youth with the creation of the Child and Youth Mental Health Strategy.

Within this strategy it became apparent that an educator’s role is to improve the mental health and well-being of children and youth by identifying and intervening early, reducing stigma, enhancing support, and aiding in the development of healthy resilient communities (OMHLTC, 2011). These ideas were then replicated by the Ontario Ministry of Education through Supporting Minds (2013) and Achieving Excellence (2014), which strive to embed mental health and well-being into the educational milieu. Where these two strategies differ is regarding their distinct focus on mental illness and the promotion of mental well-being. While both are important, the documents identify different intentions and focus. Evidently, each of the contributing policies and strategies outlined provides suggestions regarding how education can enhance the milieu of mental health and well-being. While each of the policies pertains to varying scales of society, it is important to note, that consistent among all of the documents is the necessity for education to assist in the promotion of well-being, reduction of stigma, prevention of poor mental health, and access to treatment.

While the education sector is identified as a critical respondent to the transformation of mental health and well-being within society, particularly in regard to children and youth, it is essential to acknowledge that the theme of collaboration emerged
throughout the policies reviewed. This particular theme is explicitly listed by the WHO (2001) and MHCC (2012) and also alluded to by the OMHLTC, and the Ontario Ministry of Education in Achieving Excellence (2014) and Supporting Minds (2013). It is emphasized through the five policies that educators must acknowledge they are not solely responsible for the prevention, promotion, and treatment of mental health and well-being. In fact, educators must recognize they are a part of a broader community, which must work together to enhance mental health and well-being among children and youth (Ontario Ministry of Education, 2013). This recognition is particularly important, as educators are not healthcare providers or experts in mental health. The role of educators, as outlined by these policies, is to implement preventative efforts to enhance mental health, promote well-being, identify risk factors and early signs, and connect students to the right supports. Under no circumstance are educators alone in this mission, as they are encouraged to rely on established systems of care, and advice from others.

Each of the policies explored articulate the necessity to transform the perception and condition of mental health and well-being within society. It is evident that the mental health and well-being of children and youth is a significant ambition. Based on this focused demographic it is evident that the education system is intertwined in this effort; however, it is recognized that educators are not the only individuals responsible for this transformation. In fact, the promotion of well-being, prevention of poor mental health, reduction in stigma, provision of treatment, and recovery efforts demand society to collaborate, by drawing on expertise to enhance the mental health and well-being of all individuals.

Conclusion

In response to the plethora of imperative strategies, policies, and priorities that
have been published by the WHO, MHCC, OMHLTC, and the Ontario Ministry of Education, over the past 16 years, it is apparent mental health and well-being have become an extraordinarily significant subject of focus throughout society. Undoubtedly, this newfound commitment to transforming the landscape of mental health and well-being within society has demanded changes to societies approach to prevention, treatment, identification, understanding, and stigma. While these changes are occurring on a global, national, provincial, and municipal scale it is also important to recognize that these changes have influenced the landscape of education as this sector is viewed as a key respondent to the care, well-being, growth, and development of children and youth. Ultimately, education is a crucial contributor to promoting positive mental health, preventing mental illness, reducing stigma, early intervention, and treatment (MHCC, 2012; Ontario Ministry of Education, 2013, 2014; OMHLTC, 2011).

**Child and Adolescent Mental Health and Well-Being in Education**

As policymakers, researchers, and educators continue to enhance their understanding of child and adolescent mental health, mental illness, and mental well-being it is increasingly clear that mental health concerns are on the rise (Flett & Hewitt, 2013; Santor et al., 2009). Not only does the evidence indicate an interest in those with diagnosed clinical and sub-clinical mental health/illness, but attention must also be paid to enhancing the mental health and well-being of all children and adolescents (Dassanayake, Springett, & Sherwring, 2017). This focus demands contributions through both reactive repossesses (intervention and treatment), and proactive responses—prevention and promotion based efforts (Dassanayake et al., 2017; Santor et al., 2009). The desire to enhance the mental health and well-being of all children and youth has led
to the identification of the school as a preferred environment (Dassanayake et al., 2017; Manion et al., 2012; Santor et al., 2006). While discussion reviewing key policy documents, within the context of Canada and Ontario, has outlined the suggested role of educators and schools in the promotion, prevention, identification, and treatment of mental health and well-being, this section will aim to promote an understanding of why schools are targeted environments, and why educators are seen as crucial contributors to enhancing student mental health and well-being.

Educators’ Contributions

While exploring the contributions of schools concerning student mental health and well-being it is equally important to understand the context of how educators and educational personnel perceive they can enhance the mental health and well-being of students. The following section aims to promote an understanding of why educators are central to the inclusion of mental health and well-being initiatives for students, the current context of such supports, and how educators and the education system perceive they are involved in mental health initiatives.

Initially, it is important to note that educators already work on a daily basis with students who are experiencing poor mental health, reduced well-being, and mental illness (Santor et al., 2009; Schwae & Rodger, 2013). While educators are already engaged in such responses, a self-reported measure indicated that only 67% of teachers feel prepared to support and promote the mental health and well-being of their students (Schwean & Rodger, 2013). This statistic is concerning as it demonstrates the notion that a significant portion of teachers are attempting to support their students without the necessary supports, and tools required to do so efficiently. While teachers maintain the duty to
participate in student treatment and support Individual Education Plans, it is recognized that the quest to enhance student mental health and well-being requires proper training and awareness (Schwean & Rodger, 2013). Furthermore, it is advised that professional development opportunities and educational reform must seek to advance supports for all students, extending beyond efforts targeted only at students who are clinically diagnosed or formally identified (Schwean & Rodger, 2013).

To further understand the current status of the school board and educators’ concepts of student mental health and well-being, Manion et al. (2012) cite a Canadian-wide study where 383 school boards across Canada were asked to have one representative from the board level and one representative from each school complete a survey. In total, 177 school boards and 643 schools responded to the survey (Manion et al., 2012).

From the 177 school boards that responded, it was reported that 85% of board officials are concerned with student mental health and substance use/abuse, identifying the following concerns in order of importance: attention, learning, substance use/abuse, anxiety, and bullying (Manion et al., 2012). Board level respondents indicated that further protocol development, community collaboration, and professional development opportunities, in addition to the existing success of team collaboration, are necessary to enhance capacity to meet the needs of students (Manion et al., 2012). When asked to identify the role of school boards in meeting the needs of their students it was overwhelming reported that school boards emphasized their role in intervention efforts (Manion et al., 2012). Evidently, while school boards are concerned with the mental health and substance use of their students, it is clear that school boards are most concerned with intervention and treatment efforts (Manion et al., 2012).
Alternatively, the school-level respondents indicated unique concerns regarding the mental health needs of students. According to the data collected, 65% of educators are severely concerned with mental health and substance abuse among their students, indicating concerns over attention, learning, anxiety, depression, substance use, and bullying (Manion et al., 2012). Additionally, 80% of respondents believe that an unmet need exists, revealing the following barriers to supporting student mental health and well-being: lack of funds, limited service availability and support staff, high stigmatization, lack of parent/guardian engagement and awareness, limited professional development opportunities, and reduced access to promotion/prevention efforts (Manion et al., 2012). It is clear that educators are increasingly concerned with mental health problems, over substance use and abuse problems, and are most interested in preventative care, versus intervention efforts (Manion et al., 2012).

Evidently, while many similarities exist between board-level responses and school-level respondents, it is clear that distinctions also exist. Educators appear to be more focused on mental health concerns, and interested in preventative and promotion efforts, while board-level representatives seem most concerned with substance use/abuse and are concentrated on treatment (Manion et al., 2012). This demonstrates an apparent gap in understanding between policymakers and policy implementers in Canadian schools. The discrepancies and results ultimately promote the notion that organizational limitations must be addressed, professional development must be increased, evidence-based practices must be promoted, and enhanced partnerships must be fostered (Manion et al., 2012). While it is acknowledged that educators play a crucial role in mental health
and well-being promotion, prevention, early identification, and intervention, it is evident that improvements are necessary to support educators in this role.

**Schools’ Contributions**

Increasing recognition of the prevalence of mental illness, and necessity to promote mental health and well-being, while preventing mental illness and distress, has led to the identification of the school as a health-promoting environment (Dassanayake et al., 2017; OECD, 2017). This shift is accredited to the WHO’s belief that schools should “aim to produce students with a state of complete physical, mental, and social well-being” in combination with the belief that schools are only second to family in promoting development (Dassanayake et al., 2017, p. 221; see also Schwean & Rodger, 2013). The following will outline key evidence for the school, as a vital environment for the promotion of mental health well-being.

**Impact of Inhibited Development.** A principal argument for the incorporation of mental health and well-being prevention, promotion, and intervention in schools is rooted in the belief that mental health development starts in childhood and is fundamental to overall health, well-being, and active participation (Schwean & Rodger, 2013). The early development of mental health is considered to be essential, as social-emotional and behavioural competencies impact all aspects of childhood development, including: school readiness, attendance, academic achievement, familial relationships, school and peer connections, and focus (MHCC, 2013; Millar et al., 2013; Schwean & Rodger, 2013). This belief is supported by the fact that 14% of school dropouts are linked to mental illness, and those with mental health problems miss approximately 40% more school than their peers (Schwean & Rodger, 2013). Additionally, the association between poor mental health and academic achievement is significant as reduced performance is
associated with limited employment opportunities, inadequate financial independence, and inhibited health (Schwean & Rodger, 2013).

**Access to care.** In addition to recognizing how poor mental health, mental illness, and reduced mental well-being contribute to significant impairments in development and academic success, consideration of treatment access reveals a substantial justification for the inclusion of mental health and well-being initiatives within schools. This justification is heavily rooted in the belief that schools are in a significant position to reduce substantial discrepancies between the need for mental health initiatives and the services available (Dissanayake et al., 2017; MHCC, 2013; Schwean & Rodger, 2013). It is understood that many children do not gain required access to treatment based on the necessity for adult referral and reliance on adults to access care (Schwean & Rodger, 2013). It is reported that 96% of students who are offered school-based services initiate treatment, however, only 13% of students referred for community-based services follow up with the provided referral (Schwean & Rodger, 2013). Additionally, Millar et al. (2013) and O’Mara and Ling (2013) report that 75-80% of students already receive treatment through initiatives and services coordinated by the education system. As schools maintain consistent access to students for a large portion of the day, foster the development of vital relationships between staff and students, and often play a role in reducing associated stigma the school is recognized as a critical environment for providing access to necessary treatments and care (Manion et al., 2012, Maras, Thompson, Lewis, Thornburg, & Hawks, 2015). Certainly, schools are unique environments that can address both the mental health and mental illness needs of students.

**Environmental conditions.** Beyond the recognition that schools are essential environments for shaping early development, and natural sites for access to treatment
programming and care, the school environment is also favoured for its wide-scale approach to improving mental health and well-being. This notion is heavily rooted in the belief that children and youth naturally spend the majority of their time in school (Millar et al., 2013). This perception emphasizes the belief that schools can promote the mental health and well-being of all students, versus focusing solely on students who are diagnosed or identified for having an increased risk of developing a mental illness (Manion et al., 2012).

It is suggested that the school setting and education system can be altered to foster an environment that aims to prevent, promote, identify, and treat the mental health and well-being needs of children and adolescents (Manion et al., 2012; Millar et al., 2013). Manion et al. (2012) emphasize the ability for schools to improve well-being by enhancing emotional and behavioural coping strategies within children and youth through awareness, skill development, modeling, implementation opportunities, and self-reflection. Furthermore, it is recognized that schools are naturally trusted resources for students, families, and caregivers as the school is often perceived as a support centre, and offers an innate ability to build trustworthy, and caring relationships with students, families/caregivers, and the surrounding community (Millar et al., 2013). Lastly, it is recognized that access to support, provided through the education system, can significantly reduce financial barriers, allowing for prevention, promotion, and treatment efforts to be equitable and accessible (Millar et al., 2013). The school environment maintains the conditions to enhance mental health and well-being, while reducing potential barriers to treatment, support, and promotion.

It is evident that schools, educators, and the education system are in a vital position to promote the health and well-being of all students. Not only do schools
maintain continuous access to all students, but they also maintain the position to foster the promotion, prevention, intervention, and treatment of child and adolescent mental health and well-being in an equitable environment. Providing these conditions, in a way that promotes equal access, is essential as schools maintain a fundamental position to enhance the mental health, well-being, and resilience of their students.

**Current Status of Child and Adolescent Mental Health**

To appreciate the recommendation for mental health and well-being initiatives to be implemented within schools it is paramount to provide evidence surrounding the current context of this issue within children and youth. To present a clear picture of the concerns surrounding the mental health and well-being of children/youth, the following section will explore the prevalence of mental illness, and challenges caused by early onset, treatment barriers, and resulting financial implications. This evidence will ultimately highlight the necessity for mental health promotion and prevention efforts to be implemented within schools. Additionally, this section will examine sub-clinical mental health and well-being concerns including disguised distress, superficial suffering, and emotional distress. The aim of this section is to promote the necessity for schools to adapt mental health and well-being as a key priority as suggested by an array of policy suggestions. More specifically, it is hopeful that this information will endorse the necessity for whole-school prevention and promotion efforts to enhance overall mental health and well-being, and encourage the development of resilience among students.

**Prevalence Rates**

Perhaps the most substantial argument for the promotion, prevention, and treatment of child/adolescent mental health and well-being is rooted in a mathematical understanding of how many individuals are impacted by mental illness. According to the
present research between 15-20% of children and youth, and 25% of adults meet the criteria for a mental health disorders in Canada (MHCC, 2013; Millar et al., 2013; O’Mara & Lind, 2013; Maras et al., 2015; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). These statistics are imperative as they represent the notion that approximately 800,000 to 1,000,000 Canadian children/youth have a significant mental health illness that causes distress and impairment at home, school, and in the community (Flett & Hewitt, 2013; MHCC, 2013; Schwean & Rodger, 2013). For educators and personnel involved in the education of children and youth, this information is significant as it promotes the notion that in a class of 30, approximately five to six students will have a mental illness, with three to four students experiencing severe symptoms (Ontario Ministry of Education, 2013). These statistics highlight the necessity for mental health and well-being initiatives, policy, and practice as a significant portion of the population experiences mental illness.

**Early onset.** Beyond the prevalence of mental disorders among children and youth, it is significant to acknowledge the vulnerability of children/adolescents in the development of poor mental health, reduced well-being, and mental illness. This vulnerability is primarily rooted in the belief that the majority of mental illnesses originate during childhood and adolescence (Santor et al., 2009). This is supported by the recognition that 50% of mental disorders diagnosed in adulthood are attributed to onset before 14 years of age, and 75% of adulthood diagnoses are attributed to an onset before the age of 24 (Manion et al., 2013; MHCC, 2013; OMHLTC, 2011; Santor et al., 2009). These statistics signify that the prevalence of mental illness increases with age, and is established during childhood and adolescence (Millar et al., 2013). This alludes to the
concept that often individuals do not obtain intervention until adulthood, although their symptoms begin during childhood and adolescence (Millar et al., 2013). Recognizing that mental illness is often linked to early onset, and is characterized by a heightened vulnerability with age is significant. This conclusion supports the necessity for further enhanced promotion and prevention efforts early in life course to build preventative resilience and awareness before onset. Additionally, this conclusion influences the decision to frame the provided resource for junior level educators, as this allows for targeted programs to be in place long before onset.

**Treatment barriers.** The prevalence of mental health problems and mental illness, in combination with the belief that 75% of mental illnesses originate before adulthood amplifies the belief that childhood and adolescence are pivotal years in the development of mental health and well-being (Manion et al., 2013; MHCC, 2013; Santor et al., 2009). While this is recognized, it is important to acknowledge how treatment access and comorbidity rates impede the enhancement of mental health and well-being. Treatment is primarily complicated by the recognition that many who require treatment, do not receive it (Flett & Hewitt, 2013; Schwean & Rodger, 2013). In fact, Flett and Hewitt (2013), alongside Schwean and Rodger (2013) report that only 25% of individuals in need of treatment receive it, indicating that approximately 75% of children and youth in need of treatment do not receive it. These implications are substantial as they promote the belief that barriers to treatment exist, and further indicate that treatment is often not sought until adulthood.

Furthering the notion of treatment barriers is the frequency of comorbidity, the presence of two or more mental health disorders at one given time (Flett & Hewitt, 2013;
According to the Ontario Ministry of Education (2013) and Flett and Hewitt (2013), 50% of mental health diagnosis are comorbid. The presence of comorbidity complicates mental illness and well-being as it represents increased vulnerability, complicates the treatment process, and can impair diagnosis validity (Ontario Ministry of Education, 2013). Evidently, between the limited access and/or willingness to receive treatment, and the complicating presence of comorbid diagnosis it is clear that mental illness is a prevailing issue in society, demanding change and adequate attention.

**Economic costs.** Recognizing that policy decisions and the resulting implications are often, at least partially, influenced by economic concern, it is significant to acknowledge that the current prevalence rates of mental illness impose substantial financial pressure on federal and provincial governments in Canada. Flett and Hewitt (2013) support this notion by reporting that mental health and mental illness treatment services cost the Canadian government, on average, $30 billion per year. This economic cost is undoubtedly substantial, as mental illness treatment is only allocated 5.5% of overall healthcare funding in Canada, yet represents 15% of the burden of disease (Millar et al., 2013). Schwean and Rodger (2013) further support the economic costs of mental illness by acknowledging that mental illness and reduced mental well-being amount to Canada’s largest workforce economic productivity loss, resulting in a 14 billion dollar economic loss per year. Interestingly, it is recognized that prevention- and promotion-based programs offer considerable economic savings to society, promoting the belief that preventative measures can reduce the economic burden of disease (WHO, 2003).
In the context of children and adolescents, it is recognized that mental health disorders are among the top five healthcare costs of children and youth in Ontario, costing on average, $7,321.90 per child in southwestern Ontario (Schwean & Rodger, 2013). This amount is alarming as approximately 54% of the average funds spent per child are dedicated to case management, often characterized by a hands-off waiting period (Schwean & Rodger, 2013). The amount of money allocated to treating child and adolescent mental illness and poor well-being is evidently costly, yet it is clear that funds are not necessarily being used effectively. While the prevalence and impact of poor mental health, mental disorders, and reduced well-being are alarming, it is further concerning to recognize the associated economic costs.

**Conclusion.** Understanding the prevalence of mental illness among children and adolescents, the dominance of early onset, the lack of treatment access, the complexity of comorbidity rates, and the economic strain caused by treatment efforts is ample justification for the necessity to acknowledge mental health and well-being as a priority. This evidence leads to the recognition that mental health promotion and prevention efforts must be implemented for the enhancement of mental health and well-being among children and youth, particularly before onset.

**Undiagnosed Implications**

Recognizing the prevalence of diagnosed mental health disorders, and the accompanying limited accessibility to treatment, the complexity of comorbidity, and economic costs is substantial, however, there is evidence supporting this acknowledgment represents an inadequate depiction of mental health and well-being concerns. While it is recognized that mental health needs are not being met, it is also
understood that the needs of children and youth are much greater than imagined (Flett & Hewitt, 2013; Schwean & Rodger, 2013). This notion is strongly supported by the concept of superficial suffering, disguised distress, and emotional suffering (Flett & Hewitt, 2013). To thoroughly understand child and adolescent mental health and well-being it is vital to outline these concepts and their resulting implications for child and adolescent mental health and well-being.

**Superficial suffering.** Superficial suffering is an imperative concept when discussing the misleading prevalence of mental health and well-being problems, as it suggests more children and youth suffer the impairing effects of mental illness and poor mental health than statistically represented. Initially, it is significant to understand that superficial suffering expresses the belief that many individuals with symptoms of mental illness, such as depression, are experiencing considerable life impairments and a high degree of suffering, however, their symptoms do not warrant clinical diagnosis or clinical treatment (Flett & Hewitt, 2013). Research conducted by Shankman, Lewinsohn, and Sealey (as cited in Flett & Hewitt, 2013) support the severity of superficial suffering, through the results of a 15-year study. According to the research conducted, two-thirds of children who experience superficial suffering, or subthreshold depressive disorders, anxiety disorders, conduct disorders, attention-deficit hyperactive disorder, eating disorders, and/or substance use disorders eventually progress to meet clinical diagnosis criteria (Shankman, Lewinsohn, & Sealey, as cited in Flett & Hewitt, 2013). This alarming percentage promotes the necessity to attend to the needs of all children and offer programming that allows for preventative measures, enhanced resiliency, and early identification to everyone. Ultimately, superficial suffering presents the notion that the
diagnosed percentage of 15-20% represents a limited depiction of mental illness. Instead, it must be recognized that symptoms of mental illness impact the lives of a higher rate of children and youth. Ultimately, this perception demands treatment and supports, to enhance well-being and reduce mental illness, must be adapted.

**Disguised distress.** Disguised distress, an extreme unwillingness to demonstrate signs and/or symptoms of mental suffering, is considered to contribute to the underrepresented need for mental health and well-being promotion, prevention, early intervention, and treatment (Flett & Hewitt, 2013). According to this view, individuals with disguised distress will go to extreme measures to hide his or her conditions of suffering (Flett & Hewitt, 2013). It is believed that self-concealment, perfectionist, and self-presentation thoughts fuel this determination, as do the stigmatization of mental illness, self-stigmatizing concerns, cultural/familiar acceptance of mental illness, social media perceptions, and school environmental factors (support, security, and acceptance) (Flett & Hewitt, 2013). Flett and Hewitt (2013) argue that disguised distress is far more common than recognized, and can occur from an early age, heightening the need to be aware of, and act on this issue.

**Emotional distress.** Beyond recognition of superficial suffering and disguised distress, there is significant data to support the belief that stress and feelings of anxiety, depression, and isolation are actively present among students. Emotional distress highlights the necessity to recognize that students often experience emotional circumstances which impede their well-being, either temporarily or persistently (OECD, 2017). Understanding the power of these emotional responses is meaningful as it highlights the notion that well-being is not only influenced by mental illness, and
promotes the necessity for interventions to be universally adopted and applied. Evidence for this experience is provided by the Programme for International Student Assessment (PISA), a substantial assessment that aims to measure the extent of acquired knowledge and skills necessary for full participation in modern society (OECD, 2017). Using mainly self-reported measures, 15 year-olds are asked to answer questions concerning negative and positive impulses that influence healthy development (OECD, 2017). The PISA results from 2015 report that students experience significant incidences of anxiety and isolation, much of which is driven by social relationships and academic demands (OECD, 2017).

According to the provided results, 10% of students within Canada are bullied verbally, and 4-7% of students are bullied physically (OECD, 2017). These statistics contribute to an understanding that approximately 42% of 15-year-olds believe they are outsiders, and as a result are three-times more likely to be unsatisfied with life (OECD, 2017). These results indicate that negative social experiences, particularly experiences of bullying, lead nearly half of adolescents to report poor well-being (OECD, 2017). Furthermore, 15-year-olds who are extreme Internet users, spending substantial periods of time in isolation, versus engaging in extracurricular activities, are more likely to feel lonely at school, exhibit decreased academic expectations, and often arrive late (OECD, 2017). This promotes the belief that students who feel isolated often feel excluded, experience reduced well-being, and face academic difficulties (OECD, 2017).

Alternatively, the PISA from 2015 also reveals significant indications of anxiety among adolescents, stemming from school work related anxiety. According to the assessment results, 59% of students often worry taking a test will be difficult, 66% worry about poor grades, 55% worry about tests even when well-prepared, 37% of students feel
tense when studying, and 52% of students report feeling nervous when they cannot complete an assignment (OECD, 2017). Evidently, a significant portion of the adolescent population reports increased feelings of anxiety rooted in school-based pressures; however, this information is concerning as OECD (2017) recognizes that academic demands and pressures to achieve high grades increase throughout school. Acknowledging this progression is substantial as it promotes the notion that such anxiety and tension begins to escalate before adolescence and continues to prevail as students progress through their education. Furthermore, this information is substantial as it suggests that schools are involved in the development of anxiety-ridden emotional reactions, and are in a unique position to utilize these experiences to develop resilience and coping strategies (OECD, 2017). This recognition promotes the necessity to implement Positive Psychology and encourage students to see academic expectations as positive challenges, versus anxiety driving experiences (OECD, 2017).

While the information provided by the 2015 PISA results represents data from 15-year-old students, the information is vital as it outlines the need for preventative- and promotion-based efforts before decreased mental health and well-being peaks. The data also presents the potential for increased risk, without considering additional risk factors students may experience based on economic, social, cultural, genetic, and/or physical conditions (OECD, 2017). The experience of emotional distress, whether rooted in anxiety, isolation, or stress, is substantial as it promotes the notion that feelings of reduced well-being are prevalent among children and youth.

**Conclusion.** Evidently, the existence of superficial suffering, disguised distress, and emotional responses insinuate the need for early promotion, prevention, intervention,
and treatment efforts (Flett & Hewitt, 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). This recognition is significant as it highlights the fact that numerous children, in addition to the 15-20% of clinically diagnosed children, demonstrate psychological symptoms, with the risk of developing full-blown mental health disorders (Flett & Hewit, 2013; MHCC, 2013; Millar et al., 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). Recognizing mental illness, and mental health and well-being as a concern, reaching far beyond those with a clinical diagnosis, indicates the necessity for promotion and preventative measures to be provided universally to all students. Furthermore, it promotes the need for treatment to be both accessible and advantageous for children and adolescents. While numerical data does not exist about superficial suffering and disguised distress, due to their unidentified and secretive nature, such experiences of suffering and impairment insinuate that the 15-20% statistic is a limited representation of the suffering experienced by children and youth. It is evident that the promotion, prevention, and treatment of mental health must be universally recognized and implemented before escalation (Flett & Hewitt, 2013).

**Integrating Mental Health Initiatives in Education: A Universal Approach**

It is evident that the mental health and well-being of students is an increasing concern among society, and it is understood that educators/ the education system are in a valuable position to respond. The number of students who experience mental illness promotes this necessity alone, however, the provided recognition of unidentified or undiagnosed suffering, early onset ages, treatment barriers, co-morbidity, and economic costs demand that immediate action be taken to rewrite the context of this issue, and implement services that meet the needs of students before the problems prevail. As
mentioned previously, this research intends to provide educators with strategies and resources that can be applied in junior grade classrooms for the proactive prevention and promotion of mental health and well-being, mainly through the enhancement of resilience. While subsequent sections of this paper will address specific avenues for achieving this goal, it is essential to outline and justify the approach that this research maintains. For this reason, the following section will describe the fundamental beliefs of the Multi-Tiered System of Support (MTSS), while also justifying its use and adaptation within the learning environment.

**Adopted Approach: A Multi-Tiered System of Support (MTSS)**

With recognition of the immediate need for mental health and well-being initiatives, supports, and programming to be implemented within schools, it is acknowledged that a wide-scale approach must be adapted to meet the needs of all students. As a result of this intention, the MTSS shown in Figure 2 is emphasized by psychologists, counsellors, social workers, and nurses as the most efficient and effective framework for organizing mental health programs in schools (August, Piehler, & Miller, 2018; Desrochers, 2017). Schools increasingly recognize this approach, rooted in three intensifying levels of support placed among a continuum of care, as a systematic method for mental health and wellness initiatives (Desrochers, 2014). Beginning with programming for all students this approach aims to increase support intensity and differentiate programming based on individual student response (August et al., 2018). The following section will provide an understanding of the MTSS model, followed by a justification for this model’s proactive approach to enhancing student mental health and well-being.
Figure 2. A multi-tiered system of support (MTSS).
**Tier 1: Universal Programming.** The first level of intervention is Universal Programming, mainly focused on proactive, preventative, promotional, and stigma-reducing interventions (August et al., 2018; Desrochers, 2014; Macklem, 2011). Within this approach, all students receive programming, as no selection process is necessary to determine inclusion or exclusion (Macklem, 2011). This approach is considered to be most beneficial when a whole-school approach is adopted, allowing for interventions to be consistently taught, reinforced, and supported by behavioural expectations (August et al., 2018; Macklem, 2011). It is referenced that this approach maintains the capacity to enhance help-seeking behaviour, reduce stigma, promote mental health literacy, and to encourage coping strategies (Macklem, 2011; Manion et al., 2012). Often this approach is most efficiently implemented when informed by: a clear goal, culturally sensitive curriculum and skill development, parent and guardian participation, sequenced, coordinated and developmentally appropriate skill acquisition, theoretical and evidence-based practices, school-wide efforts to improve school climate, holistic staff involvement, administrative support, and opportunities for professional development (Desrochers, 2014; Macklem, 2011; O’Mara, & Lind, 2013). Further, Universal Programming is seen as advantageous based on its cost-effective features, flexibility in provision, wide-scale accessibility, and customization (Desrochers, 2014).

**Tier 2: Targeted Programs.** Based on MTSS integrative model, students who do not respond to tier 1, Universal Programming, or are identified for needing enhanced support, are selected for tier 2, Targeted Programs (Macklem, 2011). This approach is typically characterized by more focused, small-group programs aimed to help students who are carefully selected based on their presentation of emotional and/or behavioural
problems, or risk of developing such problems (August et al., 2018; Desrocher, 2014; Macklem, 2011). Students involved in tier 2 interventions are either identified by universal screening measures, or by teachers who notice social, emotional, and/or behavioural difficulties attributed to an increased risk of developing a mental illness (Macklem, 2011). While this level of support is provided in a group format, the group consists of targeted students who receive formulated interventions based on a similar concern (Macklem, 2011). It is crucial that highly structured, evidence-based programs, with in-depth manuals, are used when implementing such programming to ensure effectiveness (August et al., 2018). While educators can provide targeted programs, it is often recognized that consultation with, or guidance from designated school-leads should be incorporated to support the implementation. Evidently, Targeted Programs are reflective of both prevention and intervention techniques, aimed at responding proactively to warning signs.

**Tier 3: Interventions.** When Universal Programming and Targeted Programs do not match the needs of students enhanced support, Indicated Programs or Interventions are warranted (August et al., 2018; Macklem, 2011). The Intervention level of support is the most intense intervention and is most often targeted towards students who are either at very high risk or are already experiencing substantial mental health problems or illnesses (August et al., 2018; Desrochers, 2014). This Intervention approach is focused on individualized function-based behavioural intervention plans and requires a referral to special education and/or medical services (August et al., 2018). While classroom teachers are engaged in this approach through the incorporation of Individual Education Plan requirements, treatment is not provided, nor led by educators (August et al., 2018;
Macklem, 2011). In fact, this approach to mental health and well-being is almost exclusively provided by school-based practitioners, or mental health professionals (Macklem, 2011).

**Summary.** While each of the approaches supports substantial provisions of care, for the enhancement of mental health and well-being among children and youth, it is recognized that each level of intervention maintains a unique focus, and as a result has a unique impact on child/adolescent mental health and well-being. While the application of these three levels of care are integrative and maintain the capacity to work in an array of contexts, it is crucial to avoid a one program fits all phenomenon (August et al., 2018). In fact, at each level, educators and school personnel must select interventions that are most relevant to the student composition and environmental factors (August et al., 2018). While numerous evidence-based prevention and treatment programs exist, historically addressing behavioural, social and/or emotional factors, there is a growing recognition of the need for evidence-based programs for the promotion of mental health (August et al., 2018).

**Justification for a Universal Approach**

Evidently, the focus of this research and resulting suggestions for practice are concentrated on providing necessary information and resources for the adoption of Universal Programming within the learning environment. This decision is justified by the recognition that all students, whether they are receiving tier 2 or 3 supports or not, continually benefit from Universal Programming (August et al., 2018; O’Mara, & Lind, 2013). The ability for Universal Programming to reach a broad audience and benefit the mental health and well-being of all engaged students is seen as an admirable feature of this approach. While Universal Programming is the focus of this research, it is essential
to acknowledge that tier 2 and tier 3 interventions are still viewed as critical contributions to mental health and well-being. With this focus in mind, the following will justify why this approach is accepted as beneficial, and how this approach will further enhance the health and well-being of all Ontarian children/youth. To justify this approach, the following will outline supporting evidence for the adaptation of universal promotional programming in Ontario schools.

One of the initial justifications for Universal Programming is provided by Desrochers (2014), who recognizes that one of the most substantial challenges, impeding educators’ ability to meet the academic needs of their students, is related to emotional and behavioural difficulties. This argument is founded in the belief that school-based mental health programs, which are broadly delivered and proactive, maintain the capacity to reduce behavioural problems (August et al., 2018; Desrochers, 2017). A reduction in adverse behaviours is attributed to an enhanced school climate, increased academic achievement, and reduction in the number of students who suffer without notice (August et al., 2018; Desrochers, 2011). By providing equal opportunity for all students to reduce negative behaviours, learn coping strategies, and be part of an environment that enhances mental health and well-being, it is recognized that all students can improve academic achievement and improve their resiliency.

Additionally, justification for Universal Programming is rooted in the perception that intervention-based programs, such as those found in tiers 2 and 3, are designed for individuals experiencing mental health disorders, requiring special education qualifications, individual counselling and programming, behavioural assessments/interventions, case management, and community collaboration efforts
(August et al., 2018; Desrochers, 2011; O’Mara & Lind, 2013). This heightened requirement of care and qualification is typically delivered by designated staff focused on providing specialized education supports, as many of these students have Individual Education Plans, increasing their access to established systems of advanced services and supports (August et al., 2018; Desrochers, 2014). This distinction in service requirements is substantial as such programming is focused on a more select population, versus wide-scale implementation. This recognition is important, as a universal approach allows for, and calls for, programming to be provided to all students, proactively benefiting all students.

Furthermore, a proactive universal approach is emphasized as interventions, programs, and conditions, for the enhancement of resiliency and coping strategies, must be provided within schools to reduce the number of students who require intensive interventions (Desrochers, 2014). The idea is to teach students to cope with emotional and behavioural problems, before they advance to dominate day-to-day life, and impair functionality (Desrochers, 2014). This further promotes that the efficiency and effectiveness of supports provided at the base level impact the necessity for service to be delivered in tiers 2 and 3 (Desrochers, 2014). While it is recognized that not all instances of mental health or mental illness can be prevented, it is understood that the implementation of preventative, and promotion based efforts can reduce the need for enhanced interventions/support, and protect the quality of care offered by service providers (Desrochers, 2014).

While part one of the Supporting Minds document situates the current context of student mental health and well-being, the second half primarily focuses on recognizing and responding to mental health problems among youth, providing definitions, symptomatology, educational responses, and background information for ten common mental health diagnoses (Ontario Ministry of Education, 2013). While the information provided is comprehensive and contributes to the formation of an excellent reference guide for educators, the document is mainly reactive in its approach. This shortcoming sparked recognition of the necessity for an educator’s resource guide, focused on prevention and promotion efforts. Based on this recognition a guide that strives to reduce mental illness, poor mental health, and impaired well-being by emphasizing resilience-building efforts before mental illness onset, is seen as critical.

As a result, this research and resource aims to inform educators of the proactive measures they can adopt within their classrooms and schools for the promotion of mental health, advancement of well-being, reduction in stigma, and development of resiliency. While an understanding of reactive approaches and specific mental health disorders are beneficial, this research aims to enhance educators understanding of mental health, mental illness, well-being, and resilience, by promoting universal programs that seek to benefit the entire student population, before mental illness peaks, returning a focus on how individuals can flourish. It is important to acknowledge that this approach does not exclude the need for targeted programming or interventions; in fact, this resource recognizes the significance of these programs. Instead, this resource aims to build on the existing knowledge, by supporting the ability for educators to provide for all students through universal prevention- and promotion-based care.
Resilience

A key focus of this paper is to provide educators with an understanding of mental health, outline the role of educators in promoting the mental health and well-being of their students, and offer information regarding various approaches educators can adopt within the classroom to promote student mental health and well-being. With this overarching goal in mind, it is essential to acknowledge the fundamental connection between resilience, and mental health. As a result, the following section will aim to provide key information regarding resilience. First, this section will acknowledge what defines resilience, and the key conceptual understandings of resilience theory. Following discussion on what defines resilience, the connection between resilience and mental health will be defined. This will lead to exploration of the mental resilience concept, aiming to outline why resilience is central to the promotion of mental health/well-being.

Resilience Defined

The concept of resilience has evolved from various multidisciplinary studies of children who achieve social competence, and healthy development despite the challenges they face (Rew, 2005). Initially, researchers aimed to understand what makes “at risk” children, who are perceivably vulnerable, based on the adversities they face, invulnerable (Rew, 2005; Whitney, Williams, & Weston, 2008). This approach was focused on a deficit model, aiming to understand how those who come from adversity manage to overcome challenges (Barankin & Khanlou, 2007; Rew, 2005; Whitney et al., 2008). While this contributed to the establishment of resilience research, it is vital to recognize that the current research is focused on a strength-based model (Barankin & Khanlou, 2007; Rew, 2005). This shift in perception is significant as it emphasizes what
competencies can be developed to overcome life’s challenges, versus what deficits impede the ability to overcome adversity (Barankin & Khanlou, 2007; Rew, 2005; Whitney et al., 2008). Ultimately, this shift in approach has led researchers to focus on how people cope with the challenges they face in the various stages of life (Rew, 2005; Stanley, 2008/2009).

Evidently, research regarding how children, youth, and even adults overcome adversity has shifted over time. Resilience research is no longer undermined by a deficit model, where those labeled “at risk” overcome adversity; instead, there is growing interest in how all individuals cope with life’s inevitable adversities (Barankin & Khanlou, 2007; Henderson, 2013; Whitney et al., 2008). This shift in approach is vital to understanding resilience, as it promotes the notion that the definition of resilience is continually evolving. While the definition of resilience continues to develop, it is essential to comprehend the consensus that exists surrounding the current discourse of resilience. As a result, the following will aim to explore the elements of resilience that are widely recognized as critical components of resilience. Acknowledging these components will then lead to identifying the definition of resilience utilized throughout this paper.

The first universally recognized component of resilience is the belief that resilience is not a personal trait (Davydov, Stewart, Ritchie, & Chaudieu, 2010; Rew, 2005; Stanley, 2008/2009). This shared belief is notable as it highlights the opinion that resilience is not a given quality or characteristic, but rather an acquired ability to cope with adversity (Barankin & Khanlou, 2007; Stanley, 2008/2009). While this understanding highlights what resilience is not, versus what it is, it is still significant in the process of conceptualizing what resilience entails. It is through defining what
resilience is not that promotes resilience as a developed and fostered competency within each individual, versus a given quality one may, or may not, possess.

Building on the understanding that resilience is not a personal trait, it is widely accepted that resilience efforts can be both maladaptive and adaptive (Rew, 2005). This idea is rooted in the notion that the coping strategies, which are intended buffer against stressors and adversities, are not always effective (Rew, 2005). This recognition is important as it identifies that resilience can vary by circumstances, and be impacted by environmental, social or cognitive factors (Rew, 2005). The ability for resilience to be adaptive, or maladaptive, promotes the notion that resilience is developed over time, and is circumstantial. This understanding endorses that developmentally appropriate opportunities to establish resilience are necessary (Rew, 2005). This belief emphasizes that individuals must develop competencies and coping strategies for the enhancement of resilience (Rew, 2005).

The notion that resilience can contribute to an individual’s capacity to overcome stressors in life promotes the idea that resilience can enhance health and well-being (Barankin & Khanlou, 2007). This understanding leads to the third universally agreed upon condition of resilience, the idea that resilience extends beyond an ability to “bounce back” (Barankin & Khanlou, 2007). This understanding supports the notion that resilience not only enhances the ability for an individual to cope efficiently with or adapt to stressing and challenging life situations, but also promotes the ability for each individual to learn from one experience to better cope with another (Barankin & Khanlou, 2007). This element is significant as it supports the notion that resilience is not a trait, nor is resilience universally effective (Davydov et al., 2010; Rew, 2005; Stanley, 2008/2009).
Instead, this understanding highlights that resilience is developed through the accommodation of various developmentally appropriate circumstances and experiences, which ultimately promote the establishment of adapted and enhanced coping strategies (Davydov et al., 2010; Rew, 2005; Stanley, 2008/2009).

While the concept of resilience has evolved from the discourse of risk and vulnerability, it is evident that a strength-based, optimistic approach to coping with life’s adversities has been adopted. In general, the literature agrees that resilience is not a trait and is continually evolving through experiences of adaptive and maladaptive coping (Barakin & Khanlou, 2007; Davydov et al., 2010; Rew, 2005; Stanley, 2008/2009).

Recognizing such shared understandings is vital as they promote unity surrounding what defines resilience. While various definitions of resilience exist, the description provided by Stewart, Reid, and Mangham (as cited in Rew, 2005) will be utilized throughout this paper, as it is a highly comprehensive definition and reflects vital communal understandings as listed above. According to this definition resilience represents “the capacity for individuals to cope successfully in the face of significant change, adversity, or risk. This capacity changes over time and is enhanced by protective factors in the individual and environment” (Stewart et al., 1997, as cited in Rew, 2005, p. 5). This definition is significant as it states that resilience is not an innate ability to cope, rather resilience is acquired by internal and external influences and experiences for the development of coping mechanisms and strategies (Whitney et al., 2008).

It is recognized within this definition that various individual and environmental competencies promote resilience. The following list, as supported by Barakin and Khanlou (2007), will identify these competencies, in order to provide a comprehensive
view of what defines resilience. According to Barankin and Khanlou (2007), the concept of resilience involves various competencies including: the expression of empathy and sympathy towards others, the ability to communicate to solve problems, a dedication to learning, a drive to achieve, a willingness to participate in meaningful activities, solid relationships with one or more adults, optimistic views about the future, a sense of self, self-management, connections to their surrounding environment, and the ability to live among a community/family that is functioning and safe. Evidently, resilience is comprised of an array of protective competencies that enhance an individual’s ability to overcome adversity.

While variation resides in definitions of resilience, it is evident that common elements are universally recognized. This includes the belief that resilience is not a trait, can be adaptive and maladaptive, and is innately developed through experience. Furthermore, it is recognized that resilience includes a multitude of competencies, and is focused on the ability to overcome adversity through the promotion of protective coping factors (Rew, 2005).

**Resilience Theory**

With an increasing volume of research surrounding resilience, various academics have conceptualized resilience models. These models, which often differ in complexity, attempt to justify how resilience is applied, and/or developed. To examine the various models of resilience, Conceptualizations of Resilience and Protection, an excerpt from *Adolescent Health: A Multidisciplinary Approach to Theory, Research, and Intervention* by Rew (2005) will be recognized. Ultimately, this section will explore the various models of resilience and the model adopted within this research. It is hopeful that this
examination will demonstrate the multiple ways resilience is conceptualized, and the role of resilience concerning children and youth.

**Compensatory model.** The compensatory model of resilience is the most linear and adaptive model of the proposed conceptualizations (Rew, 2005). According to this model of resilience, a risk factor poses a challenge and, as a result, a compensatory factor (such as self-esteem) is activated, striving to neutralize the risk (Rew, 2005). If the compensatory factor is effective in offsetting the presented risk, then competence is achieved, however, if the compensatory factor fails then competence is compromised (Rew, 2005). Evidently, this model is black and white, as the effectiveness of the compensatory factor directly influences the outcome (Rew, 2005). While this model is linear and easy to understand, it is known, based on the definitions provided above, that resilience is much more complicated. Ultimately, this model is denoted based on its oversimplification of resilience.

**Challenge model.** The second model of resilience, identified for its potential explanation of how resilience is enhanced and/or inhibited, is the challenge model (Rew, 2005). This model of resilience represents a curvilinear relationship between a perceived stressor and a responding adjustment (Rew, 2005). Based on this affiliation, it is suggested that an experience of stress can either positively or negatively impact competence (Rew, 2005).

According to the challenge model, a positive or negative experience influencing competence is directly related to the notion of optimal levels of stress (Rew, 2005). Optimal stress is embedded in the idea that the presented stressor and applied adjustment must match an individual’s developmental achievements (Rew, 2005). This stipulation
fosters the theory that a stressor, which exceeds an individual’s development achievements, produces feelings of defeat and helplessness, inhibiting the growth and development of resilience (Rew, 2005). Alternatively, while too much stress is hindering, it is also recognized that insufficient stress is detrimental (Rew, 2005). This theory is reflective of the belief that inadequate exposure to stressors impedes the ability for resilience to develop (Rew, 2005). Ultimately, the idea of optimal stress supports the notion that enhanced resilience is a product of exposure to developmentally appropriate stressors, in combination with successful adaptation (Rew, 2005).

The challenge model of resilience is significant as it reflects the notion that resilience reflects the unique developmental conditions of each individual. This belief signifies that adjustment responses to stressors are not universal between individuals and various circumstances. This model is also valuable as it promotes the idea that resilience can be both enhanced and inhibited depending on the outcome. Evidently, within this model resilience is not as black and white as seen in the compensatory model.

**Protection-vulnerability model.** The protection-vulnerability model of resilience aligns with the foundational beliefs of the compensatory and challenge model of resilience, as all three models perceive resilience to be activated by a conditional experience of stress/risk, combined with an adjustment/compensation for the promotion of competence (Rew, 2005). While the protection-vulnerability model also maintains the conditional relationship between a stressor and adaptation, the personal attributes, which are developed and employed in the face of stress for adaptation, are further identified (Rew, 2005).

According to this approach, personal attributes, which either dampen or amplify the impact of stress, are either protective or vulnerable (Rew, 2005). Within this model,
personal protective attributes, which are viewed as defensive adjustments, diminish the impact of stress (Rew, 2005). Alternatively, vulnerable attributes contribute to the susceptibility of stress, resulting in less favourable, or negative outcomes (Rew, 2005). Protective and vulnerable attributes maintain distinct impacts in the face of stressors; however, it is essential to note that increasing evidence acknowledges that these attributes are not distinct, rather they merely differ in impact (Rew, 2005). This leads to the conception that the presence of a coping strategy can be adaptive or maladaptive depending on the circumstances, person, and the strategies development.

It is substantial to understand that the relationship between protective factors, vulnerable factors, and stress are not linear. In fact, according to the protection-vulnerability model of resilience characteristics of a child, their surrounding family, and adjoining school community contribute to the development of protection and demolition of vulnerability (Barankin & Khanlou, 2007). To understand how protection is enhanced, each of these sub-areas of protection will be explored, demonstrating how individual characteristics, family relationships, and community contributions contribute to resilience development.

**Personality/temperament.** According to the protection-vulnerability model, a key component of resilience is a child’s unique personality and adaptive temperament (Rew, 2005). Collectively, Rew (2005) and Henderson (2013) support the idea that personality and temperament are vital contributors to resilience through the provision of an extensive list of personality traits and temperaments that enhance resilience. Rew (2005) and Henderson (2013) identify a list of impactful personality traits and temperaments which include: a natural desire to help, a sense of humour, creativity, flexibility, excellent
communication skills, good temperament, independence, inner direction, interest in learning, internal locus of control, intolerance for deviance, optimism, perceptiveness, perseverance, positive relationship building skills, positive self-image, self-care, self-motivation, self-worth, and spirituality/religiosity.

Each of the listed factors, rooted in personality and temperament, supposedly contribute to overall resilience. According to the protection-vulnerability model, the successful adaptation of these elements promotes the development of protective factors, however failure to acquire any of these elements induces vulnerability (Rew, 2005). This stipulation demonstrates that the absence or presence of certain personality traits or temperaments influences resilience. To eliminate confusion, it is important to highlight that these personality traits and temperaments are merely a sub-component of resilience according to the protection-vulnerability model of resilience (Rew, 2005). This distinction is important; as the protection-vulnerability model of resilience does not promote resilience as a personality trait, however, it does suggest that certain temperaments and personal attributes contribute to the establishment of resilience.

**Family.** The contribution of family, as a protective factor, is contentious based on the acknowledgment that family can act as either a powerful source of protection and/or as a powerful source of stress (Rew, 2005). While it is recognized family is not always a place of solace for children, inducing vulnerability, it is suggested that a stable, cohesive and supportive family environment maintains the ability to enhance protective factors (Rew, 2005). According to this domain of resilience the early establishment of caring relationships, family cohesion, the presence of parents at key times of the day (before/after school), the constructive impact of positive academic expectations, and the
disapproval of risky behaviours lead to the development of resilience competencies, such as those listed above (Rew, 2005). This emphasizes the significance of family in fostering development and contributing to the enhancement of personal attributes/temperament. It is, however, important to acknowledge that this approach suggests that children who are not surrounded by a cohesive, stable, and/or supportive family in early childhood, and throughout childhood, are likely to experience enhanced vulnerability rather than protection based on their family dynamics (Rew, 2005). While increased susceptibility may be true, it is essential to recognize that researchers, such as Henderson (2013), promote the idea that the establishment of healthy caring relationships with adults, such as educators or other caregivers, can help diminish this vulnerability.

**School community.** The third contributor to the establishment of protective factors is the school community, suggesting that the attainment of social and cognitive skills in a nurturing school environment can enhance resilience (Rew, 2005). This particular domain focuses on the belief that resilience is improved through the establishment of supportive relationships with surrounding adults (Rew, 2005). According to this perspective, the adults found within a school environment are influential role models and mentors who can positively influence the development of resilience in children (Henderson, 2013; Rew, 2005).

As educators and school support personnel maintain a precious role in the lives of their students, the school is considered to be an environment that can mitigate environmental risk factors and build resilience in the environment by: increasing prosocial bonding, setting clear and consistent boundaries, teaching life skills, providing care and support, setting and communicate expectations, and providing opportunities for
meaningful participation (Henderson, 2013; Rew, 2005). These six key influences are derived from the Resiliency Wheel, as created by Henderson and Milstein in 2003 (as cited in Henderson, 2013; Rew, 2005). The resiliency wheel is significant as it indicates that teachers and educational personnel can actively contribute to resilience by reducing risk and by enhancing resilience, through the provision of opportunities to strengthen protective factors and reduce vulnerabilities (Rew, 2005). This recognition is essential as it promotes the notion that not only individual attributes/temperament, and family cohesion support and stability encourage resilience, but schools also maintain the ability to adjust the learning environment for the promotion of resilience within children (Henderson, 2013).

This idea is further supported by the emphasis placed on the pillar of providing care and support (Rew, 2005). According to Henderson and Milstein (as cited in Rew, 2005) this particular element of the resiliency wheel is most critical. This emphasis promotes the belief that educators are vital stakeholders in the enhancement of resilience, and as a result maintain the ability to enhance mental health and well-being. This emphasis supports the notion that educators can provide the necessary care and support to improve personal attributes and temperament, while either promoting or counteracting the impact of family support. Future exploration of the connection between resilience and mental health will support this connection.

**Continuum of resilience in adolescents.** While the compensatory, challenge, and protection-vulnerability model of resilience each conceptualize resilience with varying levels of complexity, it is important to recognize that each of the three models share one similarity: the presence of a risk factor or stressor, which is ultimately responded to by a
buffer—an action, behaviour, and/or thought (Rew, 2005). This element is essential as it acknowledges a similarity among the concepts of resilience. Based on this recognition, Hunter and Chandler (1999) promote the continuum of resilience in adolescents model. This model is rooted in the belief that stress interacts bilaterally with modifying factors of resilience, resulting in an outcome of resilience, which falls along a designated continuum of optimal to less optimal resilience (Hunter & Chandler, 1999).

Within this model, the stressor, consisting of trauma, life events, adversity, and/or challenges, interact with the modifying factors of resilience, internal and external protective factors, developed competencies and developmental stages, which strive to buffer the impact of the stressors (Hunter & Chandler, 1999). The interaction between the modifying factor(s) and stressor(s) are aligned along a continuum ranging from less optimal to optimal resilience (Hunter & Chandler, 1999). Less optimal resilience represents survival tactics including: violence, high-risk behaviours, and social/emotional withdrawal (Hunter & Chandler, 1999). Defensive tactics, including isolation, self-reliance, disconnection and a lack of trust, is the middle marker between less and optimal resilience (Hunter & Chandler, 1999). Alternatively, optimal resilience is reflective of healthy tactics, including flexibility, adaptive distancing, self-esteem, self-efficiency, competence, trust, connections, and sociability (Hunter & Chandler, 1999). Ultimately, optimal resilience is considered to be the only marker on the resilience continuum that does not indicate an increased likelihood of developing a psychosocial maladaptation or psychotherapy (Hunter & Chandler, 1999).

While each of the models presented throughout this review acknowledges the relationship between stressors and response competencies, the continuum of resilience in
adolescence model further promotes similarities among models by including the resilience continuum. Although each of the models reviewed varies in complexity, it is consistent that resilience varies in its effect and strength (Rew, 2005). These parallels are significant as they promote the idea that personal, relational, and environmental influences on resilience contribute to an overall evaluation of resilience. This model indicates that resilience is based on a relationship between the perceived stressor and response mechanisms employed by the individual. This relationship is significant to highlight as it reflects the idea that stress, the stress response, and the outcome of resilience are unique to the individual and circumstance.

**Resilience as growth.** Among the various models of resilience already explored, Rew (2005) also promotes resilience as a growth experience. This model of resilience is embedded in the belief that resilience adapts over time through various life experiences (Rew, 2005). According to this model, resilience is dispositional, relational, situational, and philosophical (Rew, 2005). This belief represents that the development of resilience, in all four domains, contributes to overall resilience. To understand how this model conceptualizes resilience it is vital to understand the four domains of development and their contribution to resilience.

The first domain of dispositional resilience includes the physical and psychological attributes of a person that contribute to competence and a strong sense of self (Rew, 2005). Resilient disposition is said to be reflective of an individual’s ability to develop good temperament, maintain good health, enhance intelligence, and acquire a sense of self-worth, confidence, resilience, and autonomy (Rew, 2005). Philosophical principles are also distinct concepts that contribute to the development resilience (Rew,
According to Rew (2005), the philosophical domain includes individuals’ conceptions, understandings, and beliefs about the world influencing their perspective.

Extending beyond the individual, Rew (2005) also outlines the relational domain of resilience. This domain focuses on how significant relationships and roles within community influence the adaptation of resilience (Rew, 2005). It is suggested that the influential roles and relationships, which impact resilience, include meaningful connections with role models, mentors, confidants, and social networks (Rew, 2005). Furthermore, it is recognized that the level of commitment dedicated to these critical relationships is impactful (Rew, 2005). Lastly, situational growth experiences are identified as significant contributors to the development of resilience (Rew, 2005). This connection is embedded in the belief that various experiences in different circumstances promote problem solving, creativity, resourcefulness, and flexibility (Rew, 2005). This domain is significant as it highlights the necessity for individuals to experience a multitude of circumstances to develop resilience.

Overall, it is significant to note, that the concept of resilience as a growth experience includes four distinct domains, however, their application and development are interconnected. This is embedded in the belief that various circumstances must occur to influence the further development of relationships, adaptations to philosophical beliefs, and the application of individual disposition. Ultimately, it is clear that resilience as growth demands development in four domains, however, it is the intersection of the four developments that enhance resilience.

**Conclusion.** Evidently, numerous models of resilience, which intend to justify how resilience is developed and applied, exist. While the various models differ in
complexity, their ability to evolve, based on the core concepts of the previously presented model, highlights the fundamental concepts of resilience. This leads to the belief that resilience, at its core, is the interaction between a stressor and an activated response. This basic interaction is further developed to incorporate the notion that adjustment efforts can be both effective and ineffective depending on the individual’s experience and unique situational circumstances. The applied adjustments are further enhanced by the protection-vulnerability model, which recognizes that certain traits and temperaments can either buffer against stressors or reduce immunity. This recognition is significant, suggesting that vulnerable and protective factors are alike, however the environmental conditions of the stressor and influence of personal traits/temperament, family, and the school community influence resilience.

Furthermore, it is recognized that optimal resilience is the most rewarding response between a stressor and adjustment, however, it is documented that negative experiences, can and do occur, impeding psychological well-being. Finally, it is presented that resilience is a growth experience; this recognition is vital promoting resilience as both an internal and environmental construct. The combination of these various conceptual understandings of resilience is important, as they each highlight an additional element of resilience. Ultimately, the combination of these concepts leads to the notion that resilience is the ability to cope with stressors by applying adequate adjustment strategies successfully. Furthermore, these key understandings highlight that resilience develops over time, and is enhanced by the reduction of vulnerability, and enhancement of protective factors. Future exploration of these core concepts will highlight how resilience is embedded within mental health.
Mental Health and Resilience: Drawing Parallels

The notion that resilience is central to mental health is rooted in the belief that the promotion of mental health encourages resilience, and the promotion of resilience encourages mental health (Barankin & Khanlou, 2007; Davydov et al., 2010). The Ontario Ministry of Education (2010) recognizes and supports this relationship as it promotes resilience as a key contributor to mental health. This idea is clearly stated in The Ontario Curriculum, Grades 1-8: Health and Physical Education, which suggests that “positive mental health and emotional well-being are closely related to the development of psychological and emotional resilience” (Ontario Ministry of Education, 2010, p. 33). This section aims to reveal the interconnected relationship between resilience and mental health.

One of the core connections between mental health and resilience is the belief that they share core elements. Barankin and Khanlou (2007) support this relationship as they argue that mental health balances the physical, intellectual, social, emotional, and spiritual aspects of life, influencing an individual’s ability to think, feel, act, and interact in ways that enhance life enjoyment and the ability to cope with life challenges. Garmezy and Nuechterlien (1972, as cited in Rew, 2005) further support this connection, identifying resilience as an intertwined aspect of the ability to resist mental illness, apply and maintain coping mechanisms, and possess cognitive competencies. This connection is further enhanced by the idea that mental health impacts the ability to make realistic sense, and meaningful reactions to the world (Barankin & Khanlou, 2007). Based on this understanding, resilience and mental health are ultimately influenced by the way individuals appraise themselves, their lives, and the people they know and care about.
(Barankin & Khanlou, 2007). Based on the principle that mental health and resilience share common core elements, it is believed that they are innately connected.

Resilience is also seen as an integral component of mental health, based on the proposition that resilience is an immunity model for mental health (Davydov et al., 2010). Davydov et al. (2010) argue that mental hygiene enhances mental health immunity. According to this perspective, mental hygiene involves both psychosocial and biological health, and is defined as the ability to preserve the mind against “all incidents and influences calculated to deteriorate its qualities, impair its energies, or damage its movement” (Davydov et al., 2010, p. 438). A key component of this understanding is rooted in the belief that resilience, as mental hygiene, extends beyond the health versus illness continuum to include wellness and mental health promotion (Davydov et al., 2010). This concept supports the idea that while resilience can support immunity, it does not equate to the absence of illness, nor does poor resilience equate to a mental health disorder (Barankin & Khanlou, 2007; Davydov et al., 2010). Ultimately, mental hygiene is believed to be about good function, versus the absence of disorder, and promotes the notion that immunity is built through experience (Barankin & Khanlou, 2007; Davydov et al., 2010). In conclusion, mental hygiene, as resilience, is said to enhance the ability to protect against mental illness, promote mental health, and aid in the recovery process (Barankin & Khanlou, 2007; Davydov et al., 2010).

According to the information provided by Davydov et al. (2010), Barankin and Khanlou (2007), and the Ontario Ministry of Education (2010) it is evident that mental health and resilience are intertwined, as represented by the term mental hygiene. This innate connection is supported by the notion that the key components of resilience and
mental health are shared (Barankin & Khanlou, 2007). This suggests that by enhancing resilience or mental health, the alternative element can also be positively impacted (Barankin & Khanlou, 2007). Additionally, mental hygiene, as an immunity model, presents the notion that resilience can be employed to protect and promote mental health. This advances the idea that good mental hygiene can act as a proactive buffer against mental illness; however, it must be acknowledged that strong mental resilience does not mean the absence of mental illness, nor do low levels of resilience necessarily equate to mental illness (Davydov et al., 2010). Further exploration of the term mental resilience will amplify this connection, promoting a more comprehensive understanding of the relationship between mental health and resilience.

**Mental Resilience**

The connection between resilience, mental health, and immunity has contributed to the development of mental resilience, a biopsychosocial construct of resilience (Davydov et al., 2010). This concept represents the belief that individuals must possess built-in mechanisms to recognize and neutralize the potential impact of adversity to survive psychological struggle (Davydov et al., 2010). Davydov et al. (2010) explain that these mechanisms, which serve to protect, promote, and mitigate, are both innate constructs, developed from within, and external constructs, influenced by environmental and relational conditions.

Before exploring the three proposed constructs of mental resilience, and the necessity of experience it is essential to outline the key factors of mental resilience. According to Davydov et al. (2010), the key factors individuals can maintain to reduce harm, enhance, recovery, and promote resilience are: intellectual functioning and
cognitive flexibility; social attachment and social behaviours; positive self-concept; effective self-regulation of emotions; positive emotions such as optimism and humour; the capacity to transform traumatic helplessness into learned hopefulness; meaning (religion and spiritual); social support from role models; active coping styles when confronting stressors; a capacity to recover from negative events/stress; and a capacity to accommodate trauma-related information in a positive direction. Evidently, there is an array of protective factors individuals can develop and employ to enhance mental resilience.

Mental resilience, inclusive of numerous competencies, is ultimately composed of three key tactics, which include: harm reduction factors, protective factors, and promotion factors (Davydov et al., 2010). Harm reduction operates in response to risk, where internal/external protective barriers have been invaded, making adversity challenging to modify (Davydov et al., 2010). These factors aim to provide quick and effective recovery after stress, promoting the return of mental, emotional, and cognitive equilibrium (Davydov et al., 2010). Alternatively, protective factors are executed when faced with a level of adversity that can be mitigated through internal and external protective factors, allowing for the individual to maintain well-being regardless of risk (Davydov et al., 2010). Lastly, the theory of mental resilience recognizes promotion factors. These factors actively enhance psychological well-being by continually promoting the development of protective factors, which can be used for harm reduction or protection when facing adversity (Davydov et al., 2010). Evidently, mental resilience contributes to the recovery, protection, and promotion of mental health and well-being.

While it is recognized that various mentally resilient factors are applied in the face of adversity, it is essential, according to the resilience model, that individuals
experience developmentally appropriate exposure to risk, and the opportunity to successfully overcome challenges (Davydov et al., 2010). This belief is rooted in the notion of behavioural immunization (Davydov et al., 2010). According to this perspective, exposure to only positive experiences, or experiences that are easily overcome, lead to anti-stress training, where individuals return to their previous state without growth (Davydov et al., 2010). Alternatively, behavioural immunization, a process where individuals experience adversity that causes disorganization, yet accommodate the experience in their memory and return to homeostasis enhances resilience (Davydov et al., 2010). This component of mental resilience is vital as it presents the idea that adversity when developmentally appropriate improves resilience.

The idea that experience influences internal and external protective factors employs significant implications for practice. First, it must be recognized that not all experiences of adversity are beneficial. If an individual cannot engage effective strategies to overcome adversity and return to homeostasis, then the experience can be counterproductive (Davydov et al., 2010). This promotes the belief that developmentally appropriate exposure is vital to the development of mental resilience. Furthermore, parents, guardians, educators, and other professionals involved in the lives of children must promote and contribute to the development of protective factors. This highlights the idea that a certain level of scaffolded independence must be provided for children to develop resilience. This evaluation acknowledges that children require support from influential mentors, to optimize their ability to build internal and external protective factors. Additionally, Davydov et al. (2010), Bhugra et al. (2013), and Manwell et al. (2015) recognize that children’s ability to maintain fundamental needs also influence their ability to develop resilience. This acknowledgment further emphasizes the fact that
individual circumstances and overall health and well-being impact a child’s ability to overcome adversity. While these factors may drive the production of resilience, they may also impede the growth of resilience, affecting the acquisition of resilience (Bhugra et al., 2013; Davydov et al., 2010).

Mental resilience ultimately represents the notion that mental health and well-being can be fostered through the development and application of harm reduction, protection, and promotion factors (Davydov et al., 2010). It is recognized that these systems of resilience are developed internally and externally through experience (Davydov et al., 2010). Furthermore, this approach emphasizes the need for growth opportunities to be provided to support behavioural immunization for the enhancement of mental resilience. Evidently, this model of mental resilience endorses the relationship between mental health and resilience, enhancing their coordinated efforts.

**Key Components of Resilience Theory**

Before acknowledging the significance of schools in promoting resilience, it is important to understand four key components of resiliency theory as outlined by Stanley (2008/2009). These four components are significant as they describe vital considerations that must be taken into account when employing resilience models. Ultimately, these four components provide necessary recommendations for educators to consider within the learning environment.

A key concept of resilience theory outlined by Stanley (2008/2009) is the importance of environmental interactions and transactions. This component is consistent with the ideas of Piaget and Vygotsky, who emphasize the fundamental dynamic and interactive role that children have within their surrounding environments (Stanley,
2008/2009). This belief is supported by the notion that children are actively engaged in social settings, and maintain the capacity and agency to select and modify social settings (Stanley, 2008/2009). This capacity and agency are influential, as Stanley (2008/2009) emphasizes that all individuals have a viewpoint from which they see the world. This viewpoint is critical as it informs the necessity for individuals to acknowledge their assumptions and lenses, which they rely on to interpret the world around them (Stanley, 2008/2009). For educators, this is important as it promotes the necessity to acknowledge personal assumptions, and respect the assumptions of others. This endorses unique interpretations and recognizes that individual experiences in differing environmental circumstances inform personal resilience and mental health.

The significance of environmental influence is further supported by Stanley’s (2008/2009) emphasis on the necessity to understand that children participate in multiple settings. This component is rooted in Urie Bronfenbrenner’s bioecological model of development, which believes that an individual’s interaction with the environment, classified into four systems, influences development (Stanley, 2008/2009). According to Stanley (2008/2009), this theory is significant as a child’s interaction with the microsystem (the most immediate layer, encompassing human relationships, interpersonal interactions, and immediate surroundings; e.g., parents, siblings, school), mesosystem (interactions between crucial characters in the child’s microsystem; e.g., parents and teachers), exosystem (indirect links between two or more settings; e.g., parents’ workplace and child’s home,), macrosystem (the largest system, which is comprised of the child’s beliefs, culture, and political/ economic systems), and chronosystem (representing changes over time, reflecting change and consistency; e.g., change in family structure, parents employment status, or change in address) each
influence development. This recognition redefines the nature versus nurture debate, ultimately suggesting that nurture is not singular, but rather plural, as all environments influence mental health, well-being, and resilience (Stanley, 2008/2009). This component is vital, as it promotes the notion that resilience and mental health/well-being are influenced by various environments. Ultimately, this component suggests that educators and professionals must consider the different environmental influences on a child’s development of resilience.

The necessity to recognize the role and importance of environmental interactions, the various environments that influence development and personal assumptions, lead to discussion regarding the significance of developmental pathways and trajectories (Stanley, 2008/2009). This particular component of resilience theory recognizes that professionals are most often preoccupied with immediate concerns, and lose sight of the years of experience leading up to the immediate circumstances (Stanley, 2008/2009). This element emphasizes the need to consider the larger picture, and recognize that each individual has a distinct life course (Stanley, 2008/2009). This component is vital for educators to acknowledge as curriculum expectations and the plethora of educational trends can easily overwhelm educators, inhibiting their ability to see broader factors that influence each individual student (Stanley, 2008/2009). This further contributes to the fourth component, which emphasizes the idea that some risk factors are actively sought by risk takers (Stanley, 2008/2009). This is important, as it highlights the notion that each child is unique and maintains a distinct life path, encouraging educators to view the larger picture and reflect on their assumptions to understand and support their students (Stanley, 2008/2009).
Ultimately, Stanley (2008/2009) promotes the notion that resilience, mental health, and well-being cannot be viewed in isolation. Rather resilience takes into account the influence of environmental interactions and transactions, the multitude of environments, which influence development, personal viewpoints, and unique developmental pathways. These components of resilience theory are particularly important for education as they remind educators not to become lost in the immediate moment, and to take into consideration the individual trajectories and experiences that students bring into the learning environment on a daily basis.

**The Role of Schools**

It is hopeful that the information provided thus far, regarding resilience, has been valuable in promoting an understanding of resilience and its relation to the mental health and well-being of children and youth. While each of these components are essential to understanding resilience, it is equally important to explicitly outline why schools and teachers are considered to be crucial contributors to the development of resilience in children and youth. The following will aim to highlight the role that the school system plays in the development of resilience, and effective strategies to do so. It is hopeful that an understanding of this role and strategies to do so will compel educators to incorporate resilience in the learning environment.

**Preface.** Before exploring the unique role that educators and the education system play in the development of resilience, and how to do so, it is vital to acknowledge the immense stress that already strains the education system (Stanley, 2008/2009). It is openly recognized that educators are already overstretched by curriculum expectations, strategic policy implications, and the multitude of trending initiatives that weave in and
out of the education sector (Stanley, 2008/2009). Recognizing this pressure is significant as it informs the belief that the incorporation of resilience in schools is not intended to overhaul education (Stanley, 2008/2009). Instead, the inclusion of resilience suggests the further promotion of empathy, empowerment, and skill development to match present day societal demands (Stanley, 2008/2009).

**Why schools?** The Ontario Ministry of Education (2013, 2014, 2015) and Stanley (2008/2009) recognize that the education system is enhanced when learning is meaningful, problem behaviours are reduced, and productive citizens are shaped. The ability for education to address societal demands requires the education system to break down traditional barriers and take action, intervening proactively before warning signs fester into dangerous proportions (Stanley, 2008/2009). With these positions and challenges in mind, the following will aim to outline the significance of the school system in promoting resilience.

**Environmental conditions.** The most influential argument for the incorporation of resilience in school is embedded in the belief that schools support optimal conditions to promote resilience in children and youth (Henderson, 2013; OECD, 2017; Rew, 2005). The influence that schools possess is largely based on each school’s consistent and long-term contact with students.

The initial justification for the significance of the school environment in promoting resilience is rooted in the belief that a school milieu can enforce clear structures, reasonable boundaries, and basic human respect, while promoting dignity, optimistic possibilities, and the capacity to overcome adversity (Henderson, 2013; Rew, 2005). These environmental components are considered to be vital as they enhance
protective factors and reduce potential vulnerabilities, improving resilience (Rew, 2005). Additionally, a school’s ability to provide conditions for the enhancement of resilience is promoted by the capacity of a school to buffer against vulnerabilities, and mitigate the impact of stress (Henderson, 2013; Stanley, 2008/2009). The capacity for schools to act as a buffer is based on the belief that schools maintain consistent access to their students, enhancing their ability to identify problems and intervene early (Stanley, 2008/2009). This dynamic is considered to be vital, as early intervention, in both life course and problem development, is essential (Stanley, 2008/2009). Intervening before a problem arises, and/or before a problem escalates, helps to mitigate vulnerabilities and enhance protective factors diminishing the impact of the perceived stressor (Stanley, 2008/2009).

Ultimately, schools are seen as unique environments for the promotion of resilience based on their ability to provide environmental supports and intervene in a timely fashion. By committing to incorporating key environmental conditions, along with early intervention and prevention, the education system maintains the capacity to promote resilience in students.

**Relationships.** In addition to consistent contact time, schools are also considered to be ideal environments for the promotion of resilience as they hold the capacity to foster significant relationships between educators and students (Davydov et al., 2010; Henderson, 2013; OECD, 2017; Rew, 2005; Stanley, 2008/2009). According to the resilience model, the promotion of meaningful, caring, supportive relationships with role models, mentors, and adults is pivotal to the development of resilience in children and youth (Henderson, 2013). These meaningful and influential relationships promote the notion that adults hold the capacity to act as agents of protection by decreasing isolation and encouraging active inclusion and engagement (Rew, 2005; Stanley, 2008/2009). The
Kauai Longitudinal Study, produced by Werner and Smith, reinforces the pivotal role of positive, meaningful, and supportive relationships between educators and students (Henderson, 2013; Stanley, 2008/2009). This study concluded that educators are fundamental to child/youth resilience development as they reward competencies and foster trust, contributing to coherence and optimistic perspectives (Henderson, 2013; Stanley, 2008/2009). It appears that educators uphold a valuable role in the lives of children and youth, maintaining the capacity to enhance resilience by building caring, meaningful, and supportive relationships with their students.

**Schools concluded.** In conclusion, it is evident that schools and educators are pivotal players in the development of resilience based on their unique role in the lives of the children and youth they teach. The ability for educators to intervene early and incorporate key characteristics for the promotion of resilience into the classroom highlights the justification for schools as key promoters of resilience (Stanley, 2008/2009). Additionally, as the establishment of meaningful, caring, and supportive relationships are essential to the enhancement of resilience (Davydov et al., 2010; Henderson, 2013; Rew, 2005; Stanley, 2008/2009). It is undeniable that educators and educational personnel maintain the capacity to develop these relationships with students, allowing them to act as positive role models and mentors for students (Henderson, 2013; Rew, 2005; Stanley, 2008/2009). Ultimately, educators and the education system are genuinely in a unique position to encourage the development of resilience for the enrichment of mental health and well-being in students.

**Overall Conclusion**

In summary, resilience is reflective of an individual’s continually evolving capacity to apply individual and environmental protective factors to efficiently cope with
the challenges and adversities presented by life (Stewart et al., 1997, as cited in Rew, 2005). Recent interest surrounding resilience has undeniably led to the development of this definition along with various conceptual models of resilience (Rew, 2005). While each of the models presented represents a varying degree of complexity and unique orientations, they collaboratively contribute to an understanding of the core elements of resilience. Ultimately, this adds to the recognition that resilience is rooted in an interaction between a stressor and activated response; however, resilience is not merely a buffer, rather resilience is an acquired protective factor (Hunter & Chandler, 1999; Rew, 2005). Furthermore, it is recognized that resilience is not a given attribute, but rather a developed skill through experience, dependent on circumstantial conditions, both effective and ineffective, and influenced by internal and external growth opportunities (Barakin & Khanlou, 2007; Davydov et al., 2010;). With these critical elements in mind, it is undeniable that resilience maintains an innate connection to mental health. This relationship is evident and explained by the mental resilience and mental hygiene models, which represent the notion that mental health and well-being are fostered through the development of internal and external harm reduction, protection, and promotion factors (Davydov et al., 2010). Lastly, it is essential to recognize that educators, and the school environment, maintain a valuable role in the promotion of resilience among children and youth. The provided literature outlines that this precarious position makes schools an ideal setting for risk reduction, resilience promotion, and mental illness prevention (Rew, 2005). Evidently, exploration of resilience theory promotes the notion that educators are privy to a significant opportunity to encourage resilience within children and youth, enhancing mental health and well-being.
Chapter Summary

Before engaging in research surrounding the mental health and well-being of students, and how educators and the education system can influence mental health and well-being, it was essential to identify the theoretical approach of Positive Psychology as this approach represents the direction of this research. As suggested, Positive Psychology calls for the study and practice of psychology to acknowledge, and return to its fundamental goals, recognizing the necessity to focus on promoting mental health and the ability to flourish, in addition to meeting the needs of those with mental illness. This theoretical approach is primarily concerned with enhancing mental health and well-being through the establishment of resilience, the promotion of positive emotions, prevention of mental illness, and recognition of what makes individuals flourish. Rooted in prevention and promotion, through the development of resilience, this research calls for a positive orientated approach to helping students thrive before illness, distress, and/or suffering emerges. The foundational beliefs and approach of this theory are recognized for influencing the direction of this research.

An essential component of this literature review was the exploration of the critical terms motivating this research, including mental illness, mental health, and well-being. While these terms commonly circulate the landscape of education, it is recognized that they are often used interchangeably and without critical analysis regarding how the words are defined. This ambiguity supports the necessity to examine the overwhelming lack of consensus critically and explicitly identify how these key terms are comprehended throughout this research. The decision to include the context surrounding such ambiguity is essential, allowing for the reader to understand how their assumptions, perceptions, and understandings align, and/or contradict with the provided terminology and definitions.
With the foundations of this research explicitly identified and explained, this literature review turned to examine the current context of child and adolescent mental health and well-being. Through an examination of substantial policy documents from the WHO, MHCC, OMHLTC, and Ontario Ministry of Education, the evolution of concern for mental illness and mental health can be traced from a global to a provincial scale. This evolution is essential as it promotes how mental health has become of heightened concern within the field of education. While the outlined initiatives are all relevant, it is recognized that the policy documents produced by the Ontario Ministry of Education, directly influencing the context of education, overly focuses on mental illness, failing to provide explicit direction regarding promotion and prevention based efforts within schools. This shortcoming is essential, and drives the necessity for this research.

As this research intended to create a resource guide for educators to utilize within the classroom, it was essential to understand the current beliefs of educators and board personnel, and why the school has been selected as a critical milieu for the advancement of child/adolescent mental health and well-being. This research revealed that substantial concern exists as educators are actively striving to meet the needs of students on a daily basis. Furthermore, it is promoted that the school environment maintains key attributes required for such programming. Ultimately, it seems natural for the school environment and educators to be embedded in the process of preventatively enhancing the mental health and well-being of children and youth. Understanding the prevalence and persistence of mental illness and mental health concerns surrounding children and youth, in combination with the various suggestions provided by the examined policy documents identify the school as a key contributor to enhancing the milieu of programming and initiatives.
To further justify this need for promotion and prevention based resource, information regarding the prevalence of mental illness complications of early onset, treatment barriers, comorbidity, and associated economic costs are presented. Exploration of mental illness demonstrated significant evidence for the necessity of further programming; however, the concepts of disguised distress, superficial suffering, and emotional distress revealed the notion that the prevalence rates of mental illness and reduced mental health and well-being are much larger than statistically represented. This evidence demands that further promotion and prevention efforts be implemented to enhance the mental health and well-being of all students.

Moving forward, with an understanding of child/adolescent mental health and well-being, the innate connection between education and the Multi-Tiered System of Support (MTSS) is revealed. This model focused on providing three levels of support, including universal, targeted, and indicated/intervention programming, is identified as the selected model for the enclosed resource. The MTSS model is selected based on its support for universal programming, focused on prevention and promotion, as the foundation for all in-school initiatives. While this research focuses on universal promotion, this model supports recognition that enhanced support or interventions are still necessary, a belief that aligns with Positive Psychology and the intentions of this research.

Lastly, this literature review focused on the concept of resilience outlining its various theoretical foundations, connection with mental health, and how resilience can be naturally established within schools. As the focus on this research is on providing a resource guide for junior grade level educators, to enhance the mental health and well-
being of their students, through universal promotion and prevention efforts, aimed at enhancing resilience, this exploration was paramount, setting the direction for the created resource.

Conclusively, this literature review was a substantial component of the research process steadily revealing key findings, initiatives, and shortcomings. Ultimately, this literature review formulated the intention of the created resource, indicating the necessity for an educator’s resource guide to promoting the mental health and well-being of Junior students through the development of universal resilience. Statistics show that 15-20% of students met the criteria for mental illness; however, a significant number of students also experience disguised distress, superficial suffering, and emotional distress, in combination with early onset. This knowledge reinforces the notion that universal prevention and promotion-based efforts are essential. With these substantial gaps in practice identified, and evidence for universal promotional programming presented it is clear that further efforts and resources must be employed.
CHAPTER THREE: METHODOLOGY

This chapter provides detailed information regarding the methodological process that was used to create Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being. The chapter includes information regarding the objectives of this resource, the necessity for this resource, the resource’s intended use, and the peer revision process. The chapter aims to explicitly promote an understanding of how and why this resource is substantial for educators.

Resource Development

This research project is motivated by the researcher’s commitment to ensuring that students receive adequate mental health and well-being support to reduce the prevalence of mental illness and improve well-being. With the rise in focus on mental illness, mental health, and well-being in both education and healthcare, it was acknowledged that this topic is of significance. However, this research intends to understand how educators can more efficiently, and effectively support the mental health and well-being of their students.

The first step in creating this document was to focus on developing an informed understanding of critical concepts including mental illness, mental health, well-being, and resilience. Research regarding these concepts was the starting point of this project, as it is recognized that significant ambiguity, varying discourses, and stigma often blur universal understandings. Furthermore, it is acknowledged that the author and audience must have a shared understanding of these terms to appreciate the implications of the provided research. It is this belief that influenced the decision to offer this information at the beginning of the resource.
Following the provision of essential definitions, the resource strives to promote a justification for the necessity of mental health and well-being initiatives, targeted at children and youth, to be incorporated into schools. With this intention in mind, the status of need section was developed with the objective to identify the prominence of mental illness and mental health concerns. It is essential within this section not only to highlight the alarming prevalence of mental illness among children and youth but also to explore the necessity for universal promotion-based initiatives. This ambition is beneficial given that many students experience reduced mental health and well-being without obtaining or reaching clinical diagnosis. Furthermore, the vulnerability of children and youth was highlighted, aiming to prompted educators in understanding why their efforts are so substantial for children and youth.

With an understanding of fundamental concepts and the necessity for proactive programming, a shift in focus occurs, aiming to promote an understanding of how and why education has become embedded in the effort to promote well-being among students. As a result, the project focused on essential policy documents, varying in chronological release date and scale. This research led to a thorough review of the WHO’s (2001) *Mental Health, New Understanding, New Hope*, the MHCC’s (2012) *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, the OMHLTC’s (2011) *Open Minds, Healthy Minds: Ontario’s Comprehensive Health and Addictions Strategy*, and the Ontario Ministry of Education’ *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* (2013) and *Achieving Excellence: A Renewed Vision for Education in Ontario* (2014). Exploring the influence of these policy documents was a necessity for two reasons. Initially, this
exploration allowed for a further understanding of how and why concern for mental health and well-being has emerged from a global to provincial scale, the intended implications, and the required actions. Secondly, this review promoted an understanding of why education and educators significant, and what the role of educators and education is perceived to be. This exploration is substantial as it allows educators to understand the how and why they are embedded in improving the mental health and well-being of children and youth.

While exploration of key policy documents and implications highlighted how mental health and well-being has surfaced as a key priority within education, this review also leads to the exposure of a crucial gap in the literature. The repeated call for prevention, promotion, identification, and treatment efforts, matched by an unequal representation of initiatives and resources for prevention- and promotion-based efforts represents this gap. The existing primary resource for educators, *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* (Ontario Ministry of Education, 2013), predominantly highlights this gap in the literature. While *Supporting Minds* offers substantial information regarding child and adolescent mental health and well-being, the limited focus on identification, intervention, and treatment is a drawback. As a result of this discrepancy, the following resource strives to reduce this gap in understanding, by promoting educators’ ability to proactively promote resilience for the establishment of enhanced mental health and well-being before concerns arise.

With an understanding of this limitation, and targeted focus on enhancing resilience, mental health and well-being among students, the next goal was to identify a theoretical approach to mental health that allowed for a focus on prevention and
promotion based efforts. Positive Psychology matched the intention of this research and was therefore introduced as the recommended approach to conceptualizing the proactive efforts of educators, and for viewing mental health, mental illness, well-being, and resilience. Within this approach it is recognized that we must focus on how and why people flourish, heightening their ability to achieve greatness, abandoning the deficit, disease-based model so often adopted in reactive interventions.

With the concept of Positive Psychology framing the resources recommendations, the Multi-Tiered System of Support (MTSS) is then explored, providing an understanding of why a universal approach is emphasized by policymakers and applied within this resource. This exploration highlights the benefit of providing universal interventions for all, as this approach highlights the necessity to provide care proactively, regardless of the demonstrated (or lack of demonstrated) early warning signs.

Lastly, with an understanding of the necessity for educators to be equipped with proactive avenues for promoting mental health and well-being, research was conducted to find school-based channels for promoting mental health, well-being, and resilience. This research led to recognition of mental resilience, Implicit Theory, and Social-Emotional Learning. Each of these approaches are incorporated because they met the following criteria: are readily integrated within the classroom environment, are prevention-based, are designed for universal implementation, and demonstrate the ability to build resilience, and as a result, influence the adoption of positive mental health and well-being. By providing a detailed description of these approaches, justification for their inclusion, and strategies for implementation this section intends to highlight how educators can make simple adjustments in the learning environment to substantially impact their student's mental health and well-being proactively.
It is consistently noted, by policy implications and the current prevalence of child and adolescent mental health, that universal prevention-based programs are required to proactively enhance the mental health and well-being of children and youth; however, little information is available for Ontario educators regarding how to achieve this goal. As a result, the Promoting Resilience resource was created with the intention of complementing the crucial information provided by Supporting Minds (Ontario Ministry of Education, 2013), early intervention and treatment-based research. The purpose of Promoting Resilience is to aid educators in their ambition to both proactively and universally promote child and adolescent resilience and mental health/well-being before complications arise.

**Resource Objectives**

The resource included in this document titled *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being* was created with the following objectives in mind:

- To enhance a comprehensive understanding of key concepts including: mental illness, mental health, well-being, and resilience.
- To promote the necessity for preventative mental health, well-being, and resilience building initiatives by acknowledging the current status of need among students.
- To provide an in-depth review of previous policy documents to aid educators in understanding their role in supporting student mental health and well-being.
- To explore the benefits of Positive Psychology and universal intervention approaches in enhancing student mental health and well-being.
• To equip educators with educational strategies that can be universally utilized in the classroom to promote resilience and enhance mental health and well-being.

• To improve the ability for educators to meet the needs of their students proactively, and promote mental health and well-being through the establishment of resilience.

**Necessity for a Handbook**

Throughout the research process, a review of current policy documents and resource books contributed to the understanding that mental health and well-being initiatives within education are multi-layered and demand for both preventative and reactive programming to be provided to children and youth. However, it is also evident that little information is available for educators regarding preventative, promotion-based efforts that intend to enhance mental health and well-being. This gap in the literature was particularly apparent in *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* released by the Ontario Ministry of Education in 2013, as a response to prior policy implications. While the document title suggests a promotional based approach and previous policy documents call for prevention-based initiatives, the information provided is primarily focused on treatment and reactive efforts. The majority of the information provided in *Supporting Minds* focuses on a review of eight common mental illness diagnosis, common symptoms, and avenues for educators to utilize to support students. While all of this information is valuable in enhancing early identification and educational accommodations for students, little information is provided regarding promotion- and prevention-based initiatives. While the policy documents influencing the emergence of child and adolescent mental health and well-being within
education indicate that prevention, promotion, early identification, and treatment are significant, the limited perspective adopted within Supporting Minds is evident. As a result, this resource intends to eliminate this gap in understanding and provide avenues for educators to preventatively promote resilience, enhancing student mental health and well-being before mental illness arises and warning symptoms surface.

Peer Review Process

Following completion of the first comprehensive draft of Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being, the handbook was given to two current Junior Educators, who are actively teaching in an Ontario elementary school setting, who are personal friends of the author. To gain a broader perspective, the individuals who were included in this revision process are from different publicly funded public Ontario school boards, although, each of the participants received their Ontario College of Teachers certificate from Brock University, in St. Catharines, Ontario. None of the peer reviewers completed the review as part of their work at any school board. It is important to note also that both selected educators are familiar with the contents of Supporting Minds and are therefore able to see and comment on the contrast between the two approaches. The feedback process was informal, to reduce limitations, and participants were encouraged to provide constructive criticism on elements they liked, disliked, did not understand, wished to have more information on, and any other relevant feedback. This feedback was then used to enhance further the contents of Promoting Resilience as all commentary was reviewed and the appropriate revisions were completed.
Summary

It is evident within today’s society that increasing concern continues to rise within education surrounding the number of children and youth who are experiencing mental illness and reduced mental health and well-being. With this concern in mind and an in-depth review of relevant policy documents, it is clear that educators are at the forefront of providing both proactive and reactive support for students. While Supporting Minds, released by the Ontario Ministry of Education in 2013, is a leading document in providing educators with essential information, it is recognizably limited in scope as identification and treatment are the focus. To reduce this barrier, Promoting Resilience has been crafted with the intention of enhancing educator knowledge and understanding, while also fostering resilience, and preventatively and universally promoting the mental health and well-being within our children and youth.
CHAPTER FOUR: HANDBOOK RESOURCE

This chapter contains the contents of the resource handbook titled, *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Promoting Child and Adolescent Mental Health and Well-Being*, created for the use of junior level educators and school support staff. This resource intends to foster the implementation and enhancement of universal prevention-based mental health and well-being initiatives, to enhance child and adolescent resilience.

This guide initially promotes an in-depth understanding of relevant concepts, including mental illness, mental health, well-being, and resilience. Beyond providing an understanding of crucial definitions, the need for mental health and well-being initiatives are explored, presenting information on the prevalence of mental illness within children/youth, the dominance of early onset, the complexities of treatment barriers, the prevalence of superficial suffering, disguised distress and emotional distress, and lastly, economic implications. Each component is explored to promote an enhanced understanding of the necessity for mental health initiatives to be preventatively provided within education.

Five key policy documents and resources are explored, demonstrating how mental health, mental illness, and well-being have transcended to become a dominant concern of education. This overview identifies the crucial role of educators and education, in addition to the necessity for a resource focused primarily on proactive, prevention-based efforts.

Moving forward the concept of Positive Psychology, the adopted approach to mental health that underlines the provided research, is explored. This exploration identifies the necessity to abandon the current deficit approach regarding mental health,
and adopt a positive approach to mental health and well-being focused on how people flourish. Furthermore, as this resource has adopted a universal approach, to benefit the mental health and well-being of all students, the Multi-Tiered System of Support will be explained, justifying this decision.

Finally, educational strategies are explored. This component provides an overview of Mental Resilience, Implicit Theory, and Social-Emotional Learning. Detailed descriptions, justifications, and strategies for implementation are provided for each approach. It is hopeful that this exploration will encourage educators to adopt the presented strategies into their classroom for the establishment of resilience to preventatively boost student mental health and well-being.
PROMOTING RESILIENCE:
A JUNIOR-LEVEL EDUCATOR'S GUIDE TO PROACTIVELY SUPPORTING CHILD AND ADOLESCENT MENTAL HEALTH AND WELL-BEING.
CREATED BY: LAURA MCCARTIE
“When “I” becomes “we,” even illness becomes wellness.”

– Malcolm X
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Introduction

Growing concern continues to surface within education surrounding the number of children and youth who are experiencing mental illness, poor mental health, and reduced mental well-being. Research indicates that 15-50% of children and youth meet the criteria for a diagnosable mental health disorder in Canada (Mental Health Commission of Canada [MHCC], 2013; Millar et al., 2013; O’Mara & Lind, 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). This statistic is alarming as it indicates 800,000 to 1,000,000 children and youth in Canada are experiencing mental illness (Flett & Hewitt, 2013; MHCC, 2013; Schwean & Rodger, 2013). While this number is staggering, it is essential to recognize that such statistics only provide a numerical representation of clinically diagnosed mental illnesses, failing to adequately represent the number of children and youth who experience mental distress and suffering without a formal diagnosis. Further adding to the vulnerability of children and youth, is the recognition that 50% of all mental illness diagnoses identified in adulthood are traceable to onset before 14 years of age (Manion et al., 2013; MHCC, 2013; Ontario Ministry of Health and Long-Term Care [OMHLTC], 2011; Santor et al., 2009).

Evidently, child and adolescent mental health and well-being is a prominent concern, which requires immediate attention to eliminate the suffering experienced by children and youth. With recognition of the necessity for action, the following resource is founded on the ambition to equip educators* within our schools with knowledge and strategies to preventatively promote student mental health and well-being through the establishment of resilience.

If educators are going to invest the time and effort in promoting resilience and coping strategies, to enhance the mental health and well-being of Ontario’s students, we must ensure that educators are prepared to, and willing to, embrace such initiatives and challenges. Ultimately, the information provided in this resource aims to assist educators in (a) developing an understanding critical concepts related to mental health and wellbeing, (b) recognizing their role in supporting child and adolescent mental health and well-being, and (c) acknowledging avenues for enhancing student mental health and well-being by preventatively promoting resilience.

* Please be advised that throughout this resource the term educator is intended to represent an array of individuals that work with children and youth in a junior grade school-based setting. This includes, but is not limited to: classroom teachers, specialized subject teachers, educational assistants, child and youth workers, social workers, interdisciplinary support teams/staff, special education teachers, and principals. Each of the individuals hold a substantial position in the lives of the student’s they work with, and therefore this resource is intended to benefit all educators.
Overview

The first section of this resource is dedicated to providing educators, and educational staff, with the required background knowledge necessary to engage in complex discussions regarding child and adolescent mental health and well-being. To provide a basis of understanding the concepts of mental illness, mental health, well-being, and resilience are comprehensively explored. Offering a rich overview of the inconsistency surrounding these key terms, this chapter promotes the necessity to understand the definitions, similarities, and distinctions of key terminology.

With this basic understanding, the focus shifts, aiming to promote an awareness of the necessity for educational interventions. This exploration outlines the alarming prevalence of mental illness, the implications of early onset, the severity of treatment barriers, the impact of non-clinical suffering, including superficial suffering, disguised distress and emotional distress, and lastly the economic implications of mental illness.

Finally, this section provides an overview of policy information, outlining how mental health and mental illness transcended to the realm of education, and what the role of educators is perceived to be. This analysis looks at five key policy documents including: Mental Health, New Understanding, New Hope (World Health Organization [WHO], 2001), Changing Directions, Changing Lives: The Mental Health Strategy for Canada (MHCC, 2012), Open Minds, Healthy Minds: Ontario’s Comprehensive Health and Addictions Strategy (OMHLTC, 2011), Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-being (Ontario Ministry of Education, 2013), and Achieving Excellence: A Renewed Vision for Education in Ontario (Ontario Ministry of Education, 2014). Examining these five influential policy documents, varying in scope and publishing date, ultimately promote an understanding of how mental health and well-being has emerged as a critical concern within education, while also exposing a prevalent gap in the literature.
It is the goal of Part One to set the context for the subsequent material and promote the necessity for mental health and well-being initiatives to be embraced by educators, through a Positive Psychology approach, to enhance resilience.

**Mental Illness, Mental Health, Well-Being, and Resilience**

Before introducing the various programs and initiatives that can be adapted within the classroom, for the enhancement of child and adolescent mental health and well-being, it is essential to outline the key terminology that is continually referenced throughout this resource. Terminology, including mental illness, mental health, well-being and resilience, frequently circulate the landscape of education; however, a great deal of ambiguity surrounds these terms, causing them to be misunderstood, used interchangeably, and accepted without critical reflection.

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**Before examining the provided explanations of key definitions, you are strongly encouraged to stop and critically reflect on what the following terms mean to you. It is substantial to recognize your own position and perceptions before moving forward.**

1. What comes to mind when you think of the following terms?
2. How would you define the following terms?
3. Are these terms connected? How? Consider why or why not.
   a. Mental illness,
   b. Mental health,
   c. Well-being, and
   d. Mental well-being.
Mental Illness

Mental illness refers to clinically diagnosable disorders, as outlined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM), currently in its fifth edition (Goldman & Grob, 2006; Ontario Ministry of Education, 2013; Public Health Agency of Canada [PHAC], 2006). The diagnosable disorders listed in the DSM vary substantially, representing an array of distinctions in symptomology, diagnosis criteria, cause, and treatment. However, it is recognized that all mental illnesses share common characteristics, ultimately, influencing their classification as a mental illness. Generically shared features of mental illnesses include feelings of hopelessness or helplessness, distress, suffering, impairments in functionality, and a range of behaviour patterns, thoughts and/or emotions that vary in intensity and duration (MHCC, 2012).

These shared characteristics are summarized in the definition provided by the PHAC (2006), which states that mental illnesses are “characterized by alterations in thinking, mood, or behaviour – or some combination thereof – associated with significant distress and impaired functioning” (p. 2). Such commonalities are further articulated as PHAC adds: “the symptoms of mental illness range from mild to severe, depending on the type of illness, the individual, the family, and the social economic environment” (p.2). Ultimately, it is recognized that mental illnesses can take many forms including, but not limited to, Anxiety Disorders, Depression, Eating Disorders, Trauma, and Suicide/Self-injurious behaviours (PHAC, 2006; Shatkin, 2015).
Mental Health

When it comes to defining mental health, it is imperative to recognize that no unanimously accepted definition of mental health exists (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015). To understand this lack of consensus the following outlines three justifications for why defining mental health is a complex challenge for academics.

**Discrepancy in the ability to meet basic needs for a healthy life.**
This justification is rooted in the belief that an individual’s, or community’s ability to meet their basic needs influences definitions of health and the capacity to achieve health. Such basic needs are outlined by Abraham Maslow and include the ability to obtain: a secure source of food, shelter, protection, social support, and freedom from pain, environmental hazards, unnecessary stress and exploitation (Bhugra et al., 2013; Manwell et al., 2015). While access to basic needs is recognized as an essential human right, it is documented that not everyone maintains equitable access to these necessities, therefore challenging the ability to universally define health, a necessary element of mental health (Bhugra et al., 2013).

**Cultural distinctions.**
The concept of culture is also recognized as a vital factor limiting the ability for mental health to be defined universally (Bhugra et al., 2013; WHO, 2001). This challenge is influenced by the belief that cultural values and perceptions of health influence what defines mental health (WHO, 2001). As nations, provinces, and communities of all associations, religions, ethnicities, and organization are comprised of various cultural perspectives it is documented that universally agreeing upon a definition, that is both meaningful and culturally sensitive, is challenging.

**The influence of individual reflection.**
This challenge supports the belief that mental health is defined by how individuals feel and think about their lives and themselves, and how this perception impacts their ability to cope and manage during times of adversity (Mental Health Foundation, as cited in Bhugra et al., 2013). As a result, perceptions of mental health are influenced by an individual’s ability to adapt and develop psychologically, emotionally, intellectually, and spiritually; initiate, develop and sustain mutually emotionally satisfying relationships; be aware of others; empathize with others; and use psychological distress as a learning experience (Bhugra et al., 2013). This complexity promotes the notion that assessments of mental health are informed by an individual’s unique assessment of self, therefore complicating the ability to define mental health universally.
Defining Mental Health

While controversy regarding what defines mental health widely exists it is important to acknowledge that working definitions of mental health have been established. While perhaps not globally embraced, these definitions demonstrate the ability for definitions of mental health to be constructed. This resource incorporates two key definitions acknowledged within a Canadian context, each representing a unique approach to defining mental health.

The first widely accepted definition from a Canadian context is provided by the PHAC (2006), identifying mental health as:
the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. (p. 2)

Alternatively, the WHO (2001) defines mental health as:
a state of well-being in which the individual realizes his/her potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her own community. (As cited in MHCC, 2012, p. 14)

The definitions provided by PHAC (2006) and WHO (as cited in MHCC, 2012) both represent slightly distinct approaches to defining mental health. These differences are rooted in the understanding that the PHAC (2006) definition is prescriptive, allowing for values, morals, and personal identity to be incorporated within understandings of mental health; however, the WHO (2001) definition is descriptive, limiting room for personal interpretation. While there are distinctions in each definition, similarities also exist, including: a focus on the ability to cope and deal with challenges in life, and the recognition that mental health is a capacity or state of mind which is not stagnant (PHAC, 2006; WHO, as cited in MHCC, 2012).

Stop and consider:

1. What elements of the above definitions align with your personal definition?
2. Do you agree with one definition over the other?
3. Take a moment and revisit your definition of mental health, what might you add, remove, and/or emphasize?
With these definitions in mind, throughout the resource, mental health is conceptualized as a combination of both the WHO definition and PHAC definition. This decision is made based on the belief that both definitions represent valuable insight. Therefore, for the remainder of this guide mental health is defined as: a state of well-being in where individuals can feel, think, and act in ways that allow for him/her to enhance their ability to enjoy life, cope with and overcome challenges, work productively, and contribute to his/her community (PHAC, 2006; WHO, as cited in MHCC, 2012). It is recognized that mental health highly regards emotional and spiritual well-being by upholding culture, equity, social justice, and personal dignity (PHAC, 2006; WHO, as cited in MHCC, 2012). Lastly, it must be emphasized that mental health is not defined by the presence or absence of mental illness, nor is mental illness defined by mental health (Manwell et al., 2015; MHCC, 2009; PHAC, 2006; WHO, 2001).
Distinguishing Mental Health and Mental Illness

Conceptualizing Mental Health

It is recognized that basic living conditions, cultural beliefs, and individual perceptions impact the process of unanimously identifying a communal definition of mental health. A significant study by Manwell et al. (2015) attempted to determine a universally accepted definition of mental health, and the key concepts that are central to identifying mental health. Ultimately, no unanimous definition was endorsed, however a further understanding of the various ways mental health is uniquely conceptualized, and how mental illness is intertwined was demonstrated. It was revealed that societal perceptions and individual perspectives influenced what each participant identifies as the key concepts of mental health. This section will explore the various concepts identified through Manwell et al.’s (2015) research.

While reviewing this information you are encouraged to critically reflect on the presented models and consider which model, or which combination of the various models, align with your personal beliefs.

Categorical Model: belief that mental health and mental illness are two distinct concepts, which do not maintain any form of relationship.

Continuous Model: mental health and mental illness are interconnected however they do not overlap. Under this belief, individuals, depending on their current state, shift along a continuum between mental health and mental illness. As a result, an individual experiencing mental illness cannot experience positive mental health, and an individual experiencing mental health cannot congruently experience mental illness.
**Two Continua Model:** mental health and mental illness are each on their own continua, ranging from high to low. This model supports the belief that mental health and mental illness are connected, however they are distinct concepts. Within this model, individuals can be congruently experience a state of mental illness and mental health.

![Two Continua Model Diagram]

**Complex Model:** represents the belief that mental health is impacted by individual attributes, including the body, brain, neurons and genes, and social determinants of health, including economic conditions, social status, and personal identity.

![Complex Model Diagram]

**Overlap Model:** mental illness is simply a subcomponent of mental health, each with their own definition and characteristics.

![Overlap Model Diagram]
From the five models presented by Manwell and colleagues (2015) it is evident that an array of paradigms, for theorizing mental health, and as a result mental illness, exists among mental health experts and those with lived experiences of mental illness.

**Take a moment to consider how you conceptualize mental health.**
- Do you agree with one of the provided models?
- A combination of elements from the various models?
- Or with an entirely different model of mental health?

*Recognizing your own perceptions and concepts of mental health, and how mental illness fits into this concept is substantial to recognizing how you will be enticed to frame your own classroom practice.*

As the author, I believe it is important to expose my assumptions and beliefs, as revealing my personal biases allows for you, the reader, to recognize the framework from which I understand mental health. Personally, I believe that mental health is a combination of the Two Continua and Complex Model, with the addition of various other influencing factors. According to my personal belief mental health and mental illness, both exist among distinct continua ranging from high to low. However, an individual’s experience of mental health and mental illness is influenced by an array of environmental factors, biological/genetic factors, and social determinants of health, in addition to an individual’s exposure to education, awareness and prevention efforts focused on enhancing health and wellness preventatively.
The Relationship Between Mental Health and Mental Illness

While it is significant to distinguish the unique differences between mental health and mental illness, it is recognized that these critical terms share parallels and are often viewed as connected. Such similarities further promote the research by Manwell and colleagues (2015), which found that conceptualizations of mental health all acknowledge mental illness as part of a mental health model.

Mental health and mental illness are both influenced by shared factors.
This similarity is based in the belief that both mental health and mental illness are influenced by an array of biological, psychological, and social factors, which influence a person’s mental state and ability to function within their surrounding environment (Bhugra et al., 2013; Goldman & Grob, 2006; Manwell et al., 2015; PHAC, 2006; WHO, 2001). While various definitions also choose to include or exclude other factors, such as: environmental factors; genetic associations; intellectual, emotional, and/or spiritual development; positive self-perception; concepts of self-worth; physical health; and, interpersonal harmony both definitions consistently include biological, psychological and social factors (Manwell et al., 2015; MHCC, 2009, 2012). This similarity is substantial as it concludes that mental health and mental illness, while different, are influenced by shared factors (Bhugra et al., 2013).

Enhanced mental health can reduce the risk of mental illness.
According to this similarity, it is suggested that positive mental health can reduce the risk for, and impact of mental illness (Bhugra et al., 2013; MHCC, 2009). This shared characteristic is founded on the belief that mental health is a part of a recovery model, suggesting that mental illness and mental health can influence one another.

Mental health and mental illness do not dictate one another.
A final substantial connection between mental health and mental illness is the recognition that mental health more than a lack of mental illness (Manwell et al., 2015; MHCC, 2009; PHAC, 2006; WHO, 2001). This connection promotes the understanding that a mental illness diagnosis does not constitute poor mental health, nor does the absence of a mental illness diagnoses equate to positive mental health (MHCC, 2009). This relationship is significant as it highlights the belief that while both concepts share core characteristics, and mental health can act as a buffer to mental illness, they are not one (PHAC, 2006).

Evidently, mental health and mental illness share vital components and often categorized under the same overarching umbrella even though they represent distinct characteristics. Understanding the connections between these two concepts is substantial as it supports the notion that enhancing mental health maintains the capacity to influence experiences of mental illness positively.
Well-Being

Well-being is a highly contested and uniquely interpreted term, resulting in ambiguity regarding what defines this concept. It is recognized that political, economic, social, and cultural contexts, in addition to the timeframe and academic field of study influence how well-being is conceptualized (Dodge et al., 2012; Marjanen et al., 2017; Nelson et al., 2015). Based on these influential factors it is noted that well-being is often broadly described, limiting the depth of understanding.

In an attempt to understand how well-being is conceptualized the definitions utilized by UNICEF’s State of the World Children (2013), Child’s Developmental Index (2012), OECD’s Doing Better for Children (2009), and the Holistic Childhood Development Index (2014) were reviewed by Marjanen and colleagues (2017). It was discovered that traditional definitions of well-being thematically focus on a deficit based approach, essential needs versus rights and desires, political landscapes, and economic and material conceptions (Marjanen et al., 2017). This deficit approach represents a failure to focus on civic life participation and influential circumstances (war/peace, environmental factors, and human rights for example) (Marjanen et al., 2017). This deficit approach aligns with trends in psychology, ultimately over focusing on mental illness, neglecting to recognize the significance of mental health, mental well-being, and factors that help individuals flourish and fulfill life aspirations.

As a result of this recognition, an optimistic, strength-based approach to well-being is recommended. This shift encourages educators and supporting personnel to recognize and potentially adjust their theory of well-being to adopt strength-based concepts of well-being. According to this model, well-being is characterized by maintaining and applying the psychological, social, and physical resources necessary to meet the psychological, social, and physical demands and challenges an individual faces (Dodge et al., 2012). This perception of well-being recognizes the influence of the unique resources and challenges that individual’s experience, also acknowledging the distinct impact of surrounding cultural, political, economic, and social factors. Furthermore, under this model, it is noted that well-being is not happiness, quality of life, or the absence of illness, distress or dysfunction (Dodge et al., 2012). This leads to the recognition that well-being can be understood as the ability to cope, flourish, and
experience equilibrium when facing challenges (Dodge et al., 2012). Ultimately, this model of well-being emphasizes that psychological well-being represents the development and application of coping mechanisms to enhance resilience and maintain equilibrium (Nelson et al., 2015).

Before moving forward, it is important to acknowledge how the concept of well-being has become a central term when discussing child and adolescent mental health. Weare (2010) reports that well-being has emerged as a critical concept alongside mental health to reduce the anxiety educing, and misleading negative connotations surrounding the discourse of mental health. It is explained that the recent direction for psychology, to focus on a disease-based orientation has produced a negative discourse of mental health (Weare, 2010). As a result, it is believed that changing ‘mental health’ to ‘mental health and well-being’ eliminates such discourses and stereotypical associations, enticing stakeholders to engage in discussion of such concerns (Weare, 2010).
Resilience

The concept of resilience has evolved significantly from the multidisciplinary study of how and why children achieve social competence, and healthy development despite the challenges they face (Rew, 2005). Initially, the research surrounding resilience was focused on understanding what makes “at risk” children, who face adversity, and are perceived as vulnerable, prevail over the challenges they face (Rew, 2005; Whitney et al., 2008). Underlying this research was a deficit model approach, focused on understanding how individuals who come from adversity manage to overcome challenges (Barankin & Khanlou, 2007; Rew, 2005; Whitney et al., 2008). While this research approach represents the foreground of resilience concepts, the pendulum has shifted away from a deficit approach.

This swing of the pendulum has resulted in the introduction of a strength-based approach to resilience research, conceptions, and practice (Barankin & Khanlou, 2007; Rew, 2005). This shift is substantial as it has created new perceptions of resilience, resulting in a focus on what competencies can be developed to overcome life’s challenges, versus what deficits impede the ability to overcome adversity (Barankin & Khanlou, 2007; Rew, 2005; Whitney et al., 2008). As a result, this shift has led researchers to focus on how individuals cope with the challenges they face during the various stages of life (Rew, 2005; Stanley, 2008/2009).

Defining Resilience

The concept of resilience has evidently evolved from a discourse of risk and vulnerability to a discourse centered on strength-based and optimistic ideals, focusing on how individuals cope with life’s adversities. While various definitions of resilience exist, and definitions have evolved, this resource will utilize a definition provided by Stewart, Reid, and Meangham (as cited in Rew, 2005). This particular definition is favoured for its comprehensive description and acknowledgment of essential understandings.

Before outlining the definition promoted throughout this resource, it is noteworthy to acknowledge the key, universally accepted, components of resilience.

- **Resilience is not a personal trait**
  This recognition that resilience is a capacity and not merely a personal trait promotes the recognition that resilience is not a given quality or characteristic, but rather an acquired ability to cope with adversity (Barankin & Khanlou, 2007; Stanley, 2008/2009). Although this particular element defines what resilience is not, versus what it is, this recognition is vital as it highlights a distinct characteristic of resilience.
- **Resilience efforts can be both adaptive and maladaptive**

  This component of resilience is rooted in the belief that the coping strategies employed by an individual, intended to respond to stressors and adversity, are not always effective (Rew, 2005). This recognition is significant as it acknowledges that resilience can vary by circumstance, and is impacted by environmental, social, and/or cognitive factors (Rew, 2005). This stipulation promotes the belief that developmentally appropriate opportunities to establish, develop, and practice resilience are necessary as resilience can be circumstantial and must be acquired through exposure (Rew, 2005).

- **Resilience extends beyond the ability to ‘bounce back’**

  The third universally agreed upon condition of resilience is the notion that resilience extends beyond the ability of an individual to ‘bounce back’ (Barakin & Khanlou, 2007). Instead, it is recognized that resilience enhances an individual’s ability to overcome stressors in life, to maintain and/or enhance their health and well-being (Barakin & Khanlou, 2007). This recognition is notable as it further supports the belief that resilience is not a trait, and varies by circumstantial conditions.

**Resilience Defined**

With an understanding of the commonly accepted components of resilience, it is vital to recognize what defines resilience. It is therefore acknowledged, that resilience represents: “the capacity for individuals to cope successfully in the face of significant change, adversity, or risk. This capacity changes over time and is enhanced by protective factors in the individual and environment” (Stewart et al., 1997, as cited in Rew, 2005, p. 5). This definition is favoured throughout this resource based on its recognition that resilience is not an innate ability to cope, but rather the acquired development of competencies through exposure to internal and external influences/experiences (Whitney et al., 2008).

It is recognized, within this definition, that the establishment of various individual and environmental competencies promote resilience. The following list, as outlined by Bararkin and Khanlou (2007), outlines the various competencies connected to resilience:

- The expression of empathy and sympathy towards others;
- The ability to communicate to solve problems;
- A dedication to learning and personal development;
- A drive to achieve;
- A willingness to participate in meaningful activities;
- The establishment of a solid relationship with one or more adult;
- Optimistic views about the future;
- A sense of self;
- Self-management capacities;
- The creation of connections to his/her surrounding environment; and,
- The ability to live among a community/family that is functioning and safe.

### Concepts of Resilience

With the increasing volume of research conducted surrounding resilience, various resilience models have been developed. These models, which differ in complexity, attempt to justify how resilience is applied, and/or developed. The following outlines the various conceptualizations of resilience, and the role of resilience concerning the well-being of children and youth.

#### Compensatory Model

The compensatory model of resilience is the most straightforward and adaptive model of resilience (Rew, 2005). According to this approach, a risk factor poses a challenge and, as a result, a compensatory factor is activated, striving to neutralize the risk factor (Rew, 2005). If the compensatory factor is activated and applied successfully then competence is achieved, however, if the compensatory factor fails then competence is compromised (Rew, 2005).

Evidently, this model is black and white, as the effectiveness of the compensatory factor directly influences the outcome (Rew, 2005). While this model is useful in demonstrating the basic function of resilience, yet it is recognized that this approach oversimplifies resilience.

#### Challenge Model

The challenge model of resilience is recognized for its explanation of how resilience is enhanced, and/or inhibited (Rew, 2005). This model represents a relationship between the perceived stressor and the responding adjustment applied (Rew, 2005). This model suggests that experience of stress, and the individual’s applied adjustment, can either positively or negatively impact the situational experience and overall resilience development (Rew, 2005).
According to this model, two different factors influence the result, the applied response, and the stressor presented. There are recognizably three different levels of stress that can be experienced:

- Developmentally appropriate stress, which is optimal for the individual’s resilience level;
- Inadequate or under stimulating stress, which fails to challenge further resilience development, but is beneficial in enhancing confidence when facing stressors; and,
- Over stimulating stress, the notion that the stressor is well-beyond an individual’s capacity to respond, often resulting in feelings of defeat and helplessness, inhibiting resilience development (Rew, 2005).

Alternatively, there are also two different responses that can be applied: adequate adjustments and inadequate adjustments, reflecting an individual’s ability to implement resilience factors that match the applied level of stress. It is important to note that it is unlikely for an adequate adjustment to be applied in the face of over stimulating stress unless the individual is supported and coached in their efforts (Rew, 2005).

As you can see, the challenge model of resilience is reflective of a combined interaction between the presented stressor and the applied response. This belief signifies that reactions to stressors are not universal. This model is significant as it promotes the notion that resilience can be enhanced, or inhibited depending on the interaction between these fundamental components.
**Protection-Vulnerability Model**

The protection-vulnerability model of resilience aligns with the founding beliefs of the compensatory and challenge model of resilience as all three models perceive resilience to be activated by a conditional experience of a stressor, combined with an applied adjustment for the promotion of resilience (Rew, 2005). While the protection-vulnerability model also maintains the conditional relationship between a stressor and an adjustment, the personal attributes, which are developed and applied in the face of a stressor, are further identified (Rew, 2005).

According to this approach, personal attributes, which either dampen or amplify the impact of stress, are either protective or vulnerable (Rew, 2005). Protective attributes, which are viewed as defensive adjustments diminish the effect of stress, whereas vulnerable attributes contribute to the susceptibility of stress, resulting in less favourable or negative outcomes (Rew, 2005). While both protective and vulnerable attributes contribute to stress susceptibility, either positively or negatively, it is acknowledged that these attributes are not distinct, rather they merely differ in their impact, based on prior experience. This leads to the idea that an adjustment, or applied coping strategy, can be either adaptive, or maladaptive depending on the circumstances, and personal developmental stage (Rew, 2005).

It is substantial to understand that the relationship between protective factors, vulnerability, and stressors are not linear. In fact, according to the protection-vulnerability model of resilience characteristics of an individual, surrounding family dynamics, and the school community contribution to the development of protection and demolition of vulnerability (Brankin & Khanlou, 2007). To understand how these factors are developed the following outlines the three most influential factors in the lives of children and youth and how they contribute to resilience development.

**Personality and Temperament**

According to the Protection-Vulnerability Model, a key component of resilience is a child’s unique personality and adaptive temperament (Rew, 2005). The
following personality traits and temperaments are identified as influential factors in resilience enhancement and personal susceptibility: a natural desire to help, a sense of humour, creativity, flexibility, strong communication skills, good temperament, independence, inner direction, interest in learning, internal locus of control, intolerance for deviance, optimism, perceptiveness, perseverance, positive relationship building skills, positive self-image, self-care, self-motivation, self-worth, and spirituality/religiosity (Henderson, 2013; Rew, 2005).

It is important to note that while these characteristics are related to temperament and personality they are not necessarily innate capacities and they can and are developed with exposure and practice. It is recognized that the adoption of these elements promotes the establishment of protective factors, yet the failure to establish such capacities induces vulnerability.

**Family**

It is suggested that the early establishment of caring relationships, family cohesion, the presence of parents/caregivers at key times of the day (before and after school), along with positive academic expectations, and the disapproval of risky behaviour leads to the development of resilience (Rew, 2005).

While family can be a key inhibitor, it is also recognized that a family environment is not always a place of solstice for children, impeding resilience. Ultimately, the contribution of family is controversial as a family can either act as a powerful source of protection, and/or as a powerful source of stress in the lives of children and youth (Rew, 2005).

This model and the contribution of family promotes the belief that children who are not surrounded by a stable, supportive, and/or cohesive family are at heightened risk of vulnerability (Rew, 2005). While increased vulnerability is a foreseeable outcome it is also recognized that the establishment of healthy, caring relationships with adults, such as educators and other caregivers, can help diminish this vulnerability (Henderson, 2013; Rew, 2005).

**School Community**

The third contributor to resilience, as recognized by the Protection-Vulnerability Model, is the school community, suggesting that the attainment of social and cognitive skills in a nurturing school environment can enhance resilience (Rew, 2005).

This domain focuses on the belief that resilience can be enhanced through the establishment of supportive relationships with surrounding adults (Rew, 2005). It is agreed that teachers and support personnel found in schools are in an optimal position to act as mentors and role models for students, positively influencing the development of resilience within children (Henderson, 2013; Rew, 2005).
As educators maintain a precious role in the lives of students, the school is considered to be an environment that can mitigate environmental risk factors and build resilience by adopting the Resilience Wheel approach (Henderson, 2013; Rew, 2005). The Resilience Wheel approach includes: increasing prosocial bonding, setting clear and consistent boundaries, teaching life skills, providing care and support, setting and communicate expectations, and providing opportunities for meaningful participation (Henderson, 2013; Rew, 2005). This recognition is essential as it promotes the notion that not only individual attributes/temperament, and family cohesion support and stability encourage resilience, but schools also maintain the ability to adjust the learning environment for the promotion of resilience (Henderson, 2013).

The significant influence of the school and educators is supported by the emphasis placed on providing care and support (Rew, 2005). According to Henderson and Milstein (as cited in Rew, 2005) this particular element from the Resilience Wheel is most significant as it promotes educators as key stakeholders in the enhancement of child/adolescent resilience. This emphasis supports the notion that educators can provide the necessary care and support to enhance personal attributes and temperament, while either further promoting or counteracting the impact of family support.

**Continuum of Resilience in Adolescents**

While the Compensatory, Challenge, and Protection-Vulnerability Models of Resilience each demonstrate differences it is consistent among all three approaches that the presence of a risk factor, or stressor, is met by a response (an action, behaviour, or thought) in an attempt to overcome the proposed adversity (Rew, 2005). This similarity is also consistent within the Continuum of Resilience in Adolescents Model, which is rooted in the belief that stress interacts bilaterally with modifying factors of resilience, resulting in a continuum response, which falls along a continuum from optimal to less optimal resilience (Hunter & Chandler, 1999).

Within this mode, stressors (such as: trauma, life events, adversity, and/or challenges) interact with the modifying factors of resilience (internal and external protective factors, developed competencies, and the individual’s developmental stage) attempting to buffer the impact of the stressor (Hunter & Chandler, 1999). This interaction and the end result is then aligned along a continuum, ranging from less optimal resilience to optimal resilience (Hunter & Chandler, 1999). Less optimal resilience represents survival tactics including: violence, high-risk behaviours, and social/emotional withdrawal (Hunter & Chandler, 1999). Defensive tactics are the middle marker between less and optimal resilience and include isolation, self-reliance, disconnection and a lack of trust, (Hunter & Chandler, 1999). Alternatively, optimal resilience is reflective of beneficial tactics, including flexibility, adaptive distancing, self-esteem, self-efficiency, competence, trust, connections, and sociability (Hunter & Chandler, 1999).
The Continuum of Resilience in Adolescents Model indicates that resilience is based on a relationship between the perceived stressor and response mechanisms employed by the individual. This relationship is important to highlight as it reflects the idea that stress, the stress response, and the outcome of resilience are unique to each individual and circumstance.

**Resilience as Growth**
Another significant model recognized for explaining resilience is the Resilience as Growth Model. This model promotes resilience as a growth experience, emphasizing that resilience adapts over time through various life experiences (Rew, 2005). According to this model, resilience is a combination of dispositional, relational, situational, and philosophical factors, requiring contributions from all four domains to develop and function (Rew, 2005). The following explores these domains of growth and their influence on resilience.

**Dispositional Growth for Resilience**: includes the physical and psychological attributes of a person that contribute to competence and a strong sense of self (Rew, 2005). Dispositional Resilience represents an individual’s ability to develop excellent temperament, maintain good health, enhance intelligence, and acquire a sense of self-worth, confidence, and autonomy (Rew, 2005).

**Philosophical Growth for Resilience**: accounts for an individual’s conceptions, understandings, and beliefs about the world, influencing their perspective (Rew, 2005).
**Relational Growth for Resilience:** represents how significant relationships and roles within community influence the establishment of resilience (Rew, 2005). Influential factors include meaningful connections with role models, mentors, confidants, and social networks (Rew, 2005). Furthermore, the level of commitment exemplified in each relationship influences the level of resilience obtained (Rew, 2005).

**Situational Growth for Resilience:** a substantial contributor to resilience based on the belief that various experiences, under different circumstances promote problem-solving, creativity, resourcefulness, and flexibility influencing resilience (Rew, 2005).

**Concepts of Resilience Conclusion**
It is evident, from the five different resilience models explored, that resilience is perceived and conceptualized in a variety of ways. While each of the proposed models explains resilience with distinction, they all collaboratively contribute to understanding how resilience functions, develops and is employed in the face of a stressor. This information is vital as it aids in understanding the development, application, and role of resilience in facing stressors and adversities.

**Mental Health and Resilience, Drawing Parallels**
Shifting focus, with an in-depth understanding of resilience it is important to acknowledge how resilience and mental health are intertwined. In the purest form, the relationship between resilience and mental health is rooted in the belief that the
promotion of mental health encourages resilience, and the development of resilience encourages mental health (Barankin & Khanlou, 2007; Davydov et al., 2010). The Ontario Ministry of Education (2011) supports this connection within the Health and Physical Education Curriculum (Kindergarten to Grade Eight) by stating: “positive mental health and emotional well-being are closely related to the development of psychological and emotional resilience” (p. 33). Shared key characteristics further characterize this relationship.

Shared Commonalities
One of the essential connections between mental health and resilience is the position that they share core elements. This similarity accepts that mental health balances the physical, intellectual, social, emotional, and spiritual aspects of life, influencing an individual’s ability to think, feel, act, and interact in ways that enhance life enjoyment and the ability to cope with life’s challenges (Barankin & Khanlou, 2007). On the other hand, resilience is recognized as the capacity to apply and maintain coping mechanisms and cognitive competencies to resist the negative impact of adversity (Garmezy & Nuechterlien, 1972, as cited in Rew, 2005). Based on this understanding of mental health and resiliency it is suggested that both concepts impact life enjoyment and the capacity for individual’s to overcome proposed adversities. Furthermore, it is acknowledged that both factors influence how an individual appraises themselves, their life, and the people they know and care about (Barankin & Khanlou, 2007).

Resilience as Mental Hygiene
The relationship between mental health and resilience is supported by the belief that resilience acts as an immunity model for mental health (Davydov et al., 2010). This connection is undermined by the principle that one’s ability to resist mental illness and poor mental health/well-being is enhanced through mental hygiene, otherwise known as mental resilience (Davydov et al., 2010). According to this perspective, mental hygiene involves both psychosocial and biological health, and is defined as the ability to preserve the mind against “all incidents and influences calculated to deteriorate its qualities, impair its energies, or damage its movement” (Davydov et al., 2010, p. 438). A key component of this connection is the recognition that mental hygiene extends beyond the health versus illness continuum to include wellness and mental health promotion (Davydov et al., 2010). The concept of resilience as a form of mental hygiene supports the notion that resilience can support immunity against mental illness and poor mental health, however, it does not equate to the complete absence of mental illness, nor does reduced immunity lead to a mental health disorder (Barankin & Khanlou, 2007; Davydov et al., 2010). In conclusion, mental hygiene, as resilience, is said to enhance the ability for resilience to protect against mental illness, promote mental health, and aid in the recovery process (Barankin & Khanlou, 2007; Davydov et al., 2010).
Status of Need

To appreciate the need for mental health and well-being initiatives to be implemented within schools it is paramount to provide evidence in support of the necessity for services and programs targeted at children and youth. To demonstrate the concern surrounding child and adolescent mental health and well-being the following section will highlight the prevalence of mental illnesses, the challenges caused by early onset, subclinical mental health and well-being concerns including disguised distress, superficial suffering and emotional distress, and the economic demand on mental illness. This information will endorse the necessity for whole-school prevention and promotion efforts, to enhance overall mental health and well-being, and encourage the development of resilience among students.

The Prevalence of Mental Illness

Arguably, the most substantial justification for the promotion, prevention, intervention, and treatment of child/adolescent mental health and well-being is rooted in statistical data surrounding the prevalence of mental illness.

According to current research statistics, it is recognized that 15-20% of children and youth, and 25% of adults meet the criteria for a diagnosable mental health disorder in Canada (Maras et al., 2015; MHCC, 2013; Millar et al., 2013; O’Mara & Lind, 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013).

These statistics are astounding as they represent the belief that approximately 800,000 to 1,000,000 Canadian children and youth experience a significant mental illness that causes distress and impairments at home, school and in the community (Flett & Hewitt, 2013; MHCC, 2013; Schwean & Rodger, 2013).

In the context of education, this translates to support the notion that in a class of 30 students approximately 5-6 students will have a diagnosable mental illness, and 3-4 additional students will experience severe symptoms (Ontario Ministry of Education, 2013).

Early Age Onset

Beyond alarming mental illness prevalence rates, there is significant research supporting the vulnerability of children and youth in the progression of poor mental health, reduced well-being, and the development of mental illness. This enhanced vulnerability is rooted in the belief that the majority of mental illnesses originate during childhood and adolescence (Santor et al., 2009).
This susceptibility is supported by recognition that 50% of mental disorders diagnosed in adulthood are attributed to onset before 14 years of age, and 75% of adulthood diagnoses are attributed to an onset before the age of 24 (Manion et al., 2013; MHCC, 2013; OMHLTC, 2011; Santor et al., 2009). These statistics signify that the prevalence of mental illness increases with age, and is established during childhood and adolescence (Millar et al., 2013).

Recognizing that mental illness is often linked to early onset during school-aged years, and is characterized by a heightened vulnerability with age, is significant. This supports the necessity for further enhanced promotion and prevention efforts to be offered early in life course to build preventative resilience and awareness before onset.

Treatment Barriers

While the prevalence of mental illness and mental health problems, in conjunction with early onset amplify the belief that childhood and adolescence are critical years in the development of mental health and well-being, it is essential to acknowledge that comorbidity rates and treatment barriers further promote the necessity for prevention and promotion based interventions.

Comorbidity, the presence of two or more mental health disorders at one given time, reportedly exists among 50% of diagnosed mental illnesses (Flett & Hewitt, 2013; Ontario Ministry of Education, 2013). The presence of a comorbid mental health diagnosis further complicates mental illness and well-being, as it represents increased vulnerability, complex treatment processes, and can impair diagnosis validity (Ontario Ministry of Education, 2013). The popularity of comorbid diagnosis is alarming as it presents the notion that of the 15-20% of children and youth diagnosed with a mental illness approximately 7.5-10% of students meet clinical diagnostic criteria for at least two or more mental illnesses.

In addition to the necessity raised by comorbidity, barriers to treatment access also represent alarming demand for enhanced treatment access. This recognition is reflected in the understanding that many individuals who require treatment and intervention services do not receive them (Flett & Hewitt, 2013; Schwean & Rodger, 2013). This understanding is statistically represented by the belief that only 25% of children and adolescents who require treatment receive it, indicating that the remaining 75% of students in need of care do not receive it (Flett & Hewitt, 2013; Schwean & Rodger, 2013). Such limited access and use of treatment is alarming and highlights the belief that barriers to treatment exist and must be reduced.
Superficial Suffering

Superficial suffering is an imperative concept to explore when discussing the prevalence of mental health problems and mental illness. Superficial suffering is important as it suggests that more children and youth suffer the detrimental effects of mental illness and poor mental health than statistically represented.

Initially, it is important to understand that the concept of superficial suffering represents the belief that many individuals experience symptoms of mental illnesses, enduring significant life impairments and a high degree of suffering, however, their symptoms do not warrant clinical diagnosis or clinical treatment (Flett & Hewitt, 2013). Superficial suffering ultimately supports the belief that statistical evidence, indicating 15-20% of children and youth experiencing mental illness, is restricted, only recognizing diagnosed cases of mental illness. This limitation neglects to acknowledge the experiences of individuals who endure life impairments and suffering caused by poor mental health and well-being, although their symptoms do not meet full clinical diagnosis criteria.

The concept of superficial suffering is also recognized for its ability to predict future diagnosis. According to a 15 year study completed by Shankman, Lewinsohn and Sealy (as cited in Flett & Hewitt, 2013) two-thirds of children who experience superficial suffering, or sub-threshold depressive disorders, anxiety disorders, conduct disorders, attention-deficit hyperactive disorder, eating disorders, and/or substance use disorders eventually progress to meet clinical diagnosis criteria (Shankman et al., as cited in Flett & Hewitt, 2013). This research is crucial as it suggests that this waiting method is not beneficial for children, in fact for the majority it is harmful.

Superficial suffering reveals that the statistical evidence, indicating 15-50% of children and youth experience mental illness, is only a snapshot of the larger issue. It must be recognized that the needs of all children must be met, and programming must be implemented to prevent mental illness, promote mental health, enhance mental well-being, improve early intervention techniques, and foster resiliency development.

Disguised Distress

Furthering the implications of superficial suffering is disguised distress, an extreme unwillingness to demonstrate signs and/or symptoms of mental suffering, is recognized as a vital concern when acknowledging the underrepresented need for mental health and well-being promotion, prevention, early intervention, and treatment (Flett & Hewitt, 2013).
The desire to disguise one’s distress is often fuelled by self-concealment, perfectionist ideologies of self, thoughts of self-presentation, the stigmatization of mental illness, self-stigmatizing beliefs, cultural and familiar acceptance of mental illness, social media perceptions, and school environmental factors, including support, security and acceptance (Flett & Hewitt, 2013). It is recognized that these fuelling ambitions can prompt individuals to go to extreme measures to hide his/her conditions of suffering. Furthermore, it is known that this desire leads to the belief that disguised distress is far more common than recognized, and can occur from a strikingly young age, heightening the need for preventative awareness and action.

**Emotional Distress**

Recognition of superficial suffering and disguised distress highlights the belief that a higher number of children and youth are experiencing poor mental health, symptoms of mental illness, and reduced well-being than clinically diagnosed and represented by statistical evidence. Emotional distress acknowledges the belief that a significant number of students are also actively enduring negative emotional experiences, including feelings of anxiety, depression, and isolation. Ultimately, this recognition highlights the necessity to understand that students endure emotional circumstances, which impede their well-being, both temporarily and persistently (OECD, 2017).

The Program for International Student Assessment (PISA) provides supporting evidence for the impactful experience of emotional distress. Within PISA data collection 15 year-olds are asked to complete self-reporting measures, on negative and positive impulses that influence healthy development (OECD, 2017). The PISA results from 2015 report that students experience substantial incidents of anxiety and isolation, mainly fuelled by social relationships and academic demands (OECD, 2017). The following outlines statistical evidence for these conclusions, supporting the presence of emotional distress among children and youth.

**Emotional Distress and Social Relationships**

- Originally, it is stated that 10% of students report being subject to verbal bullying and 4-7% of students report being the victim of physical bullying.
- Such instances of bullying reportedly contribute to the recognition that 42% of 15 year-olds believe they are outsiders.
- The perception of self as an outsider further complicates emotional experiences as these individuals are three times more likely to be reportedly unsatisfied with life.
- Furthermore, 15 year-olds who self-report as extreme Internet users, spending a substantial amount of time in isolation, are more likely to feel lonely at school, exhibit decreased academic expectations, and are often tardy for class.
The provided data promotes the belief that students who feel isolated often feel excluded from their social networks influencing the experience of reduced well-being (OECD, 2017).

**Emotional Distress and Feelings of Anxiety**
- 59% of students often worry taking a test will be difficult;
- 66% worry about poor grades;
- 55% worry about tests even when well prepared;
- 37% of students feel tense when studying; and
- 52% of students report feeling nervous when they cannot complete an assignment. (OECD, 2017)

This information indicates that a significant number of students report experiencing distressing emotions related to school expectations. The OECD (2017) recognizes that this can be concerning as academic demands and the pressure to achieve high grades increase each academic year. However, this information also suggests that schools are in a unique position to optimize these experiences, utilizing such circumstances as occasions to promote the development of resilience and effective coping strategies (OECD, 2017).

While the information provided by the 2015 PISA results is representative of data from 15-year-old students, it is evident that the data supports the presence of emotional distress among students caused by academic demands and environmental circumstances connected with the school. This data sponsors the belief that students readily experience emotional distress, without taking into consideration additional risk factors, such as economic, social, cultural, genetic, environmental, and/or physical conditions (OECD, 2017). These experiences of emotional distress, rooted in anxiety, isolation and/or stress, are substantial as they promote the notion that feelings of reduced well-being are prevalent among children and youth. Moreover, this data further support the idea that schools must utilize these opportunities to employ prevention and promotion based efforts to enhance resiliency and well-being.

**Economic Implications**

While it is hopeful that the information presented regarding mental illness prevalence rates, early onset, treatment barriers, superficial suffering, disguised distress, and emotional distress have provoked an understanding of the necessity for mental health, mental illness, and mental well-being initiatives within education, it is also recognized that economic factors often drive decisions to invest resources, time, and funding. While the willingness to support child and adolescent mental health and well-being hopefully extends far beyond economic demands, the following will further support this necessity by addressing the economic impact.
It is reported that mental illness places the following economic pressure on federal and provincial governments in Canada:

- Mental health and mental illness treatments cost on average 30 billion dollars per year in Canada (Flett & Hewitt, 2013).
- Mental health and mental illness initiatives are only allocated 5.5% of healthcare funding within Canada; however, mental illnesses represent 15% of the burden of disease (Millar et al., 2013).
- Mental health and mental illness are acclaimed to result in Canada’s most expensive workplace economic productivity loss (Schwean & Rodger, 2013). It is reported that these losses equate to a 14 billion dollar economic injury per year (Schwean & Rodger, 2013).

More specifically, in regards to children and youth, the following economic costs are outlined:

- Mental health disorders are among the top five health care costs for children and youth in Ontario (Schwean & Rodger, 2013).
- On average, mental healthcare costs $7,321.90 per child in south-western Ontario (Schwean & Rodger, 2013).
- 54% of this funding is dedicated to case management, often characterized by hands-off waiting periods, suggesting a miss-use of available funding (Schwean & Rodger, 2013).

Evidently, the cost of mental health care treatment in Canada and Ontario is costly and demonstrates a disproportionate allocation of funding. While economic means for providing treatment interventions are recognized, it is noted that investments in preventative measures, including mental health promotion and mental illness prevention initiatives, can dramatically reduce the economic burden of disease (WHO, 2003). This realization is interesting as it further supports the belief that proactive initiatives are valuable, reducing the financial cost of reactive treatment efforts. This realization further promotes the necessity for prevention and promotion based programming to reduce the prevalence of poor mental health and mental illness.
The Background

In education, there is an abundance of educational trends that weave in and out of the learning environment, each more substantial, imminent, and relevant than the last. Commonly these trends are reflective of standardized test scores, educational research, government agendas, and technology advancements, but how did mental health and well-being immerse within education, and with such distinction? The following aims to outline the critical shifts in policy that ultimately informs the necessity for mental health and well-being initiatives within education. To understand the role of educators in supporting the mental health and well-being of students five significant policy documents will be explored. This exploration will expose the multi-level recommendations that have influenced the prominence of concern for, and attention to, mental health within education. In turn, this research will reflect a gap in the literature surrounding the provision of promotion and prevention techniques and initiatives aimed at enhancing mental health, mental well-being, and resilience.

Before exploring the five influential policy documents further, it is important to note that mental health and well-being, like physical health, are not merely trending fads within education. This translates to the belief that the prominence of mental health and well-being within education is not limited by an expiry date or a pending replacement trend. While instructional methods and approaches may evolve, just as they do in math instruction, the recognition of mental health as a fundamental issue within education is unlikely to dwindle.

Mental Health: New Understanding, New Hope

The policy document *Mental Health: New Understanding, New Hope* released by the World Health Organization (WHO) in 2001 is considered to be a ground-breaking policy document in transforming the landscape of mental health and well-being. This document is accredited for raising mental health as a paramount concern within mainstream society (O’mara, & Lind, 2013). The overarching purpose of this document, released by WHO, is to ignite a societal revolution where those with mental illnesses or mental health concerns are no longer excluded from society, or left to suffer in silence, alone (WHO, 2001). The WHO (2001) states: “mental health – neglected far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in new light” (p. ix).

According to WHO (2001), the desire to attend to, and invest in mental health is due to a paradigm shift in the second half of the 20th Century. This paradigm shift includes:

“Schools are crucial in preparing children for life, but they need to be more involved in fostering health social and emotional development”
- (WHO, 2001, p. 98)
significant progress in psychopharmacology; the international recognition of the human rights movement; the incorporation of social and mental aspects into the WHO definition of health; and, the recognition that one-in-four individuals will be diagnosed with a mental illness, yet available funding allocations and resources underrepresent the necessity for care. Additionally, the need for such care is attributed to the notion that in 2001 40% of countries reportedly did not have a mental health policy, and 30% did not have a formulated mental health program (WHO, 2001). Perhaps more astonishing is the report that 90% of countries did not have a mental health policy as of 2001 that included children and adolescents (WHO, 2001). As a result, WHO (2001) prompted government institutions, across diverse nations and levels of power, to take responsibility for transforming and enhancing the climate of mental health for all.

To enhance the climate of mental health, mental illness, and mental well-being worldwide recommendations for action are presented, to reduce associated stigma and discrimination, and promote effective treatment and prevention initiatives (WHO, 2001). The 10 recommendations outlined by WHO in 2001 include:

- Provide treatment in primary care;
- Make psychotropic drugs available;
- Give care in the community*;
- Educate the public*;
- Involve communities, families, and consumers;
- Establish national policies, programs, and legislation;
- Develop human resources;
- Link with other sectors*;
- Monitor community health; and,
- Support more research.

While each of the listed recommendations maintains strong recommendations for enhancing the climate of mental health, mental illness, and mental well-being, three of the listed recommendations are noteworthy for their direct influence on education. Relevant recommendations for education include: give care in the community, educate the public, and link with other sectors. The following provides details regarding these recommendations, identifying their impact on education.

**Give Care in the Community**
This goal is significant as it emphasizes the role of the community in revolutionizing conceptualizations of care, and practices of care (WHO, 2001). According to this focus, the benefits of community-based interventions, which strive to dismantle stigma and enhance access to care are most powerful (WHO, 2001).

This goal relates to education because the school often functions as a central hub for gathering. The capacity of the school, to act as a hub for community care, is both preventative and reactive. From a preventative standpoint, it is recognized that schools
maintain consistent community connections, and are known as credible organizations, aiding in their ability to promote awareness and reduce stigma (WHO, 2001). Furthermore, it is recognized that schools provide an environment where necessary care provisions can be made readily available, accessed, and supported for students (WHO, 2001).

**Educate the Public**

The fourth priority, educate the public, directly emphasizes the power of public education and awareness campaigns in transforming the status of mental health, mental illness, and well-being within society. This goal highlights how education can increase awareness, reduce barriers to treatment, aid in the recovery process, and help maintain the human rights of individuals impacted by mental health disorders (WHO, 2001). Here it is recognized that schools can extend their natural role as an educational institution to teach their students about mental health and well-being.

**Link with Other Sectors**

This goal is essential to education based on the recognition that mental health cannot be conceptualized from a single framework, nor can it be attended to by a single sector (WHO, 2001). In fact, this recommendation encourages community members, organized resources, established institutions, and various governmental bodies to collaborate in the promotion of healthy communities (WHO, 2001). This goal is substantial as it emphasizes the belief that no single sector is solely responsible for the transformation of mental health, but rather collaborative efforts, including those offered, supported and facilitated by the education system, must work together for a shared vision of a better future.

These three goals are essential to understanding how a new hope for mental health is partially dependent on the contribution of the education sector. This report emphasizes the authentic role of the education system in contributing to awareness, stigma reduction, and the promotion of access to care for both children and adolescents, and surrounding community stakeholders. While the school’s innate role in this work is essential, it is acknowledged that collaborative efforts across various sectors are a necessity to transform the context of mental health within society.

*Changing Directions, Changing Lives: The Mental Health Strategy for Canada*

As a result of *Mental Health: New Understanding, New Hope* by the World Health Organization in 2001, a mandate to review and construct a Canadian mental health policy was placed upon the Mental Health Commission of Canada (MHCC) in April of 2012. The MHCC drew on the stories, experiences, and expertise of Canadian’s, producing the first Canadian strategy document *Changing Directions, Changing Lives: The Mental Health Strategy of Canada*. Central to this strategy is the necessity to “bring
mental health ‘out of the shadows’ emphasizing the need to reduce the stigma surrounding mental health, increase access to equal support, treatment and services, and employ all available efforts towards promoting mental health and preventing mental illness and/or distress (MHCC, 2012, p. 8).

Ultimately, six comprehensive blueprint strategies were proposed by MHCC (2012). The six blueprint strategies are supported by various priorities and recommendations for action, enhancing the widespread implementation of this comprehensive blueprint. As the strategies provided are nationwide, this document maintains substantial influence over policy, practice, and implementation, at various governmental levels. Ultimately, these strategies offer a noteworthy impact on the role of the education system in enhancing the mental health and well-being of Canadians. The following lists the six blueprint recommendations listed by MHCC (2012), and describes their significance in regards to education.

Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible;
This strategy focuses on the necessity to be proactive and to reduce the need for reactive measures. In particular, this strategy calls for mental health promotion within schools, workplaces, and homes to reduce stigma, prevent mental health problems/illness, and promote mental well-being (MHCC, 2012). It is strongly implied that the ability for frontline staff to educate, spread awareness, and intervene when necessary is the first priority to achieve mental health promotion, mental illness prevention, and stigma reduction (MHCC, 2012).

This strategy highlights the importance of teachers and the school system in providing students, and their surrounding community with educational programming for the promotion of mental health and well-being, prevention of mental illness/distress, reduction of stigma, and enhancement of early intervention (MHCC, 2012). While schools are the central hub for awareness among children and youth it is recognized that workplaces must also take on such responsibility for staff, as should senior care providers for the senior population. This recognition is essential as this focus on promoting mental health also includes the provision of mental health enhancing services for educators.

Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights;
While it is hopeful that prevention and promotion efforts will be effective, it is recognized that intervention and treatment efforts are also necessary to enhance the mental health and well-being of individuals who are experiencing a mental illness or mental health problems. This goal emphasizes the need for policy and practice to focus on intervention and treatment, in addition to prevention and promotion efforts (MHCC, 2012). To achieve this goal, the MHCC emphasizes the need for the voices of those living with mental illness and mental health problems to be listened to (MHCC, 2012).
This strategy demands that the education system must recognize and invests efforts towards reactive and proactive care. It is suggested that policy and practice must collaborate to meet the needs of the communities they serve by listening to the voices of our students and adopting a recovery and well-being framework. By adopting both preventative and recovery-based frameworks the education system will ultimately demonstrate their commitment to meeting the needs of all students.

Provide access to the right combination of services, treatments, and supports, when and where people need them;

Readily available access, to the right combination of services, treatments, and supports, is emphasized as a significant step towards enhancing the mental health and well-being of all Canadians. For this reason, it is emphasized by MHCC (2012) that an enhanced availability of support, offered through a collaborative effort, is vital. It is recognized that such collaborative efforts include social and medical services, along with peer support and patient engagement (MHCC, 2012). From an educational standpoint, this recommendation presents two significant efforts: coordination and involvement.

Coordination is significant as it promotes that no single service provider, or service sector, is solely responsible for enhancing the milieu of mental health and/or offering promotion, prevention, and treatment initiatives. In fact, collaboration, drawing on various levels and areas of expertise, is encouraged. This is significant for education as it promotes the notion that education is a contributing system for the advancement of mental health and well-being, but is not the only provider. Furthermore, this element is substantial as it recognizes that educators should draw on the expertise of those surrounding them for assistance.

Secondly, involvement is vital as it dignifies the individual’s human rights and provides an essence of control, enhancing the production of care (MHCC, 2012). Educators and educational organizations must remember that students have a valuable voice, offering unique insights and perspectives. By listening to these voices, during treatment and prevention efforts, educators can ensure the strategies they employ are perceived as beneficial. The ability to include students in this learning process, and value their input is significant, in all aspects of learning and care.

Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners;

Within this strategy, it is recognized that the MHCC acknowledges the multitude of diversities among the Canadian population, and the vast geographic landscape of Canada, demanding equitable access to service for all. Not only do Northern, more remote communities require access to equitable service, but immigrants, ethno-cultural, racialized, and LGBTQ communities also require a level of care that respects the individuals’ identity and beliefs (MHCC, 2012). This strategy ultimately reflects the
necessity for a reduction in service gaps, and the strengthening of resource availability, to meet the needs of diverse community members.

This strategy is important for education as it highlights the notion that prevention, promotion, intervention, and treatment efforts must reflect the community they service. This reveals that there is no magical solution for preventing mental illness/problems, promoting positive mental health, enhancing well-being, or responding/treating mental health needs. Ultimately, professional discretion must be applied to ensure that the utilized practices meet the needs of the student body they are intended for.

Work with First Nation, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures; and,

Acknowledging the unique rights, and cultures of First Nation, Inuit, and Métis groups is especially significant when considering the context of mental health within Canada (MHCC, 2012). The MHCC (2012) recognizes the distinct needs and cultural perspectives of the Aboriginal population within Canada, and promotes the necessity to increase culturally sensitive access to mental health care and prevention services. This strategy demands for a continuum of mental health services to be offered, including traditional, cultural, and mainstream practices (MHCC, 2012).

For education and educators in Ontario, this is significant as it highlights the necessity for policy and practice to reflect the unique needs of the student body and community that it services. Additionally, this goal highlights the necessity to recognize that mental health is perceived differently by various cultures, and therefore the interpretation of mental health, mental illness, and mental well-being varies by child.

Mobilize leadership, improve knowledge, and foster collaboration at all levels.
The final strategy proposed by MHCC (2012) is significant based on its desire to foster policy development and improve knowledge exchange across Canada. As mental health and well-being emerge from the shadow of silence, the ability for collaboration, to make informed research-driven decisions is essential.

For education, this goal is noteworthy, as it promotes the necessity for the education sector to take the lead in enhancing the milieu of mental health and well-being among children and youth, and promotes the role of the education system in collaborating and maximizing the capacity to find intervention methods that are effective. The mindset better together certainly applies to this strategy and encourages collaboration from a variety of organizations, populations, government

“Improving the mental health and well-being for everyone and creating, together, a mental health system that can truly meet the needs of all people of all ages living with mental health problems and illnesses, and their families”
- (MHCC, 2012, p. 2).
bodies, and professionals to enhance the mental health and well-being of Canadians.

Evidently, *Changing Direction, Changing Lives: The Mental Health Strategy for Canada* by MHCC (2012) promotes an array of blueprint strategies, which are each comprehensively outlined, for the enhancement of mental health and well-being among Canadians. It is evident, from the six strategies explored, that the education sector must strive to include mental health prevention, mental well-being promotion, and mental illness treatment; readily available access to coordinated services, treatment, and care; culturally sensitive and relevant programming and service provisions; and, act as a leader in the enhancement of knowledge and collaboration efforts (MHCC, 2012).

*Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy*

On a provincial scale, aspirations to transform the status of mental health and well-being are promoted directly by *Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy* by the Ontario Ministry of Health and Long-Term Care (OMHLTC) in 2011. *Open Minds, Healthy Minds* promotes an Ontario where everyone maintains equal opportunity to thrive, through the promotion of well-being, influencing good health, and the support of caring communities, enhancing recovery (OMHLTC, 2011). *Open Minds, Healthy Minds* aims to positively transform the mental health climate in Ontario through the provision of four key priorities based on core principals, including: respect and understanding, person-directed services, excellence and innovation, healthy development, hope and recovery, diversity, equity, social justice, and accountability, (OMHLTC, 2011). The stipulated priorities outline the province’s commitment to:

1) Improve the mental health and well-being of all Ontarians;
2) Create healthy, resilient, inclusive communities;
3) Identify mental health and addiction problems early and intervene; and,
4) Provide timely, high quality, integrated, person directed and other human services. (OMHLTC, 2011).

The established goals ultimately promote a focus on positive mental health and well-being, along with treatment and recovery efforts. The following will explore these four key ambitions, outlining the goals objectives and the direct impact on education.

**Improve the mental health and well-being of all Ontarians**

The first goal established by in *Open Minds, Healthy Minds* focuses on the belief that sufficient mental health resources improve quality of life, contribute to the productivity of citizens, enhance health, advance stress management, create supportive relationships, increase self-confidence, and influence the establishment of productive coping strategies. To achieve these benefits, it is acknowledged that the foundation for good mental health must be laid early in life, encouraging early identification, reduced
stigma, and the development of supports specifically for children and youth. To achieve this goal, the OMHLTC (2011) outlines the importance of skill development and educational awareness surrounding mental health literacy, resilience, and mental wellness.

**Create healthy, resilient, inclusive communities**
To achieve healthy, resilient, and inclusive communities, the province indicates their desire to reduce stigma through enhanced awareness, improved housing and increased employment opportunities through a reduction in barriers, and the promotion of well-being, through the establishment of community-based services (OMHLTC, 2011). This goal focuses on transforming the community landscape by focusing on anti-stigma efforts, the provision of mental health and illness supports, and the promotion of community hubs, customized to meet the needs of community members (OMHLTC, 2011).

**Identify mental health and addiction problems early and intervene**
The provision of early recognition and intervention is primarily focused on enhancing the capacity of first responders, school-based personnel, and family health care services (OMHLTC, 2011). This objective is engrained in the belief that front-line personnel must be educated to recognize key symptoms and respond accordingly. A particular interest in training school-based personnel is evident, as school staff often acknowledge initial warning symptoms, and schools maintain the capacity to intervene. It is recommended that mental health literacy and cross-sector training be provided, along with increased resource accessibility.

**Provide timely, high quality, integrated, person directed and other human services**
While promotion, prevention, early identification, and intervention efforts are seen as favourable responses, the province also explicitly recognizes the need to provide timely, high-quality, integrated, person-directed services to its citizens (OMHLTC, 2011). Under this objective, it is emphasized that community hubs must be well equipped to educate, respond, and collaborate (OMHLTC, 2011). Here it is recognized that mental health is not a quick fix, nor does the responsibility fall on a single sector or organization. Instead, it is understood that collaborative efforts, from the entire community, are required to enhance the milieu of care, treatment, prevention, and awareness necessary to transform the status of mental health, mental well-being, and mental illness.

“With the right mix of integrated, evidence-informed services and supports, mental illnesses and addictions can be treated and – in many cases – they can be prevented. People can recover. They can regain hope and joy in life, and lead fulfilling lives in their communities.”
- (OMHLTC, 2011, p. 6)
Evidently, the four goals established by OMHLTC (2011) in *Open Minds, Healthy Minds* are broad in scope, genuinely aiming to transform mental health and well-being initiatives, perceptions, and understandings. Acknowledging the scale of this undertaking the OMHLTC (2011) created *The Child and Youth Mental Health Strategy*, representing a 3-year focus on improving the mental health and well-being of children and youth. Based on a report that 70% of adults indicated their mental health problems and symptoms originated during childhood or adolescence but were not met with the appropriate treatment and care, the OMHLTC (2011) determined that an initial focus on children and youth is warranted. The OMHLTC (2011) further promoted a focus on children and youth as early identification leads to better outcomes, improved school attendance and achievement, a higher capacity to contribute to society, and a reduction in social service cost (healthcare, justice system, and social services). To provide the best start to life for all children and youth, by enhancing mental health and well-being, and preventing mental illness, the Province of Ontario, led by OMHLTC (2011), set its focus on the following goals:

1. **Improve access to high quality services for children, youth and their families;**
   To improve service access, the province enlisted the following recommendations: monitor service wait times; build the capacity to meet local demands; create a waitlist strategy; increase funds for mental health services; hire more youth mental health care workers; construct a directory of services to help individuals navigate the system; and, promote links between education, healthcare and community resources. This goal evidently calls for an extensive list of revisions, recommendations, and additions to improve the climate of child/youth mental health care in Ontario. For educators, this list represents the necessity to advocate for enhanced mental health services, and aid students, who require further support, in accessing these systems of care.

2. **Identify and intervene in mental health and addiction issues early; and,**
   To enhance early identification and intervention efforts, the Province of Ontario heavily promotes the role of the education sector. The education system is encouraged to equip their staff with essential skills, and awareness to both recognize and respond to mental health problems and mental illnesses early. The Ontario Ministry of Education was strongly encouraged to enhance curriculum surrounding healthy development and mental health, and build on their provision of mental health programs and services. In addition to focusing on awareness and curriculum revisions, the OMHLTC (2011) encouraged the Ontario Ministry of Education to create a resource guide for education, focused on early intervention and prevention. Ultimately this goal was achieved, through the creation of *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* in 2013. Evidently, this ambition encourages the need for educators to be well informed and well equipped to recognize and respond to the needs of their diverse students.
3. **Close critical service gaps for children and youth.**
   Moving away from an isolated focus on the education system, the need to close the critical service gap for children and youth was enlisted. This focus mainly recognizes the need to promote culturally sensitive services, which benefit Aboriginal populations, underserviced communities, and communities with amplified demand, enhance the level of care available for eating disorders, and reduce the gap between Secondary and Postsecondary Education services (OMHLTC, 2011). To meet this need, the OMHLTC (2011) promoted the creation of 18 service collaborations to enhance coordinated care for children, youth, and adults. Evidently, the education system and educators are participants in this ambition as they aim to ensure the prevention, promotion and treatment efforts they utilize are applicable to the surrounding community, and strive to support the transition to Post-Secondary Education.

It is clear that the Ontario Ministry of Health and Long-Term Care (2011) has aimed to raise the bar in Ontario, and enhance the climate of mental health, mental illness, and mental well-being for all individuals. While the Ontario Ministry of Health and Long-Term Care (2011) recognizes the necessity to transform the landscape for everyone, the decision to focus on children and youth is enlisted as a critical priority. Based on the belief that mental illness often originates in childhood, that early intervention is pivotal, and early awareness is most useful in transforming the climate of society children and youth are at the center of these initiatives. For educators, this document stipulates a variety of crucial contributions from educators and promotes substantial adaptations to enhance service delivery and access.

**Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-being**

*Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-being* was released by the Ontario Ministry of Education in 2013, as a direct response to the recommendations put forth in 2011 by the OMHLTC’s *Open Minds, Healthy Minds*. *Supporting Minds* intended to respond to the need for an educator’s resource guide, focused on early intervention and prevention efforts, aiding the province in their focus on children and youth. This document was ultimately created to provide educators with the vital information they require to support student mental health and addiction problems through early recognition and effective classroom strategies (Ontario Ministry of Education, 2013).

> “Because educators play an important role in the lives of most children and youth, they need to be aware of mental health issues that many affect students and understanding how to contribute to a multifaceted response”
> — Ontario Ministry of Education (2013, p. 5)
To clearly outline the key responsibility of educators in enhancing the mental health and well-being of children and youth three main goals are outlined by the Ontario Ministry of Education (2013), including:

1. Promote positive mental health at school;
2. Identify students who have mental health problems; and,
3. Connect those students (with mental health difficulties) to the appropriate services.

The necessity for these goals, and the substantial contribution of educators, is promoted based on the notion that educators play an essential role in the lives of most children and youth, maintain a duty to meet the needs of all students, and strive to promote safe and accepting learning environments (Ontario Ministry of Education, 2013). It is emphasized by the Ontario Ministry of Education (2013) that collaborating for the treatment, intervention, prevention, and support of all students’ mental health and well-being is a key responsibility within education. To aid Educator’s in this role Supporting Minds was created with the intention of helping educators to:

- Better understand the context of mental health for promotion;
- Recognize distress and support the pathway to care;
- Better understand the signs, symptoms, causes, and frequency of mental illness;
- Understand the impact of mental health on learning; and,
- Recognize strategies for supporting academic and social development.

Evidently, the Ontario Ministry of Education established Supporting Minds with the purpose of providing vital information to educators regarding the current context of child and adolescent mental health and well-being. It is important to note that this document is not created alike the previously explored documents, which promote a variety of policy recommendations. Instead, this document is designed with the intention of acting as a resource for educators providing vital information.

**Achieving Excellence: A Renewed Vision for Education in Ontario**

The release of Achieving Excellence: A Renewed Vision for Education in Ontario represents the revision of Ontario’s core provincial policies within public education. Before the release of Achieving Excellence in 2014, the Ontario Ministry of Education abided by the goals outlined in Reach Every Student: Energizing Ontario Education from 2008. Within Reach Every Student (Ontario Ministry of Education, 2008) three core goals were described including: increase student achievement, close gaps in student achievement, and increase public confidence in publically funded education. It is evident from these ambitions that the Ontario Ministry of Education (2008) was primarily concerned with literacy and numeracy scores, graduation rates, barriers to academic success, and public trust/engagement within the public education system.
With these pre-existing ambitions in mind, the Ontario Ministry of Education (2014) replaced Reach Every Student with Achieving Excellence, representing a revision of the key priorities within education. Under the newly revised provincial focus four goals were enlisted including: achieve excellence, ensure equity, promote well-being, and enhance public confidence. While core similarities remain, it is recognized that substantial advances were announced. According to the Ontario Ministry of Education (2014) the renewed goals for education represented the desire to create an education system, which aids students in the development of essential knowledge, skills, and characteristics that will prepare them to be personally successful, economically productive, and actively engaged citizens. Furthermore, the Ontario Ministry of Education (2014) outlined a commitment “to the success and well-being of every student and child” (p. 1), representing a shifting focus to include well-being. To understand the implications of these goals the following will explore the four established priorities demonstrating the Ontario Ministry of Education’s (2014) key concerns.

**Achieve Excellence**
The first goal enlisted ironically is achieve excellence, mainly focused on aiding students in achieving academic expectations, promoting the development of valuable skills required for active citizenship and the jobs of tomorrow (Ontario Ministry of Education, 2014). This goal primarily highlights the role of the education system in shaping the development of future citizens who are prepared to adapt, achieve, and excel in society due to their exposure to enhanced engagement opportunities and the development of higher-order thinking skills (Ontario Ministry of Education, 2014). To enhance each individual's capacity to adapt, achieve, and excel relevant, engaging and inspiring learning opportunities, technology integration, and the development of key characteristics (including: perseverance, resilience, imaginative thinking, compassion, and empathy) are recognized as essential components for lifelong success. Throughout this document, it is evident that the province of Ontario strives to foster the education and development of future citizens capable of employing functional skills, and higher-order thinking skills for the opportunities of today and tomorrow.

**Ensure Equality**
The focus on ensuring equity is directly linked to the acknowledgement that Ontario recognizes diversity as one of its key assets (Ontario Ministry of Education, 2014).
key priority and asset is justified by the belief that all students, regardless of “ancestry, culture, ethnicity, gender, gender identity, language, physical and intellectual ability, race, religion, sex, sexual orientation, [and] socio-economic status” must maintain equal and equitable opportunity to achieve excellence (Ontario Ministry of Education, 2014, p. 8). To accomplish this goal, the Ontario Ministry of Education (2014) promotes a shift from tolerance to celebration and inclusivity to respect, to ensure all students are inspired to reach their full potential, free of barriers and obstructions. While this goal is pivotal to the success of all students and respect of all students and staff alike, it is recognized that this goal specifically marks the first reference to intellectual ability, resembling concern for mental health and well-being as a fundamental contributor to student achievement.

**Promote Well-Being**
Furthering the suggestion that intellectual ability is significant to achieving excellence, the Ontario Ministry of Education (2014) recognized, for the first time, in *Achieving Excellence* that educators maintain a crucial role in the promotion and development of student well-being. This goal outlines the belief that the education system, educators, and support personnel must foster the development of the whole child, including academic, social, emotional, cognitive, and physical well-being (Ontario Ministry of Education, 2014). Specifically, *Achieving Excellence* outlines the necessity to promote resilience to enhance well-being and academic achievement. As a result of this commitment, the Ontario Ministry of Education (2014) proclaims their desire to foster a positive sense of self and sense of belonging, enhance emotional intelligence, and teach the necessary skills and understandings required to make healthy choices. For the first time well-being, and a holistic definition of health is embraced by the Ontario Ministry of Education, demonstrating a substantial shift in education.

**Enhance Public Confidence**
Representing the continuation of a previously established goal, enhancing public confidence represents the Ontario Ministry of Education’s commitment to maintaining and strengthening the public education system to be sustainable, responsible, accountable, and transparent. To achieve such markers of success, the need to make evidence-based informed decisions and collaborate with community stakeholders is emphasized. Ultimately, the Ontario Ministry of Education (2014) recognizes that increased EQAO (Education Quality and Accountability Office) results in mathematics and literacy, along with improved graduation rates are relevant indicators of success, contributing to confidence in the education system. Evidently, the Ontario Ministry of Education (2014) continues to recognize their role as a public service and acknowledges the necessity for public cooperation and support.

The revision and addition of the key priorities for education, as listed in *Achieving Excellence*, represent the Ontario Ministry of Education’s (2014) current focus within publically funded education. The renewed goals expose the provinces focus on the
future of society, and the vital incorporation of well-being. These shifts are substantial as the highlight the direction of education and future educational experiences.

Of course, it would be naive to solely praise the recommendations outlined in Achieving Excellence, without acknowledging potential shortcomings within the provided priorities. Wanting to focus on the positive impact this document has upon education, the following will simply list the recognized shortfalls.

- A failure to explicitly recognize mental health, mental illness, and mental well-being as key components within ensuring equity.
- A hyper focus on EQAO test results and graduation rates as a measure of success, with little to no recognition of how the promotion of well-being is measured.
- Neglect to explicitly recognize mental health, mental illness, and mental well-being within the provinces focus on promoting well-being.

**Summary of Policy Implications for Practice**

Examination of the five key policy documents, as provided above, demonstrates how policy at various governmental levels has contributed towards the necessity to transform the climate of mental health. More specifically, these documents offer substantial implications for educators and the education system, calling on a shift in education for the promotion of well-being, enhancement of mental health, prevention of mental illness, and provision of early identification to children and youth. It is recognized that these recommendations and ambitions are plentiful and complex, for this reason, the following outlines the three key take-away themes found among these documents, ultimately providing a starting point for educators to adopt.

**Focus on Children and Youth**

It is apparent throughout each of the provided policy documents that children and youth are not only a focus for this societal transformation but a priority. The following outlines supporting evidence from each of the discussed policy documents, ultimately supporting how this goal is a shared priority.

*Mental Health: New Understanding, New Hope:* It can be speculated that this heightened aspiration is in part due to the WHO (2001) report, which states that as of 2001 90% of countries did not have a mental health strategy inclusive of children and youth. While only 60% of countries had an identified mental health strategy, it is substantial that only 10% of countries had an established mental health strategy inclusive of its entire population (WHO, 2001).

*Changing Directions, Changing Lives:* A focus on children and youth is further supported by the MHCC (2012), recognizing early intervention as a vital approach to preventing the development of poor mental health and mental illness. Furthermore, MHCC (2012) acknowledges that a focus on children and
youth contributes to a societal shift as the younger generation develops with this newfound understanding and appreciation.

**Open Minds, Healthy Minds:** An explicit focus on children and youth is outwardly expressed by the OMHLTC (2011) as this policy document announces a three-year focus on children and youth. This focus is promoted by the establishment of the Child and Youth Mental Health Strategy for the transformation of the mental health climate in Ontario.

**Supporting Minds:** The Ontario Ministry of Education (2013), in response to Open Minds, Healthy Minds undeniably aims to focus on children and youth as the document is focused on how the education system and educators can transform the education environment to enhance the mental health and well-being of all children and youth. Focused primarily on further understanding mental health and mental illnesses, the document mainly supports the notion that educators are vital contributors to the promotion of well-being, enhancement of mental health, provision of early identification, and the establishment of care and support.

**Achieving Excellence:** Following the lead of Open Minds, Healthy Minds and Supporting Minds, Achieving Excellence ultimately promotes the provision of mental health and well-being as a key concern within the field of education. To ensure that this goal is not forgotten or led astray Achieving Excellence strives to enlist well-being as a critical priority. This promotes an enlisted focus on children and youth, while also encouraging the crucial role of educators.

While each of the policies maintain a unique approach and scale, to enhancing the mental health and well-being of all children and youth, one thing is consistent — children and youth are at the center of this societal shift to improve mental health and well-being.

**The Role of Education**

While the substantial focus on children and youth is undoubtedly present within the policy documents reviewed, this focus further alludes to the demand for the cooperation and contribution of educators and the education system. The following provides an overview of how the explored policy documents perceive the role of education, and educators, in enhancing mental health and well-being among children and youth.

**Mental Health: New Understanding, New Hope:** As the leading policy in striving to transform the landscape of mental health and well-being, WHO (2001) was the first to suggest the key role of education by highlighting the necessity to educate the community and provide care within the community. WHO (2001) views the education system as a vital contributor given that schools maintain
consistent access to children and youth, also acting as a community hub enhancing their ability to promote, prevent, and treat mental illness, mental health, and mental well-being.

**Changing Directions, Changing Lives:** The MHCC (2012) further supports the vital contribution of educators as the strategy indicates that: prevention, recovery, coordinated care, equitable access, culturally responsive care for various populations, and improvements in knowledge/research are significant within the context of education. These recommendations impact the realm of education as they encourage the cooperation and contribution of the education sector, to enhance prevention, promotion, intervention, and treatment efforts targeted for child and youth mental health and well-being.

**Open Minds, Healthy Minds:** The OMHLTC (2011) beings to navigate a more Ontario-based approach to transforming the climate of mental health and well-being. *Open Minds, Healthy Minds* and the Child and Youth Strategy further pronounce that educators are significant contributors to this revolution, supporting their ability to improve the mental health and well-being of children and youth by identifying and intervening early, reducing stigma, enhancing support, and aiding in the development of health resilient communities (OMHLTC, 2011).

**Supporting Minds:** Interestingly, the release of Supporting Minds on its own supports the significant role of educators and the education system in improving child and adolescent mental health and well-being. Supporting Minds is primarily focused on outlining the role of educators, mainly focusing on the provision of information on mental illness. This information is relevant as Supporting Minds promotes an understanding of common mental illness disorders, information about warning signs and symptoms for early identification, and classroom strategies to support students with a mental illness diagnosis or mental health problem. It is evident within Supporting Minds that the province is dedicated to enhancing mental well-being, but is chiefly concerned with preventing and treating mental illness.

**Achieving Excellence:** Alike the *Supporting Minds* document, *Achieving Excellence*, released by the Ontario Ministry of Education (2014), also implies a direct recognition of the role of educators. This document focuses on how the education system and educators must recognize the significance of promoting well-being, to produce actively engaged and skillful citizens for future contribution to society. While promoting well-being does not explicitly focus on mental health or mental illness, it is recognized as a vital document enhancing the prevalence of such topics within education, and placing a level of expectation on the system and educators to deliver programming and environments that promote child and adolescent well-being.
Congruent with a primary focus on children and youth, it is evident in each of the explored policy documents that the education system and educators play a substantial role in the prevention of mental illness, enhancement of mental well-being, promotion of mental health, and employment of early intervention techniques. While each policy document addresses the role of education with a distinct approach and scale, it is recognized that educators and the education system are unanimously seen as key contributions and leaders in this movement.

The Significance of Collaboration
While the education sector is undeniably highlighted as a key contributor to the transformation of child and adolescent mental health and well-being, it is important to acknowledge that the theme of collaboration also emerged throughout each of the explored policy documents. This particular theme is explicitly mentioned by in Mental Health: New Understanding, New Hope (WHO, 2001) Changing Directions, Changing Lives (MHCC, 2012), Open Minds, Healthy Minds (OMHLTC, 2011), Supporting Minds and Achieving Excellence (Ontario Ministry of Education, 2013; 2014).

It is emphasized that educators must acknowledge they are not solely responsible for the prevention, promotion, and treatment of mental health, mental illness, and mental well-being, but are rather apart of a larger community which must work together to transform and improve the climate of child and adolescent mental health and well-being. This theme and recognition is particularly important as educators are not healthcare providers or expected to be mental health experts.

The role of educators is ultimately to implement preventative efforts to enhance mental health, promote well-being, identify risk factors and early symptoms, support student learning, and connect students to the appropriate supports. Under no circumstances are educators alone in this mission; in fact, they are encouraged to rely on the established system of support and care (MHCC, 2012). This recognition is a strong theme to explicitly recognize, as the recommendations outlined in the policy document could be easily misconstrued, presenting the notion that educators and the education system maintain sole responsibility for transforming child and adolescent mental health and well-being.

The World Health Organization, Mental Health Commission of Canada, Ontario Ministry of Health and Long-term Care, and the Ontario Ministry of Education have ultimately published important strategies, policies, and priorities, over the past 16 years. These documents, strategies, and policies demonstrate that mental health and well-being have become an extraordinarily significant subject of focus throughout society. This commitment towards transforming the landscape of mental health and well-being has demanded alterations in thought regarding treatment, prevention, and stigma, along with transformed perceptions of mental health and well-being.
While these changes are occurring on a global, national, provincial, and municipal scale it is also important to recognize that these changes have influenced the landscape of education as this sector is a crucial respondent to the care, well-being, growth, and development of children and youth. Ultimately, the education system and educators are recognized as key contributors to promoting positive mental health, preventing mental illness, reducing stigma, and intervening early when it comes to children and youth (MHCC, 2012; OMHLTC, 2011; Ontario Ministry of Education, 2013; Ontario Ministry of Education, 2014).

While Supporting Minds, released by the Ontario Ministry of Education, in 2013, promotes an avenue for early identification and classroom strategies, to support students who have a clinical diagnosis or are exhibiting such symptoms, it is recognized that little information is provided to educators regarding preventative and promotional based interventions and programs for enhanced mental well-being, mental health, and resilience. The work conducted to date is monumental; however, this limitation is an undeniable shortcoming, influencing the direction of this resource for educators.
Overview

Moving forward, with an in-depth understanding of foundational knowledge necessary to utilize this recourse, Part Two strives to provide an overview of the approach adopted within this resource. First and foremost, the concept of Positive Psychology is outlined offering a description of the theoretical approach to mental health that is applied throughout this resource. This section strives to describe an approach to mental health that is primarily concerned prevention and promotion based efforts focused on positive emotions, positive individual traits, positive relationships, and positive institutions (Seligman, 2002). This focus is essential as it signifies the importance of broadening available resources for educators, by abandoning the primary focus on the deficit approach, as seen in Supporting Minds, and providing a relevant avenue for promoting overall mental health, well-being, and resilience.

Subsequently, the intended scope for implementation of the provided suggestions is addressed. This discussion highlights the Multi-Tiered System of Support, providing a detailed explanation of universal, targeted, and indicated intervention programs. Seeing as this resource aligns with universal programming, a justification for this scope is presented, highlighting how this style of programming allows for all students to benefit, and is focused on prevention and promotion based programs.
Positive Psychology

Consistent with mental health, mental illness, well-being and resilience definitions, there are various theoretical approaches and concepts of mental health. Each theoretical approach interprets and responds to mental health distinctly, representing a variety of approaches to understanding, perceiving, and addressing mental health. While no method is more ‘correct’ than another, this resource admittedly elected to align its self with the beliefs of Positive Psychology. Positive Psychology was seen as a natural fit as this resource recognizes the necessity to incorporate an approach to mental health that values prevention, promotion, and treatment efforts.

As the educator utilizing this resource you are encouraged to reflect on the position of Positive Psychology in order to establish an understanding of the multidimensional aspects of psychology in research, practice, and education.

It is important to recognize that the theoretical concept of Positive Psychology is a product of the belief that mental health, in both practice and research, has deviated from its founding ambitions, neglecting to acknowledge the founding goals of psychology equally. To understand this deviated focus, it is important to recognize that psychology was founded on three ambitions including to:

1) Cure mental illness,
2) Improve individual productivity and life fulfillment, and
3) Identify high talent (Chodkiewicz & Boyle, 2017; Seligman & Csikszentmihalyi, 2000).

These goals promote the notion that psychology was initially founded based on the desire to further understand mental health, mental well-being, and mental illness. While all three goals are relevant, it is recognized by Positive Psychology that a heightened focus has been placed on curing mental illness, resulting in a neglect of the remaining goals (Chodkiewicz & Boyle, 2017).

A hyper-focus on mental illness, primarily represents a deficit, disease-based approach to mental health, consistent with the medical model, and is mainly accredited to a shift following World War II (Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2002). It is recognized that the establishment of the Veteran’s Administration (now known as Veteran Affairs) in 1946, and the National Institute of Mental Health in 1947 enhanced funding opportunities for mental illness research, allowing for psychologists and researchers to make a living by curing illness (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). This shift ultimately influenced a hyper-focus on mental illness as it enhanced eligibility for funding.
This hyper-focus is also evident today as the most widely recognized reference guide among the field of psychology is the *Diagnostic and Statistical Manual* (DSM) created by the American Psychiatric Association (Kawa & Giordano, 2012). Now in its fifth edition, the DSM has evolved overtime, however, a medical model approach to mental health, with a focus on disease, is still overwhelming represented within the DSM (Kawa & Giordano, 2012).

Furthermore, the focus on mental illness is evident in one of the most substantial documents released by the Ontario Ministry of Education in 2013, titled *Supporting Minds: An Educator’s Guide to Promoting Students’ Health and Well-Being*. While the release of *Supporting Minds* is substantial, and the document provides valuable information regarding the current context of mental illness in children/adolescents, descriptions of key mental illnesses, and a variety of suggestions for educator’s regarding how to support students with mental illness diagnosis, little information is provided regarding how to promote individual productivity/life fulfillment, and recognize high talent among all students. It is this gap in understanding and resource availability that has influenced the necessity for this resource to be developed, and adopt a Positive Psychology approach to mental health and well-being within schools.

It is also substantial to recognize how this constricted focus on mental illness has led to blurred definitions of mental illness and mental health, the stigmatization of mental health and mental illness, the abandonment of research pertaining to child/youth mental health/illness, and an under-representation of how individuals do and can flourish (Chodkiewicz & Boyle, 2017; Kobau et al., 2011). While it is recognized that research focused on mental illness has reached substantial contributions, significantly improving societies understanding and ability to respond to mental illness, Positive Psychology promotes the necessity to refocus on the roots of psychology, providing equal attention to the currently neglected goals of psychology.

By the 20th Century, the limited focus of psychology and resulting shortcomings were recognized as problematic (Chodkiewicz & Boyle, 2017). While ample advances are noted regarding negative emotions and mental illness, the limited understanding of positive emotions and mental health/well-being is recognized as alarming (Kobau et al., 2011). This acknowledgment, in combination with the increasing prevalence and recognition of mental illness, demands a renewed focus to be established within the field of psychology to understand and emphasize what is right, versus primarily focusing on what is wrong (Chodkiewicz & Boyle, 2017; Kobau et al., 2011). As a result of the unbalanced attention, Martin Seligman identified the need for Positive Psychology at the American Psychiatric Association Conference in 1998 (Chafouleas & Bray, 2004; Seligman & Csikszentmihalyi, 2000). Focused on further understanding and identifying strength and positivity, this approach does not denote the existing contributions of psychology or the impact of adverse emotions (Chodkiewicz & Boyle, 2017; Seligman, 2002). Instead, Positive Psychology encourages a more balanced understanding of
mental health, allowing for strength-based orientations to be placed at the forefront of treatment and prevention efforts (Chodkiewicz & Boyle, 2017; Seligman, 2002).

The establishment of Positive Psychology, as an approach to mental health, has thus reinforced the need for a revitalized approach to mental health, heightening the necessity to study resilience, well-being, and prevention efforts (Carr, 2011; Chafouleas & Bray, 2004; Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman & Csikszentmihalyi, 2000). To achieve this fundamental goal four pillars of Positive Psychology have been established by Seligman, including:

1) Positive Emotions (gratitude, happiness, and fulfillment);
2) Positive Individual Traits (optimism, resiliency, character, wisdom, interpersonal skills, high talent, and perseverance);
3) Positive Relationships Among Groups; and,
4) The Promotion of Positive Institutions (civic virtues and institutions that move individuals towards better citizenship)

Evidently, Positive Psychology recognizes the need for both individual and community-based adaptations, aimed towards enhancing mental health and well-being. These pillars ultimately act as the founding criteria for practical suggestions encouraged larger in this resource. Furthermore, as a result of this focus, Positive Psychology maintains two key components: prevention-based efforts, and learned optimism, which are included in both individual and community-based practices.

**Prevention-based efforts.**
Positive psychology is undeniably concerned with fostering and recognizing innate individual competencies, resources, and psychological strengths, to preventatively enhance community assets, prevent mental illness, and promote the development of well-being (Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Under this focus, it is recognized that a Positive Psychology approach to mental health aims to focus on systemically building competence and promoting mental health, versus applying all efforts towards correcting weaknesses and treating mental illnesses (O’Connor et al., 2017; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Grounded in the belief that there is a significant value in dealing with problems before they emerge, and human strength is a buffer against illness, Positive Psychology promotes individual strengths, and teaches adaptive skills through preventative measures and interventions, for the advancement of healthy and positive development (Chodkiewicz & Boyle, 2017; O’Connor et al., 2017; Seligman, 2002; Shoshani & Steinmetz, 2013).

**Learned Optimism.**
Beyond promoting positive development and good health, learned optimism is also fundamental to this mental health approach (Carr, 2011; Seligman, 2002). The concept of learned optimism represents the belief that when a person is wagered that they...
cannot succeed, they will do all they can to dispute that idea; however, when an individual believes they cannot succeed, they will surrender (Seligman, 2002). This concept is fundamental to the Positive Psychology approach, as catastrophic thinking patterns can become self-reinforcing, heightening the prevalence, and risk of developing a mental illness such as anxiety and depression (Seligman, 2002). Learned optimism is therefore significant as the ability to be a skilled disputer of catastrophic thinking, through learned optimism, enhances an individual’s capacity to combat negativity, influencing positivity (Seligman, 2002).

By providing a designated focus on mental health promotion, mental illness prevention, and learned optimism, Positive Psychology represents an approach to mental health that is focused on inspiring a positive objective experience, in the past, present and future, through the incorporation of well-being, resilience, and prevention efforts (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). It is essential to keep these two founding elements in mind when utilizing this resource as the proposed initiatives and educational implications are constructed based on the necessity for prevention-based efforts and learned optimism.

Just as it is important to understand the motivation for Positive Psychology and the fundamental beliefs of this approach, it is also substantial to understand why this particular approach was selected as the underlying theoretical framework for this resource. The following justifies the inclusion of Positive Psychology, listing the distinguished positive characteristics of this approach in regards to mental health.

- Positive Psychology as an approach to mental health demands that educators abandon the deficit, disease-based model to approach mental health preventatively and with optimism.

- Positive Psychology maintains the fundamental belief that raising children is about recognizing, amplifying, and nurturing their marvellous strengths, leading to a good life, and enhanced buffers against weaknesses and challenges (Seligman & Csikszentmihalyi, 2000).

- This approach innately sponsors the need to establish resilience and promote well-being (Carr, 2011; Kobau et al., 2011; Seligman, 2002).

- Positive Psychology recognizes that cultivating resilience within people, among people, and across social levels is important, as resilience maintains the capacity to decrease recovery time, enhance resources for everyday living, buffer against negativity, and promote the experience of positive emotions (Kobau et al., 2011; Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

- Positive psychology aims to promote well-being both cognitively and emotionally:
  - Cognitive well-being is promoted through advancements in the
capacity to positively evaluate life, enhancing the development of psychological and academic success required for a fulfilled life (O’Connor et al., 2017).

- Emotional well-being is promoted through the experience of positive emotions, also influencing: physical health, healthier lifestyle choices, enhanced coping strategies, long-term adaptability, a reduction in negative emotions, enhanced social experiences, and reduced psychological suffering (Carr, 2011; Kobau et al., 2011).

- Individuals are recognized as decision makers, maintaining autonomy over their ability to enhance adaptive functioning even when experiencing distress or psychological impairments (O’Connor et al., 2017; Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

While each of the recognized justifications for Positive Psychology are relevant, this approach is favoured in an educational resource for two reasons:

- The fundamental inclusion of prevention, resilience, and well-being efforts; and,

- The ability to positively reconceptualise child/adolescent development (Chodkiewicz & Boyle, 2017).

These elements make this approach relevant within schools as they emphasize the need to recognized developmental challenges and learning difficulties, further promoting the school as a key environment for universal mental health promotion and prevention efforts (Chadouleas & Bray, 2004; Chodkiewicz & Boyle, 2017; O’ Connor et al., 2017; Seligman, 2002; Shoshani & Steinmetz, 2013).

As further academic demands are placed upon the education system, and concern is increasingly raised regarding child/adolescent mental health and well-being schools are in a precarious position to not only respond to illness, but to prevent further difficulties and improve the developmental trajectory of young people (Chodkiewicz & Boyle, 2017). According to Positive Psychology, this proactive response can be achieved by encouraging positive self-perceptions, positive emotions and positive behaviours, and contributing to the establishment of academic, social and emotional literacy, for the development of young people who will maintain the skills, abilities and emotional resiliency to thrive in a changing world (Chodkiewicz & Boyle, 2017).

By reuniting social and emotional practices in the learning environment, an academic and skill based curriculum can be supported, reducing the negative emotions that inhibit growth, focusing on high talent, and how individuals can live a fulfilled life (Chafouleas & Bray, 2004; Chodkiewicz & Boyle, 2017; Shoshani & Steinmetz, 2013). To promote the mastery of academic, social, and behavioural competencies, for enhanced mental health and well-being, Positive Psychology in school is typically founded by the PERMA framework, which includes:
Positive emotions, emotional experiences, emotional well-being, and a healthy response to negative emotions:
  - Includes feelings of happiness, joy, and cheer

Engagement and immersion in activities:
  - Psychological and emotional connections to intriguing activities/organizations

Social skills for healthy Relationships:
  - Feelings of social integration, care and support from others, and satisfactory social connections

Meaning through purposeful service to others:
  - Believing that one’s life is valuable, and feeling connected to something greater than oneself

The Achievement of meaningful goals:
  - Incorporates making progress towards goals, feeling capable of daily goals, and experiencing achievement and success (Kern et al., 2015; O’Connor et al., 2017).

According to Positive Psychology, the incorporation of PERMA maintains the capacity to provide health-promoting conditions and resiliency building capacities (O’Connor et al., 2017). Positive Psychology in schools aims to encourage the promotion of well-being, resilience, and prevention efforts, supporting significant advancements in child/adolescent mental health and well-being through school-based programming.

It is evident that the overwhelming emphasis on clinical psychology motivates the establishment of Positive Psychology (Carr, 2011; Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2002). While Positive Psychology does not belittle or deny the need for research regarding mental illness, mental distress, or negative experiences, it does promote an alternative way to describing and valuing the complete spectrum of mental health (Carr, 2011; Kobau et al., 2011). Instead of focusing on what is wrong, Positive Psychology intends to promote what is right, advocating for the development of coping strategies, resilience, well-being, and positive emotional experiences (Chodkiewicz & Boyle, 2017; Kobau et al., 2011; Seligman, 2002). Aiming to renew how mental is conceptualized, Positive Psychology privileges the need for resilience, resourcefulness, well-being, and mental health promotion/prevention to enrich the human experience (Kobau et al., 2011; Seligman, 2002). It is recognized that good health is about more than the absence of illness, and Positive Psychology believes that mental health programs, initiatives, and supports must aim to nurture strong qualities and help individual find niches that will allow them to live out their strengths (Seligman & Csikszentmihalyi, 2000).
A Multi-Tiered Approach to Mental Health and Well-Being Initiatives in Education

It is recognized that mental health and well-being initiatives intended for children and youth are essential. More so, it is understood that such initiatives and programs must provide a balanced focus on prevention, promotion, and treatment efforts. As Positive Psychology outlines, the fundamental goals of psychology are to not only cure mental illness, but also to improve individual productivity and life fulfillment, and nurture and identify high talent (Chodkiewicz & Boyle, 2017; Seligman & Csikszentmihalyi, 2000). This balanced recognition calls for prevention and promotion efforts, in addition to treatment efforts, to be readily available. For this reason, the Multi-Tiered System of Support (MTSS) is recognized as an efficient model for the implementation of mental health and well-being initiatives, focused on building resilience within schools.

The Multi-Tiered System of Support (MTSS)

The MTSS model, as pictured, is recognized by psychologists, counselors, social workers, nurses, and increasingly by schools as the most efficient and effective framework for organizing mental health programs within schools (August et al., 2018; Desrochers, 2014). This model is recognized for its provision of three intensifying levels of support, placed among a continuum of care, offering a systemic method for implementing prevention, promotion, and treatment efforts within schools (Desrochers, 2014). While understanding the various layers of this model is essential, it is necessary to recognize that the suggestions ultimately provided within this resource are focused on Tier One: Universal Programming. While this resource offers programming suggestions that could be implemented efficiently in higher tiers the focus is on universal provision for the benefit of all students. To understand how this model is constructed, and how each level of care is characterized the following outlines the three tiers of this model.
Tier One – Universal Programming

The first level of programming, outlined by the MTSS model, is Universal Programming. This tier of support is concentrated on providing proactive initiatives, including mental illness prevention, mental health and well-being promotion, mental health/illness awareness, and mental health/illness stigma reduction (August et al., 2018; Desrochers, 2014; Macklem, 2011).

The most noteworthy aspect of this tier is the fact that all students receive this baseline programming, as no selection process is implemented or required (Macklem, 2011). This component is essential as all students within a classroom/school, regardless of the presence or absence of mental illness, superficial suffering, emotional distress and/or disguised distress, receive exposure to universally offered programming.

This approach supports the ability for whole class or school implementation, allowing for interventions and initiatives to be consistently taught, reinforced, and supported by behavioural expectations (August et al., 2018; Macklem, 2011). It is recognized that the most effective Universal Programming initiatives are informed by:

- A concise and clear goal;
- Culturally sensitive curriculum and skill development;
- Parent and Guardian participation;
- Sequenced, coordinated, and developmentally appropriate skill accusation;
- Theoretical and evidence-based practices; and,
- School-wide efforts (advancements in school climate, holistic staff involvement, administrative support, and professional development opportunities) (Desrochers, 2014; Macklem, 2011; O’Mara & Lind, 2013).

Research on Universal Programming has found that initiatives implemented universally lead to: enhanced help-seeking behaviour, reduced stigma, improved mental health literacy, and the adaption of effective coping strategies among participants and communities promoting resilience (Macklem, 2011; Manion et al., 2012). Evidently, this tier of intervention promotes the two key goals of Positive Psychology, aiming to improve individual productivity and life fulfillment, and nurture and identify high talent.

Tier Two – Selected/Targeted Programming

Tier Two, Selected or Targeted Programming, is intended for students who require further support beyond what is offered at Tier One in Universal Programming. Student’s who are identified for Targeted Programming are selected to participate in small-group initiatives focused on helping students who are experiencing emotional and/or behavioural problems or are at increased risk of further developing mental health complications (August et al., 2018; Desrochers, 2014; Macklem, 2011). This tier of programming boarders between proactive and reactive care, offering programming that
is focused on prevention and promotion, but includes useful early intervention techniques. Ultimately, Targeted Programming is focused on responding proactively to early warning signs by providing enhanced support.

The small group selection process for Targeted Programming is informed by universal screening measures, or by teachers who notice social, emotional and/or behavioural difficulties, which could lead to the development of mental illness (Macklem, 2011). It is significant to specify that groups are established based on similar characteristics and concerns, aiming to provide programming that is specific to the groups shared needs (Macklem, 2011). When providing targeted care, it is recognized that more formally established and structured, evidence-based programs are utilized to ensure effectiveness (August et al., 2018). While teachers can lead this level of support, it is often in consultation with, or with guidance from designated school mental health leads.

**Tier Three – Indicated/Intervention Programming**

When Universal and Targeted Programming do not meet the needs of students, enhanced support, through Indicated Programming or Interventions, are warranted (August et al., 2018; Macklem, 2011). This tier of support is the most intense and is often targeted towards students who are already experiencing mental health problems or illnesses or at high risk (August et al., 2018; Desrochers, 2014).

This level of intervention is focused on promoting individualized intervention plans, treatment, and coping strategies (August et al., 2018). Such initiatives and responses within this tier require referral to medical services, and the support of specialized school personnel including resource teachers, mental health leads, and support teams. While classroom teachers are actively involved in implementing the prescribed programming and can adjust their classroom to meet the student's needs, they are not responsible for providing treatment interventions (August et al., 2018; Macklem, 2011).

This level of programming is almost exclusively led by school-based experts, mental health professionals, and/or medical personnel, in-class teachers only support the student's needs within the learning environment while continuing to expose the student to universal supports.
Overview of the Multi-Tiered System of Support

<table>
<thead>
<tr>
<th>Tier One Universal Programming</th>
<th>Tier Two Targeted Programming</th>
<th>Tier Three Indicated Programming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Select students who demonstrate increase risk or warning symptoms.</td>
<td>Students at extreme risk of developing a mental illness and/or students with a mental illness diagnosis.</td>
</tr>
<tr>
<td>Setting</td>
<td>All-inclusive programming, within the classroom.</td>
<td>Small-group programming, separate from class instruction.</td>
</tr>
<tr>
<td>Program Lead</td>
<td>Classroom teacher.</td>
<td>Classroom teacher supported by school-based experts or Special Education Teacher(s).</td>
</tr>
<tr>
<td>Role of the Teacher</td>
<td>Responsible for the implementation and maintenance of initiatives.</td>
<td>To support the initiatives within the classroom and/or provide the targeted programming.</td>
</tr>
</tbody>
</table>

The three approaches listed within the MTSS model support significant care provisions for the enhancement of child/adolescent mental health and well-being. Each approach maintains a unique focus, and it is recognized that the application of all three levels of care is essential to the success of school programming. While this resource guide focuses on the provision of Universal Programming, to improve the mental health and well-being of all students, through prevention and promotion-based efforts, it is emphasized that Targeted and Intended Programming are also substantial to the
success to mental health and well-being advancement among children and youth. This focus in no way denotes the significance of intensified support, however it does focus on how all students can be proactively reached.

In general, a Universal approach to mental health and well-being initiatives within schools is promoted for key reasons, including:

**To balance the focus of Supporting Minds.**
As mentioned previously, the document released by the Ontario Ministry of Education (2013) *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* is primarily focused on a medical model approach, emphasizing how to respond to mental illness within the classroom. While this information is valuable, it neglects to recognize how mental health can be promoted, and mental illness can be prevented through the establishment of resiliency. Evidently, the Universal Programming tier of the MTSS approach recognizes the need for prevention and promotion based initiatives to be provided to all students, while the MTSS model maintains recognition of the significance of *Supporting Minds* and treatment agendas.

**To reduce enhanced need.**
A proactive, promotion, and prevention based approach, such as Universal Programming, is recognized for its ability to enhance resiliency and coping strategies, hopefully reducing the demand for intensive interventions (Desrochers, 2014). It is acknowledged that not all instances of mental illness can be prevented, however, it is hopeful that the implementation of preventative programming can reduce the need for enhanced support, and help preserve the quality of care provided by intense care providers.

**To eliminate the service gap.**
If not for Universal Programming it is recognized that the majority of students would be unlikely to receive support or programming. This division in service is problematic, as established modes of care exist for those experiencing mental health disorders or recognized distress, however, there is little in place for the remainder of the population. It is therefore recognized that the establishment of Universal Programming both allows for, and calls for, programming to be provided for the benefit of all students.

**To reduce academic challenges.**
It is recognized that one of the most substantial challenges impeding an educator’s ability to meet the academic needs of their students is emotional and/or behavioural challenges (Desrochers, 2014). This is substantial as the implementation of Universal Programming promotes the ability to reduce negative behaviours, by establishing coping strategies, ultimately enhancing resilience and academic success (August et al., 2018; Desrochers, 2014).
Overview

The final section of this resource is dedicated to providing a comprehensive overview of the universal approaches to promoting mental health and well-being that align with the Positive Psychology Framework.

The first approach explored is the concept of Mental Resilience. This approach is rooted in the belief that resilience can act as an immunity model to mental illness and poor mental health, and therefore should be incorporated to neutralize the potential impact of adversity caused by psychological struggle (Davydov et al., 2010). By recognizing the role of harm reduction factors, protective factors, and promotional factors the necessity for resilience building efforts is explored, along with strategies for implementation.

Following Mental Resilience, the concept of Implicit Theory or Mindset is explored. This section provides an overview of Implicit Theory and the two associations within Implicit Theory, including Incremental Theory (Growth Mindset) and Entity Theory (Fixed Mindset). With an understanding of Implicit Theory and its significance, the focus then shifts to explore practical strategies for implementing Incremental Theory.

Additionally, Social-Emotional Learning is thoroughly explored. Similarly structured, this section provides an overview of Social-Emotional Learning, the five core competencies that comprise Social-Emotional Learning. An in-depth justification for the adoption of this approach and an overview of a variety of implementation strategies and methods are provided.
Mental Resilience

Exploration of the commonalities between resilience and mental health, and with the acknowledgment that resilience can act as an immunity model to mental illness has contributed to the recognition of mental resilience. Mental resilience primarily roots itself in the belief that individuals must possess biological, psychological and social mechanisms to recognize and neutralize the potential impact of adversity to survive psychological struggle (Davydov et al., 2010). These built in mechanisms ultimately consist of both internal and external constructs serving to protect, promote, and mitigate subjectivity to adversity (Davydov et al., 2010).

It is proposed that this construct includes various competencies, however, three key tactics ultimately comprise mental resilience. This includes harm reduction factors, protective factors, and promotion factors (Davydov et al., 2010).

Harm Reduction Factors
Harm reduction factors are reactive tactics, primarily operating in response to the invasion of internal and/or external protective barriers (Davydov et al., 2010). Harm reduction factors ultimately strive to respond to such invasions, or risks, by providing quick and effective recovery after stress, promoting the return of mental, emotional, and cognitive equilibrium (Davydov et al., 2010).

Protective Factors
In opposition to harm reduction factors, protective factors are applied when an individual is faced with a level of adversity that can be reduced through the application of internal and external protective factors (Davydov et al., 2010). Such responses, when circumstantially appropriate, allow for the individual to maintain well-being regardless of the proposed risks (Davydov et al., 2010). It is important to note that protective factors can be deployed without success, requiring a response from harm reduction factors.

Promotional Factors
Promotional factors aim to enhance psychological well-being by continually promoting the development of mental resilience through the establishment of competencies used for harm reduction and protection (Davydov et al., 2010).

It is clear that mental resilience involves an array of factors that are applied both proactively and reactively. While these factors (harm reduction, protection, and promotion) strive to respond to the adversity it is further recognized by Davydov et al. (2010), that the following competencies contribute to harm reduction, enhanced recovery, and the promotion of mental resilience:

- Intellectual functioning and cognitive flexibility;
- Social attachment and social behaviours;
Positive self-concept;
- Effective self-regulation of emotions;
- Positive emotions such as optimism and humour;
- The capacity to transform traumatic helplessness into learned hopefulness;
- Meaning (religion and spiritual);
- Social support from role models;
- Active coping styles when confronting stressors;
- A capacity to recover from negative events/stress; and
- A capacity to accommodate trauma-related information in a positive direction.

Evidently, individuals can develop and possess an array of internal and external factors that will enhance their mental resilience.

Exposure and Resilience Development

It is acknowledged that mental resilience is comprised of mental resilience competencies and factors, which are applied in the face of adversity; however, it is also substantial to understand how these competencies develop. According to the presented research, it is through developmentally appropriate exposure to adversity, and the opportunity to successfully overcome challenges that individuals build mental resilience (Davydov et al., 2010). It is reported that behavioural immunization, a process where individuals experience adversity, resulting in disorganization, and are able to accommodate the experience in their memory and return to equilibrium, builds mental resilience (Davydov et al., 2010).

Alternatively, it is recognized that exposure too only positive experiences, or experiences that are easily overcome lead to anti-stress training (Davydov et al., 2010). Anti-stress training is concerning as individuals simply return to their previous state without growth or the development of key competencies/factors (Davydov et al., 2010). Evidently, it is through experience and exposure that mental resilience is achieved and maintained.

The notion that exposure to various developmentally appropriate experiences influences the establishment of internal/external protective factors implies significant implications for practice. This includes:

**Not all experiences of adversity are beneficial**

If an individual cannot employ effective strategies to overcome adversity and return to equilibrium, then the experience can be counterproductive (Davydov et al., 2010). This implication promotes the belief that developmentally appropriate exposure is necessary for the development of mental resilience.
The necessity to scaffold independence
It is recognized that parents, guardians, educators, and influential adults involved in the lives of children and youth must promote and contribute to the development of mental resilience. This contribution is recognized as scaffolding, where adults support independence and offer support when necessary (Davydov et al., 2010). This implication is important as it promotes the role of adults as a supporter. It must be specified that too much independence and/or too much support are inhibiting factors in resilience development.

Fundamental needs and resilience
On another note, it is widely recognized that an individual’s ability to develop and employ mental resilience is influenced by their ability to maintain fundamental needs (Bhugra et al., 2013; Davydov et al., 2010; Manwell et al., 2015). This acknowledgment emphasizes the belief that individual circumstances and overall health and well-being impact a child/adolescents ability to overcome adversity.

It is evident that mental resilience incorporates a variety of competencies and approaches towards resisting adversity related to mental health, mental well-being, and mental illness. The combination of harm reduction, prevention, and promotion factors support the belief that mental resilience is multifaceted. It is also recognized that mental resilience must be developed, as opportunities to establish resilience are vital. This alludes to the belief that the scaffolding of child/adolescent experiences is necessary.

Why Resilience in Schools?
It is recognized, and generally agreed upon, that education is enhanced when learning is meaningful, problem behaviours are reduced, and productive citizens are shaped (Ontario Ministry of Education, 2013, 2014, 2015; Stanley, 2008/2009). However, it is also acknowledged that the ability for education to address such demands requires the system to rethink traditionally instilled barriers and take proactive action, intervening before warning signs fester into dangerous proportions (Stanley, 2008/2009). With the understanding that schools strive to support students and enhance learning outcomes proactively, the following will outline why the incorporation of resilience into schools is a perfect fit.

Ideal Environmental Conditions
The most influential argument for the incorporation of resilience within schools is based in the belief that schools support the most optimal conditions to promote mental resilience within children and youth (Henderson, 2013; OECD, 2017; Rew, 2005). This justification is supported by the following beliefs:
The school milieu is optimal for enforcing clear structures, fair boundaries, and basic human respect, while congruently promoting dignity, optimistic possibilities, and the capacity to overcome adversity (Henderson, 2013; Rew, 2005). These environmental factors are considered to be vital as they enhance protective factors and reduce potential vulnerabilities, enhancing resilience (Rew, 2005).

Schools and the staff within them maintain the capacity to help students buffer against vulnerabilities, and mitigate the impact of stressors (Henderson, 2013; Rew, 2005; Stanley, 2008/2009). This factor is embedded in the belief that educators and school support personnel maintain consistent access to their students, enhancing the ability to identify problems and intervene early (Stanley, 2008/2009). This dynamic is significant as early intervention in both life course and problem development is essential to mitigating vulnerabilities and enhancing protective factors (Stanley, 2008/2009).

Relational Connections
Schools are also considered to be ideal environments for the promotion of resilience as they hold the capacity to foster significant relationships between educators and students (Davydov et al., 2010; Henderson, 2013; OECD, 2017; Rew, 2005; Stanley, 2008/2009). Consistent with resilience, the promotion of meaningful, caring, and supportive relationships with role models, mentors, and adults are vital to the development of resilience and youth within our students (Henderson, 2013). These relationships are reportedly meaningful as adults maintain the capacity to act as mentors, role models, confidants, and as agents of protection, decreasing isolation and encouraging active inclusion and engagement (Stanley, 2008/2009). Ultimately, it is believed that educators uphold a valuable role in the lives of children and youth, maintaining the capacity to enhance resilience by building caring, meaningful, and supportive relationships with students.

Incorporating Resilience in Schools
It is understood that educators are in a unique position to promote resilience within children and youth. However, it is equally important to understand how resilience can be incorporated into the learning environment. Research suggests two key shifts that ultimately support the ability for educations to promote mental resilience within the classroom: a shift in pedagogy, and the inclusion of the resilience wheel.

Negotiate Independence and Resilience Development
As established previously, for resilience to be developed within children and youth students must be provided developmentally appropriate opportunities to negotiate adversity and develop and apply resilience orientated skills (Davydov et al., 2010). This stipulation requires educators to understand that they must learn to scaffold students to engage in and approach adverse situations independently. While offering
independence can require further time and effort it is important not to overstep, and to provide students with the opportunity to navigate the situation independently, only providing support as absolutely necessary (Davydov et al., 2010). This negotiation is recognizably challenging, as too much independence and/or too much support are both inhibiting factors in resilience development.

**Shifting Pedagogies**

For educators to foster mental resilience within their students it is recommended that educators undergo a slight, but significant shift in philosophical beliefs. This recommendation stems back to the notion that resilience, as a theory, was born out of the 1980s focus on children and youth who were considered to be ‘at risk’ of failure (Whitney et al., 2008). Essentially, the term ‘at risk’ which was embedded in the founding beliefs of resilience, was coined to represent a vulnerability or shortcoming in an individual’s social, cognitive, psychological, intellectual, and/or environmental development/circumstances (Whitney et al., 2008). While the concept of resilience has transformed significantly, it notably maintains its negative underlying connotation, influencing perceptions of resilience (Whitney et al., 2008).

Based on the recognition of this deficit approach, it is acknowledged that educators must consider their perceptions and abandon the deficit approach (Henderson, 2013). Instead, educators are encouraged to believe that all children can poses resilience regardless of the challenges they may face, consistent with the beliefs of Positive Psychology. This shift is significant as it encourages educators to emphasize, reinforce, and promote student strengths (Henderson, 2013). When this change occurs the conversation shifts, changing a child’s perception from “I am a problem” to “I have strengths despite my problems” (Henderson, 2013). This shift in perspective is essential, for both educators and students, as it aids in the development of self-concept, optimism, hope, and self-worth, enhancing resilience (Davydov et al., 2010; Henderson, 2013). Ultimately, a shift from a position of vulnerability to competence empowers educators to make changes in their classroom and enhance the development of resilience within their students. Furthermore, this shift entices students to focus on their strengths and build resilience.

**The Resilience Wheel**

While a shift in pedagogy, neglecting the deficit model and embracing the competence model, is recognized as the first step towards incorporating mental resilience within education schools are also strongly encouraged to adopt the Resilience Wheel model. This particular framework is rooted in the belief that schools can promote mental resilience within children and youth, for the enhancement of mental health and well-being, by mitigating environmental risk factors, and promoting resilience in the school environment (Henderson & Milstein, 2003; Whitney et al., 2008).

This resilience wheel is designed to be a comprehensive tool for the promotion of resilient behaviours and positive developmental outcomes among students (Whitney et
Initially, educators are encouraged to foster resilience among children and youth by mitigating risk factors (Henderson & Milstein, 2003). This focus encourages educators to increase pro-social bonding opportunities, set clear and consistent boundaries, and teach life skills (Henderson & Milstein, 2003). Alternatively, educators can build resilience in the learning environment by providing care and support, setting and communicating high expectations, and by providing students with opportunities for meaningful participation (Henderson & Milstein, 2003).

It is recognized that the inclusion of these six elements, paired with a shift in pedagogy, withstands the power to enhance resilience capacity within students. In fact, a 3-year research study from Albuquerque, New Mexico indicated that a commitment to embedding these six principals into the school milieu and the school’s mission and values resulted in significantly enhanced student resilience (Henderson & Milstein, 2003). It is believed that when the Resilience Wheel is embedded into the learning environment that students will develop the required competencies to enhance resilience within a context that supports this growth (Whitney et al., 2008).
Increase Prosocial Bounding
School Visions and missions are clear, communicated, and agreed upon.
Equity, risk taking, and learning are promoted.
A positive and supportive organizational climate and culture exists.

Provide Opportunities for Meaningful Participation
Students are viewed as workers, and teachers as coaches.
Everyone's contributions are valued.
Members grow and learn by sharing and treating one another with respect.
Experimentation is encouraged.

Set Clear, Consistent Boundaries
Cooperation and support exist.
School wide objectives are shared.
Members are involved in setting policies and rules.

Teach “Life Skills”
Efforts are actively made to improve the school.
Risk taking is supported.
Individual and group skill development is promoted.
Positive role modeling is practiced.

Provide Care and Support*
Members have a sense of belonging.
Cooperation is promoted.
Success is celebrated.
Leaders share numerous positive interactions with members.
Resources are obtained with a minimal effort.

Build Resilience in the Environment
Mitigate Risk Factors in the Environment
Implicit Theory or Mindset

Within education, the concept of Mindsets, Fixed and Growth, have recently surfaced as popular topics of discussion, research, and practice. The incorporation of Mindsets within education has primarily been associated with benefits in student educational outcomes, demonstrating that students with a growth mindset are more resilient, and more likely to achieve academic success. However, there is growing research to justify that Mindsets hold the potential for much more significant impacts. Included in this belief, is a promising connection between mindset and student mental health and well-being, reflecting the notion that a growth mindset can enhance mental health and well-being while building resilience. The following aims to provide an explanation, justification, and necessary resources to implement this approach. It is hopeful that this information will encourage and equip you to incorporate Implicit Theories within your classroom for the enhancement of resilience, influencing mental health and well-being.

Implicit Theory

In the simplest sense, Implicit Theory, otherwise known as Mindset, is indicative of how an individual perceives self, and how these beliefs impact resulting actions and resilience (Seaton, 2018). According to this model, two distinct theories/mindsets exist including:

A) Incremental Theory, otherwise known as Growth Mindset, and
B) Entity Theory, otherwise known as a Fixed Mindset (Seaton, 2018).

These mindsets are reportedly responsible for influencing an individual’s response to challenges and setbacks, shaping how meaning is derived from situations, motivation is applied, behaviour is exhibited, and goals are met (Schroder et al., 2015).

The main distinction between these mindsets is embedded in their perspective regarding the malleability of human attributes, influencing self-regulatory processes and outcomes (Burnette et al., 2014; Schroder et al., 2015; Yeager et al., 2014). The unique distinction, between incremental and entity theory, is primarily linked to an individual’s perceived control, applied response, and resulting outcome, all of which is applied in response to the prompted challenge (Burnette et al., 2014).

It is important to acknowledge that such mindsets are not static and/or permanent, nor are they consistent among various attributes, as an individual’s mindset is domain specific, and can be altered (Seaton, 2018). It is important to highlight that individuals maintain distinct mindsets in a variety of basic qualities and/or global attributes, including:

- Personality,
- Intelligence,
- Social characteristics,
- Moral character,
- Peer relations,
- Cognitive ability,
- Emotional regulation, and
- Mental health/resilience,

(Robinson, 2017; Schleider et al., 2015; Schroder et al., 2015; Seaton, 2018; Yeager et al., 2014). It is important to note that no single theory or mindset is attributed universally to all global attributes, as each attribute is distinctly aligned with either an entity or incremental theory (Burnette et al., 2014; Schroder et al., 2015).

While every individual maintains a substantial number of Implicit Theories of self, it is important to acknowledge that these beliefs are considered to be lay theories (Burnette et al., 2014). Lay theories represent that the Implicit Theory held by an individual, in each unique domain, is often not explicitly recognized by the individual (Burnette et al., 2014).

While Implicit Theories are often unrecognized, they are influential perceptions as Implicit Theories are embedded in schematic knowledge structures, maintaining beliefs about attribute stability, and organizing the way that events are given meaning (Burnette et al., 2014). Ultimately, these theories and schematic structures impact self-regulation and behaviour, by shaping how information is processed and perceived (Yeager et al., 2014).

Although often unrecognized, the influence of Implicit Theory is reportedly most influential and recognizable when an individual is faced with adversity, difficulty, or a situation that is perceived to be challenging (Hochanadel & Finamore, 2015; Schroder et al., 2015; Yeager et al., 2014). It is recognized that an individual’s Mindset when facing adversity influences the following circumstances:

A) The level of motivation applied to face the challenging situation (Kneeland et al., 2016);
B) The attributions an individual’s makes about themself (Kneeland et al., 2016);
C) The degree of control the individual believes they maintain over their abilities and external circumstances (Kneeland et al., 2016);
D) Associations made regarding the challenge (positive or negative) (Peterson & Seligman, 1984, as cited in Hochanadel, & Finamore, 2015);
E) How performance is appraised (Schroder et al., 2015); and
F) Beliefs about how behaviour and emotion can, or cannot, be modified (Schroder et al., 2015).

It is believed that an individual’s Implicit Theory, in the challenged domain(s), is said to moderate the interaction between the proposed challenge level, and the subsequent performance, influencing the adjustment approach and action applied (Seaton, 2018). It is important to note, that much of the research surrounding mental resilience, internal...
and external circumstances and the intensity of the challenge presented can impact the outcome (Seaton, 2018).

Ultimately, the significance of Implicit Theory and Mindset is grounded in the understanding that an individual’s Implicit Theory, or Mindset, in each domain reflects a well-established predictor of resilience to challenges (Schroder et al., 2015). It is understood that Implicit Theories impact day-to-day, and moment-to-moment function, forming a framework for interpreting and responding to adversity (Schleider et al., 2015). The distinction between Incremental theory (Growth Mindset), and Entity Theory (Fixed Mindset) contribute to an understanding of how resilience is affected, and how resilience can be increased (Seaton, 2018). It is conclusive that Implicit Theories are more predictive of self-regulation and behaviour when a difficulty is imposed (Yeager et al., 2014). However, the different psychological worlds, created by entity versus incremental theory, when facing adversity are substantial, motivating or inhibiting coping strategies and resilient behaviours (Yeager et al., 2014).

**Entity Theory or Fixed Mindset**

The Entity Theory, otherwise known as the Fixed Mindset, is primarily rooted in an individual’s belief that their personal attributes and abilities are embedded in genetic and biological origins and are therefore inherent, fixed, and unchanging (Burnette et al., 2014; Hochanadel & Finamore, 2015; Robinson, 2017; Schroder et al., 2015). Such beliefs result in the conviction that attributes cannot be developed or altered (Burnette et al., 2014; Hochanadel & Finamore, 2015; Robinson, 2017; Schroder et al., 2015). This fixed perspective leads to an innate unwillingness to exert extra effort, as the individual is unable to see the possibility of, and for, change (Hochanadel & Finamore, 2015).

Those who exhibit Entity Theories are most often fixated on personal performance over the outcome and often disengage when faced with challenges and setbacks, demonstrating feelings of helplessness and hopelessness (Schroder et al., 2015; Seaton, 2018). Feelings of helplessness and hopelessness are a result of the entity perspective that performance is indicative of ability, and mistakes are threats to abilities, therefore failure reflects poorly on the individual (Schroder et al., 2015).

A Fixed Mindset is impactful as it influences the establishment of static frameworks for responding to a variety of tasks including, but not limited to affective, cognitive, and behavioural domains (Kneeland et al., 2016; Seaton, 2018). These fixed beliefs are reinforced by prior experience, influencing predictions of success or failure, as Entity Theories impede the ability to see change (Chiu et al., 1997; Hochanadel & Finamore, 2015; Kneeland et al., 2016; Seaton, 2018).

The static, beyond-control mindset of Entity Theory is attributed to influencing individuals in the following ways:
Individuals believe they are in a world where negative people and negative circumstances are set in stone, compromising resilience (Yeager et al., 2014); The conviction that circumstances are beyond personal control (Kneeland et al., 2016); An unwillingness to apply effort when faced with challenges (Kneeland et al., 2016); Reduced capacity to exhibit self-control (Kneeland et al., 2016); The attribution of ability, or inability, to intrinsic capacities (Kneeland et al., 2016); Decreased performance and slower recovery form challenges (Schleider et al., 2015); The application of helpless-orientated strategies when faced with challenges or in pursuit of goals (Burnette et al., 2014); Goals established primarily on performance (Burnette et al., 2014); Feelings of vulnerability and anxiousness when evaluating past and future performance (Burnette et al., 2014); Self-blaming attributions and low self-esteem (Yeager et al., 2014); Negative reactions to social adversities such as exclusion (Yeager et al., 2014); Unobtainable standards and perfectionism, enhancing the likelihood of negative affect and depression or anxiety symptoms (Schroder et al., 2015); The adoption of learned helplessness beliefs (Hochanadel & Finamore, 2015); and, The negative reinforcement of learned optimism, where those who do not believe they can, will not (Seligman, 2002).

It is clear from the list provided that Entity Theories strongly impede the individual’s capacity to see and strive for change. The rigidity of the Entity Theory limits an individual’s motivation, resulting in a compromised ability to demonstrate resilience and overcome adversity.

**Incremental Theory or Growth Mindset**

The alternative to Entity Theory or a Fixed Mindset is Incremental Theory, otherwise known as a Growth Mindset. Incremental Theory is embedded in the belief that abilities are changing, dynamic, and malleable with the potential to be developed and improved overtime with practice and effort (Burnette et al., 2014; Kneeland et al., 2016; Robinson, 2017; Seaton, 2018). As a result of the malleable belief Incremental Theories are linked to perseverance in the face of adversity, higher intrinsic motivation, an appreciation for effort, and the perception that ability is malleable (Hochanadel & Finamore, 2015; Schroder et al., 2015).
Students who exhibit Incremental Theories are likely to embrace and seek challenges by applying coping mechanisms, problem-solving strategies, and by seeking support when deemed necessary (Schleider et al., 2015; Seaton, 2018). When adversity is not overcome, those with Incremental Theories view setbacks as learning opportunities and demonstrate adaptability to enhance performance and recovery (Schleider et al., 2015; Schroder et al., 2015).

When an Incremental Theory is maintained the individual set goals focused on learning, striving to employ mastery-orientated strategies to reach goals, report greater confidence, and indicate higher expectations of self when evaluating the potential for goal success (Burnette et al., 2014). Within an Incremental Theory personal attributes are seen as a product of improvement and growth caused by learning and motivation, and performance is seen as a result of motivation and effort (Schroder et al., 2015). This position is substantial as it represents the notion that personal attributes, in a variety of domains, are continually developed, and developing (Schleider et al., 2015; Seaton, 2018).

The notion of continual growth is essential as those who withhold a Growth Mindset continue to persevere when faced with challenges and adversity, developing the ‘grit’ to overcome proposed challenges (Duckworth et al., 2007; Hochanadel & Finamore, 2015). Grit is considered to be essential as it represents not only the application of resilience in the face of adversity and failure, but also the possession of, and maintenance of long-term, loyal commitments (Hochanadel & Finamore, 2015). From grit, individuals demonstrate a desire to overcome adversity and prevail against failure, developing passion and perseverance, a predictor of the ability to achieve long-term goals and overcome obstacles (Duckworth et al., 2007; Hochanadel & Finamore, 2015).

**Implications for Practice**

While understanding what defines Implicit Theory (Mindset), Entity Theory (Fixed Mindset), and Incremental Theory (Growth Mindset) is essential to promoting the adoption of this approach within education it is also essential to outline the implications of this theory concerning resilience, and mental health and well-being. It is hopeful that an overview of the implications for practice will provide a better understanding of how Implicit Theory maintains the capacity to enhance the learning milieu and support child and adolescent resilience, to benefit mental health and well-being.

**Intelligence**

First and foremost, it would be naive to explore the benefits of Implicit Theory without first acknowledging the connection between Mindset and intelligence. This exploration is relevant seeing as the Growth Mindset movement within education has mostly thus far been about academic achievements and success (Kneeland et al., 2016).
The connection between Mindset and intelligence is rooted in the belief that students’ mindset, growth or fixed, represents their perception of self and impacts learning behaviours (Robinson, 2017; Seaton, 2018).

Those with a Growth Mindset are reported to be naturally more willing to put extra time and effort into their learning and apply positive coping strategies when faced with academic challenges, as they view intelligence as malleable (Kneeland et al., 2016; Robinson, 2017). Incremental Theory of intelligence is associated with learning goals, where students aim to acquire new knowledge and skills, increasing their competence (Sternberg & Subotkin, 2006). These goals often encourage students to pursue challenging tasks, in the hopes of achieving future success, even though there is a risk of failure (Sternberg & Subotkin, 2006).

Alternatively, students with a Fixed Mindset are more likely to surrender in the face of a challenge, and unlikely to embrace challenges as intelligence is static and unchanging (Robinson, 2017). Often students with Entity Theory set performance orientated goals, associated with little risk for failure, instead of promoting their established abilities (Sternberg & Subotkin, 2006).

Evidently, Mindset, concerning intelligence, is impactful as the Implicit Theory a student holds about their intelligence and academic capacity to learn influences their ability to develop reliable coping strategies and embrace challenges, impacting their ability to obtain success in academic related achievements.

Emotional Regulation
Emotional regulation represents the ability for an individual (child, adolescent, adult and/or senior) to control his/her emotional experience and emotional expression in alignment with one’s goals and desires (Kneeland et al., 2016). Research regarding the implications for emotional regulation and Implicit Theory are noteworthy as emotional regulation promotes psychological health and is associated with greater perceived well-being, positive psychological outcomes, and enhanced interpersonal functioning (Kneeland et al., 2016; Schroder et al., 2015). Alternatively, difficulty controlling one’s own emotions, known as emotional dysregulation, is linked to a variety of undesirable outcomes including chronic worrying, feelings of anxiety and/or depression, and an array of mental illness diagnoses including anxiety and depression (Kneeland et al., 2016; Schroder et al., 2015).

Emotional malleability represents the assumptions that an individual holds about whether emotions are flexible or static, and whether or not emotions can be altered by individual effort or are fixed beyond personal control (Kneeland et al., 2016). This concept is essential for understanding emotional regulation as the direct relationship between Mindset, and emotional regulation is malleability, which happens to be the central determinant of Incremental or Entity Theory (Kneeland et al., 2016). This
connection is vital as malleability and Implicit Theory are not only tied to effort but are also tied to how individual’s perceive situations and how they apply resilience when facing adversity (Kneeland et al., 2016).

The following will aim to explore the connection between Incremental Theory and emotional regulation, followed by Entity Theory and emotional regulation. It is hopeful that this discussion promotes an understanding of how Implicit Theories influence emotional regulation, ultimately influencing mental well-being and resilience.

**Incremental Theory of Emotional Regulation**

Those with an Incremental Theory of Emotional Regulation are recognizably more likely to:

- Engage in more active efforts to regulate their emotions (Kneeland et al., 2016);
- Make more flexible appraisals regarding their degree of self-control (Kneeland et al., 2016); and
- Enhance the likelihood of pursuing and obtaining goals (Kneeland et al., 2016);

These impacts are substantial as they translate to an individual’s ability and willingness to self-regulate (Kneeland et al., 2016).

This notion is further promoted by the recognition that those with an Incremental Theory are more likely to engage in Cognitive Reappraisal when faced with a challenge and experiencing an emotional reaction (Schroder et al., 2015). Cognitive Reappraisal maintains a substantial impact as it involves the process of challenging the way you think about an event before it occurs (Kneeland et al., 2016; Schroder et al., 2015). This leads to an altered response before the emotional reaction is fully experienced, reducing emotional intensity and enhancing overall well-being (Kneeland et al., 2016; Schroder et al., 2015). While the Cognitive Reappraisal of emotions is impactful for emotional regulation it important to note that this does not mean those with Incremental Theories of emotional regulation do not experience or feel emotion, it simply means that individual’s are responsive to their emotional state, understand their ability to regulation emotions, and maintain a willingness to overcome emotional difficulties proactively.

As a result of the ability see emotions as malleable, apply Cognitive Reappraisal, and demonstrate the willingness and motivation to adjust emotional reactions it is recognized that the Incremental Theory of Emotional Regulation is liked to:

- Higher well-being,
- Higher emotional regulation,
- Higher self-efficacy,
- Greater willingness to confront negative affect,
- Lower experiences of mental illness or mental illness symptomology, and
- Lower levels of negative affect in stressful circumstances (Kneeland et al., 2016).
Entity Theory of Emotional Regulation

Alternatively, those with an Entity Theory of emotional regulation are less likely to be motivated or willing to identify and recognize their emotions to exert control (Kneeland et al., 2016). Instead, those with an Entity Theory of emotional regulation apply a reactive response-focused effort after an emotional reaction has been fully experienced (Kneeland et al., 2016). Emotional Suppression represents this response, signifying an attempt to hide any signs of outward emotional expression, even though they continue to experience the full effect of the emotional reaction (Schroder et al., 2015).

Evidently, those with Entity Theory do not believe that their emotional reactions are malleable, nor do they think that personal effort and motivation can alter the outcome (Kneeland et al., 2016). The result of this interaction is largely associated with decreased well-being, negative affect, lower self-efficacy, higher experiences of depression or anxiety symptoms, increased risk for mental illness, and reduced resiliency to overcome adversity (Kneeland et al., 2016).

Conclusively, it is recognized that personal beliefs regarding emotional malleability and emotional regulation are applied most strongly when circumstantial adversity involves negative affect and conditions that could lead to psychological distress (Kneeland et al., 2016). However, the ability to apply an Incremental Theory and Cognitive Reappraisal demonstrates substantial benefits for overall well-being, enhanced mental health, and boosted resilience (Kneeland et al., 2016).

Mental Health

It is believed that the association between mental health problems and Implicit Theory is firmly connected in both educational and social-psychology contexts (Schroder et al., 2015). This connection is highlighted based on the belief that maladaptive perceptions are central to the development of youth depression, anxiety, and aggression (Schleider et al., 2015; Schroder et al., 2015). This association is imperative as beliefs about self are important factors in understanding depression and anxiety, which are linked to lower-life satisfaction, lost work productivity, impairments in goal attainment, and distress (Schroder et al., 2015). Alternatively, the presence of Incremental Theory is associated with enhanced resilience against adversity, impacting mental health, as motivation is enhanced, self-beliefs are established, and resilience efforts are supported and developed (Schleider et al., 2015).
Incremental Theory of Mental Health
It is recognized that an Incremental Theory of self aids in protecting youth from developing mental health problems (Schleider et al., 2015). This connection is rooted in the belief that those with an Incremental Theory of self are more likely to demonstrate:

- Optimism,
- Self-regulation,
- Adaptive resilience strategies,
- The motivation to strengthen their abilities when faced with adversity, and
- Avoid feelings of helplessness (Schleider et al., 2015).

Such impacts translate to the belief that those who view resilience and mental health as malleable are more likely to demonstrate enhanced self-efficacy (Schleider et al., 2015). Self-efficacy, amplified beliefs regarding one’s ability to manage and control life’s events, is crucial as it contributes to individuals’ perception of their ability to alter personal traits and strengths to cope with adversity (Schleider et al., 2015). Furthermore, an Incremental Theory of mental health is important as self-regulation, self-efficacy, positive affect, and a desire for goal achievement are predictive of positive outcomes during unwanted or adverse situations (Schleider et al., 2015). Enhanced self-efficacy is essential as these key traits buffer against psychological distress and perhaps provide a rationale for increased efforts to reverse and avoid setbacks through personal improvement (Schleider et al., 2015).

The provided conclusions, regarding Incremental Theory and overall mental health and well being, are substantial as Incremental beliefs not only proactively reduce the impact of adversity but are also linked to positive symptom trajectories when a diagnosis or symptomology is present (Schleider et al., 2015). While it is recognized that teaching about Incremental Theory maintains the power to alter mindsets proactively, it is also recognized here that an Incremental Theory can improve treatment trajectories (Schleider et al., 2015).

Entity Theory of Mental Health
When it comes to mental health and Entity Theory, it is reported that a “robust link between entity theories and youth mental health problems” exist (Schleider et al., 2015, p. 8). This association is based on the belief that youth who demonstrate Entity Theory report higher levels of mental health problems, identifying Entity Theory as a notable risk factor in the advancement of mental health problems (Schleider et al., 2015).

This connection between mental illness and/or distress and Entity theory is rooted in the belief that those with an Entity Theory often feel they have little control over their thoughts, feelings, and environment (Schleider et al., 2015). Furthermore, the association that negative and challenging life events are unchangeable and rooted in predetermined causes/reactions leads to internal and external problems including enhanced anxiety, depression, and aggression (Schleider et al., 2015).
It is recognized that those with an Entity Theory of mental health are likely to experience and demonstrate the following symptoms:

- Mental health challenges rooted in internalized and externalized problems (Schleider et al., 2015);
- Feelings of helpless and hopelessness (Schleider et al., 2015);
- Inability to self-regulate thoughts, feelings, emotions, and behaviours (Schleider et al., 2015);
- A fear of inconsistent outcomes and failure as such results represent an irreversible lack of ability (Schleider et al., 2015); and
- A lack of control and enhanced vulnerability to external influences. This is engrained in the belief that attributes are stagnant and circumstances are beyond personal control (Schleider et al., 2015).

Alternatively, a connection between mental health and Entity theories exists. This side of the multi-directional relationship implies that those with mental health problems and an Entity Theory may experience:

- The reduced or non-existent application of cognitive reappraisal in the face of adversity (Schroder et al., 2015).
- The application of emotional suppression strategies, associated with increased anxiety and poor mental health outcomes (Schroder et al., 2015).
- Increased feelings of anxiety, depression, maladaptive perfectionism, and interpersonal conflicts (in both frequency and reaction) (Schroder et al., 2015).
- Depressive and aggressive symptoms when involved in peer-to-peer conflict (Schleider et al., 2015).
- The belief that mental illness treatment must target biological and genetic causes, as only medical orientated treatments maintain the capacity to produce change (Schroder et al., 2015).

It is recognized that Entity Theory is correlated with mental health problems, decreased well-being and inhibited resilience efforts in the face of psychological adversity (Schleider et al., 2015). It is important to note that understanding this is helpful in two ways: A) understanding how Entity theory impedes mental health, and B) understanding a targeted avenue for mental health promotion (Schleider et al., 2015).

**Implications for Clinical Psychology**

The previous discussion of the relationship between Implicit Theory and mental health highlights how the Entity or Incremental Theory impacts mental health, mental illness, and mental well-being. The following aims to promote an understanding of the implication of these connections.

- The correlation between mindset and mental health symptoms are strongest. It is recognized that the connection between mindset, emotion regulation, and anxiety is strongest, as a reduced connection is present
between personality and intelligence (Schroder et al., 2015).

- A connection between treatment and mindset exists. A patient’s individual Mindset influences treatment effectiveness, patient willingness, and often the targeted treatment approach (Schroder et al., 2015).

- Incremental Theory education can enhance mental health. It is reported that 30 minutes of teaching Incremental Theory in emotion and personality domains can reduce the incidence of clinically evaluated depression by 40% and reduce negative reactions to social adversity (Yeager et al., 2014; Yeager & Walton, 2011, as cited in Schroder et al., 2015). Furthermore, it is recognized that exposure to Incremental Theory can reduce stress and physical illness (Yeager et al., 2014).

- Those with a fixed mindset attribute their symptoms to their core disposition. For instance, those with symptoms of anxiety and Entity Theory believe their anxious state is caused by their core disposition as an anxious person and are unable to see the connection between anxiousness and circumstantial factors (Schroder et al., 2015).

- Incremental Theories buffer the negative consequences of challenging and demanding environments. This is significant given the understanding that life events can be risk factors in developing psychological distress (Schroder et al., 2015).

- Incremental Theory enhances emotional regulation. Incremental Theory, in the emotion and anxiety domain, is associated with adaptive emotional regulation strategies, reducing negative affect (Schroder et al., 2015).

- Willingness to engage in treatment is enhanced with an Incremental Theory. It is reported that anxiety and emotion based growth mindsets enhance patient willingness and motivation to engage in therapy based treatments (Schroder et al., 2015).

- Incremental Theory can buffer against adversity. When facing adversity, associated with stressful life events, it is reported that a Growth Mindset in the anxious domain enhanced resilience and diminishes negative results (Schroder et al., 2015).

- Entity Personality can influence mental illness. When personal traits, such as shyness, are perceived to be fixed mental health problems, such as social anxiety, can be enhanced (Schroder et al.,
This is rooted in the belief that an unwillingness to confront the adversity caused by such personality traits can allow for mental health problems to fester without attention.

In conclusion, it is recognized that students who maintain an Incremental theory are able to and are willing to confront challenges (Sternberg & Subotkin, 2006). The potential risk for failure is not viewed as debilitating, and students become focused on engaging in opportunities to better their ability to overcome challenges (Sternberg & Subotkin, 2006). In relation to mental health and well-being this is substantial as resilience is necessary to overcome the adversities students face.

Justification

Information provided thus far has aimed to support an understanding of how Implicit Theories impact control, resilience, and motivation in children and youth. This has painted a clear picture of how Incremental Theory enhances an individual’s willingness, and ability to prevail in the face of adversity. However, it is recognizably essential to justify this approach within education. As a result of the recognition, the following outlines key support for Incremental Theory to be taught to students based on its relation to mental health, mental illness, and mental well-being.

First and foremost, it is important to emphasize that the Entity Mindset is predictive of greater overall stress, poorer health and worse grades (Yeager et al., 2014). Alternatively, an Incremental Mindset is associated with reduced stress, enhanced health, and improved grades (Yeager et al., 2014). These distinctions are important as each theory has a profound impact on life course, however, it is important to recognize that our mindset, “what seems like an unshakable reality is basically just a story that we learned to tell ourselves” (Yeager et al., 2014, p. 881). This points to the notion that explicitly teaching Incremental Theory to student’s increases confidence, which in turn influences investment in establishing strategies to cope with everyday stressors, prevent and alleviate distress, and build on the skills needed to enhance overall resilience, reducing Entity Theory (Schleider et al., 2015). It is promoted that students can learn to tell themselves a different story, a story in which they have the potential to change, and are not defined by their current capacities (Yeager et al., 2014). Students who can make and support this shift in mindset are able to enhance their resilience, reduce stress, improve their overall health and well-being, and experience enhanced academic success (Yeager et al., 2014). By finding ways to emphasize the possibility for the potential to change and overcome adversity students can enhance psychological resiliency and experience personal development (Yeager et al., 2014).

Furthermore, this information leads to the conclusion that an Incremental Theory is positively associated with enhanced resilience, school engagement, academic achievement, and psychological well-being (Yeager & Dweck, 2012; Zeng et al., 2016). It
is understood that an Incremental Theory of personal malleability, in a variety of domains, contributes to the following adjustments:

- Higher psychological well-being and engagement due to enhanced resilience;
- Higher levels of resilience, resulting in enhanced well-being;
- Higher reports of academic achievement and school engagement fostering resilience;
- Higher resilience influencing academic achievement and school engagement; and,
- Enhanced self-regulation and goal achievement (Zeng et al., 2016).

While these positive impacts are all a result of Incremental Theory, in a variety of domains, they are all important as they promote the notion that the establishment of Incremental Theory in one domain promotes resilience development, enhancing the capacity for well-being (Yeager & Dweck, 2012; Zeng et al., 2016). This is important, as teaching students the skills they need to be resilient is only half the battle; it is ultimately a student’s mindset that impacts the effectiveness of taught skills (Zeng et al., 2016). If students can learn to adopt an Incremental Theory in one domain such as intelligence, they can thus enhance resilience and the likelihood of developing an Incremental Theory in other influential areas (Yeager & Dweck, 2012; Zeng et al., 2016).

### Practical Suggestions

With a developed understanding of how Incremental Theory and Entity Theory distinctly influence perceptions of control, effort, motivation, resilience, and outcomes in the face of adversity, and how Implicit Theories are linked to mental health and well-being it is essential to provide strategies for the implementation of this strategy within the classroom environment. The following aims to highlight key adaptations that can be made in an attempt to foster Incremental Theory and eliminate the debilitating impact of Entity Theory.

### Educators Must Adopt Incremental Theory

A teacher’s mindset is particularly vital when supporting students in reflecting on their mindsets and establishing strategies to promote their development (Educational Horizons, 2012; Seaton, 2018). This is connected to the notion that teachers’ belief regarding themselves and their students has the most significant influence on mindset and development (Seaton, 2018).

It is acknowledged that teachers maintain the capacity to have the greatest impact on students when they see experiences through the eyes of their students, supporting and scaffolding their development (Robinson, 2017; Seaton, 2018). Furthermore, it is recognized that a teacher’s perception of a student strongly influences the student’s mindset, motivation, and resilience level (Educational Horizons, 2012). For instance,
perceptions of students as low-achieving, nervous, or as the class bully causes a self-reinforcing prophecy limiting the potential for adjustment (Educational Horizons, 2012). As a result of this understanding, teachers must be cautious of their pre-determined categorical assumptions of students, eliminating their own bias, to motivate student development (Educational Horizons, 2012). It must be recognized that this influence is not only embedded in how we perceive our students, but is also embedded in how we address our students, the expectations we set for our students, and as a result how students view their own work and efforts (Robinson, 2017).

Not only does a teacher’s perception of students reinforce the student’s view of himself or herself, but a teacher’s self-view impacts their approach and confidence towards promoting Incremental Theories (Seaton, 2018). This is important, as educators must first reflect on their own mindsets, through self-reflection, before they address the mindset of their students (Educational Horizons, 2012). Educators who maintain an Incremental Theory are better equipped to support their students in acknowledging their mindset and developing strategies to employ an Incremental Theory (Seaton, 2018). This requires educators to self-reflect and listen to their internal voices to identify their positionality (Educational Horizons, 2012). Furthermore, educators must believe they can, and strive to, adjust their theory to adopt Incremental Theory for authenticity purposes (Robinson, 2017).

This recommendation is substantial as it directly influences the belief that educators must be cognizant of their mindset, regarding self and students, before attempting to address the mindset of their students (Educational Horizons, 2012).

Explicitly Teach Implicit Theories
While teachers can adopt a variety of strategies and methods implement Incremental Theory in the classroom for the enhancement of resilience, well-being, and mental health; however, teaching students about Implicit theory, the difference between Entity and Incremental Theory, and the impact of each mindset is essential (Robinson, 2017).

If we want our students to reflect on their own mindsets and self-beliefs for the adoption of Incremental Theories of self, they must understand this theory (Robinson, 2017). This is particularly important as research suggests that simply teaching about Incremental Theory boosts student confidence and their willingness to adopt such practices (Schleider et al., 2015). Not only are educators asked to teach students about these theories, but they can also teach students about brain plasticity (Robinson, 2017). Furthermore, educators are strongly encouraged to model their own mindset reflections/adjustments, while also guiding students in this process (Robinson, 2017).

Focus on Process not Product
One of the most influential adjustments educators and school staff personnel can make to promote Incremental Theory is to adjust feedback and praise to focus on process-
based praise (Robinson, 2017; Yeager & Dweck, 2012).

This adjustment is essential as product based praise, or praise based only on the result, represents Entity Theory, reinforcing a student’s willingness only to attempt problems that have a high likelihood of success (Yeager & Dweck, 2012). Alternatively, process-based praise, based on the strategies, effort, focus, and perseverance applied to challenges, promote an Incremental Theory, reinforcing a willingness to engage in challenging tasks (Yeager & Dweck, 2012). This shift is essential as students will begin to associate success with motivation and effort neglecting the belief that success in the face of adversity is rooted in natural talent (Vella et al., 2014). This shift supports the development of competence as motivation is fostered and resilience is developed, eliminating helplessness (Vella et al., 2014).

A prime example of this shift is changing praise for ability, and the end product, such as “you are so smart” to “you worked so hard,” recognizing student effort, strategy, and motivation (Schleider et al., 2015). Comments recognizing smartness are debilitating as it leads to the adoption of Entity based behaviours, attitudes, and beliefs reproducing helplessness in challenging situations (Schleider et al., 2015). Alternatively, praising effort, strategy and motivation result in Incremental beliefs, attitudes, and behaviours, enhancing resilience (Schleider et al., 2015). Such alternative praise can also be adjusted to social situations where statements like “you are so nice” turn into “you shared so nicely with your peers.”

**Set High Expectations, and Scaffold Challenges**

It is noted, that the provision of high expectations, with appropriate scaffolding, is essential for promoting resilience, enhancing motivation, changing behaviour and beliefs, and supporting an Incremental Theory (Vella et al., 2014). This is founded on the assumption that motivation is heightened when students perceive a challenge to be moderately challenging, but not unrealistic (Vella et al., 2014). Opportunities to overcome such problems are important as children and adolescents enjoy challenges that extend the current skill set, resulting in new learning, enhanced perseverance, the establishment of strategies, greater motivation, and heightened self-efficacy (Vella et al., 2014).

**Utilize Active Learning Methods**

In an attempt to foster Incremental Theory within the learning environment, the following instructional strategies are encouraged (Vella et al., 2014). These strategies are supported for their incorporation of student-directed learning opportunities, where students are encouraged to reflect on and track their progress, allowing them to self-evaluate the control they withhold over their learning and development (Vella et al., 2014). Undeniably, this particular strategy is intellectual based; however, the results maintain the potential to be widespread across domains.
Suggested strategies include:

- **Task-based Lessons**
  Task-based lessons are learning opportunities that are based on a reasonable level of challenge (Vella et al., 2014). These lessons encourage students to establish short-term self-referencing goals to support the use of active learning strategies to overcome the proposed challenge (Vella et al., 2014). Often these tasks are based on student interest and require skills that can be utilized in a variety of circumstances (Vella et al., 2014). While such tasks are often linked to intellectual capacities, challenges regarding social, emotional, and psychological problems can be utilized.

- **Authority-based Strategies**
  This strategy is based on allowing students to take authority, or control, over their learning pathway (Vella et al., 2014). Within this technique, students are the decision makers, and decisions are made based on choices on effort (Vella et al., 2014). Such opportunities are beneficial as students begin to develop a sense of independence along with self-management and self-monitoring skills (Vella et al., 2014).

- **Evaluation-based Strategies**
  Providing an array of opportunities for students to self-assess and monitor individual mastery is important to develop students’ ability to see control and change as something they possess within (Vella et al., 2014). Furthermore, it is also important that students are encouraged to recognize and review failure as a natural part of learning (Vella et al., 2014).

- **Reflection-based Strategies**
  Teachers are also encouraged to promote reflection-based strategies where students take the opportunity to recall and reveal what they have learned (Robinson, 2017). This strategy is beneficial as allowing students to revisit how engagement in the learning process has expanded their knowledge, and ability, allows them to recognize the potential to change and develop (Robinson, 2017). Examples of this can include free recall, where students take a designated period of time to jot down everything they have learned and are then given an opportunity to cross-check their list with notes to add missing pieces (Robinson, 2017).

**Encourage and Support Goal Setting**
The notion of setting high expectations and scaffolding the achievement of such expectations directly connects to the necessity for goal setting (Robinson, 2017; Vella et al., 2014). Setting SMART realistic goals is considered to be essential to this implication of Implicit Theories (Vella et al., 2014). SMART goals, ultimately stand for goals that are:
Specific, Measurable, Action-orientated, Realistic, and Timely (Vella et al., 2014). Such goals set a vision for empowerment, allow students to track their progress, and enable students to recognize how challenges can be confronted and overcome (Robinson, 2017; Vella et al., 2014).

Two important factors when considering the implementation of goals are:

A) Students must track their progress from baseline to see the potential for, and achievement of change (Robinson, 2017). This is important as students recognize the growth pattern and become more motivated to apply effort, in turn building resiliency (Robinson, 2017).

B) Goals should represent a variety of domains; therefore they should not only be restricted to academic achievements (Robinson, 2017). This is substantial as while schools are focused on academic achievement, goals related to personality/temperament, emotional regulation, and social skills are equally important (Vella et al., 2014).

Normalize Mistakes and Failure
When it comes to differentiating between Entity and Incremental Theory, it is in the face of adversity, where failure is a possibility that the strongest distinctions are present. As a result, it is important to foster an environment where perspectives of failure are transformed (Robinson, 2017; Vella et al., 2014). According to this view, the Entity Theory promotes setbacks and failure as an inability, resulting in: negative affect, a decreased willing to engage, and a diminished motivation to persevere (Vella et al., 2014). On the contrary, adopting an Incremental Theory of failure causes students to see failure as a temporary setback that provides an opportunity for growth, leading to resilient efforts characterized by a willingness to engage and strong motivation (Vella et al., 2014). By fostering the notion that failure enhances development and contributes to learning, students will begin to recognize the importance of effort and perseverance, leading students to believe they are in control of their reaction, adaptations, and goal achievement (Robinson, 2017; Vella et al., 2014).

Simple strategies teachers can adopt include: celebrating FAI Lure as a First Attempt In Learning (recognizing that learning is a process that extends well beyond academic achievements), ensuring that educators openly share their own mistakes and failures with students, and by scaffolding low to high-risk failure opportunities allowing students to experience gradual exposure (Robinson, 2017).

Transform Self-Talk
In addition to altering how student’s view failure and the potential for failure when facing challenging situations, it is also vital that student’s transform their self-talk (Robinson, 2017; Vella et al., 2014). Shifts in self-talk from pessimistic to optimistic statements, such as turning “I can’t” into “I can’t yet”, are powerful as beliefs in personal ability influence how students deal with mistakes, confront challenges,
perceive and provide feedback, and persevere through challenges (Robinson, 2017). Explicitly teaching students how to eliminate pessimistic predictions about themselves and their abilities is important as it contributes to confidence development (Robinson, 2017). Such shifts in thinking are substantial as they promote students to: believe in their personal efforts, avoid feelings and predictions of helplessness, persevere in the face of adversity, see ability as fluctuating, and promotes resilience to try again (Vella et al., 2014).
Social-Emotional Learning

Developed from research on prevention and resilience, Social-Emotional Learning involves the process through which individual social-emotional competencies are developed, acquired and applied through the establishment of essential skills, knowledge, attitudes, and behaviours (Domitrovich et al., 2017; Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016). The essential elements are necessary to recognize and understand emotions, self-manage, set and achieve positive goals, establish and maintain positive relationships, demonstrate empathy, make responsible decisions, work effectively, and behave ethically (Domitrovich et al., 2017; Kendziora & Yoder, 2016).

The Collaborative for Academic Social and Emotional Learning (CASEL), a leading contributor to social-emotional learning research and practice, defines Social-Emotional Learning as: “[the] process of acquiring and effectively applying the knowledge, attitudes, and skills necessary to recognize and manage emotions; develop caring and concern for others; making responsible decisions; establishing positive relationships; and handling challenging situations capably” (Guyn Cooper Research Associates, 2013).

Social-Emotional Learning is divided into five competencies including: self-awareness, self-management, social awareness, relationship skills, and responsible decision making, each of which is embedded in knowledge, skills, attitudes, and beliefs (Guyn Cooper Research Associates, 2013). While each of the five components will be further described comprehensively, Social-Emotional Learning is largely associated with the following skill sets, knowledge, attitudes, and behaviours, which are identified for their capacity to positively enhance developmental trajectories (Taylor et al., 2017):

- Recognizing and managing emotions;
- Developing care and concern for others;
- Establishing positive relationships with others;
- Collaborating effectively with others;
- Interacting comfortably and respectfully with individuals from diverse backgrounds;
- Resolving conflict peacefully;
- Making responsible decisions; and,
- Handling situations constructively (Kendziora & Yoder, 2016).

It is important to note that the five Social-Emotional Learning domains are not comprised of fixed or static competencies and characteristics, rather it is believed that such knowledge, skills, beliefs, and attitudes can be taught, learned, and developed within people of all ages (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016). This recognition is significant as Social-Emotional Learning is identified as a
multi-dimensional construct that is vital to success in school, life, and emotional/behavioural development (Domitrovich et al., 2017).

Social-Emotional Learning is accredited for its ability to impact and attend to the cognitive, affective and behavioural systems (Domitrovich et al., 2017). It is acknowledged that the cognitive, affective and behavioural impact maintains the capacity to influence both interpersonal and intrapersonal domains (Domitrovich et al., 2017). The interpersonal domain is impacted as students develop the capacity to listen, communicate, empathize, negotiate, problem solve, and work collaboratively/cooperatively (Domitrovich et al., 2017). On the other hand, interpersonal skills are impacted by the developed and enhanced capacity to set realistic goals, maintain a positive mindset, exert self-control, apply emotional regulation strategies, and employ coping strategies (Domitrovich et al., 2017). Ultimately, interpersonal and intrapersonal competency development is significant as proper behaviour is encouraged, avoidance of risk is reduced, the development of healthy relationships is supported, and emotional dysregulation, aggression, delinquency, and substance use are reduced (Domitrovich et al., 2017).
Core Competencies of Social-Emotional Learning

As stated previously, Social-Emotional Learning is comprised of five fundamental domains including self-awareness, self-management, social awareness, relationship skills, and responsible decision-making (Guyn Cooper and Research Associates, 2013). To understand what each of the five domains the following will provide detail regarding key components and competencies.

Self-Awareness
Self-awareness, as a key competency of Social-Emotional Learning, is representative of the ability for an individual to accurately recognize their emotions and thoughts, and identify how their emotions/thoughts influence behaviour (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016). This domain of Social-Emotional Learning defines the necessity for individuals to self-assess and recognize their strengths and limitations, while also maintaining a sense of confidence and optimism (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016).

Within self-awareness, the following knowledge, skills, attitudes, and beliefs are seen as essential components of self-awareness.

- **Personal Responsibility**
  Personal responsibility is concerned with the capacity to engage in healthy behaviours, and be honest and fair in dealing with others (Payton et al., 2000). This element is linked to self-awareness based on its dedication to recognizing personal health and well-being, and the health and well-being of others, to strive for the best possible outcomes.

- **Awareness of Feelings**
  Simplistically, this component involves the ability for an individual to accurately recognize and identify their feelings (Payton et al., 2000). This skill is essential, as students must possess the knowledge and self-awareness to be able to identify their emotional states, reflect on the impact of their feelings, and recognize emotional trends, especially when feelings of emotional distress arise.

- **A Constructive Sense of Self**
  The capacity to accurately reflect on and identify one’s strengths and limitations, and handle everyday challenges with this sense of self, confidence, and optimism (Payton et al., 2000). This capacity is influential as individuals must be aware of their developed skills, behaviours and attitudes, be confident in their ability to utilize these skills, and optimistic in their ability to apply and further develop such knowledge, skills, behaviours, and attitudes.
In conclusion, self-awareness is concerned with the ability for an individual to know what they are thinking and feeling, accurately assess their abilities, and demonstrate a well-grounded sense of confidence and optimism (Weissberg & O’Brien, 2004).

**Self-Management**
The component of Social-Emotional Learning dedicated to self-management builds on the context of self-awareness, alluding to the necessity for individuals to not only recognize, but also regulate their emotions, thoughts, and behaviours in a variety of situations (Guyn Cooper Research Associates, 2013). The management component of social-emotional learning includes managing stress, controlling impulses, motivating oneself, and persevering in the face of adversity (Guyn Cooper Research Associates, 2013).

Furthermore, self-management encompasses the skills required to not only to regulate emotions and behaviours, but also to set and achieve realistic goals, by persevering and proactively addressing negative emotions, behaviours and thoughts (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016).

The key competency of this social-emotional domain is the management of feelings (Payton et al., 2000). This domain involves the capacity for emotional and behavioural regulation, where reactions are not made based on impulse but are based on reflection and consideration for the possible outcome and intended outcome (Payton et al., 2000).

Ultimately, Self-Management is concerned with developing the capacity to manipulate emotions too:

- Facilitate achievement, rather than interfere with task achievement,
- Aid in the ability to accomplish goals,
- Assist in demonstrating perseverance in the face of negative emotions and/or heightened adversity, and
- Set, monitor and achieve positive and realistic goals (Payton et al., 2000; Weissberg & O’Brien, 2004)

**Social Awareness**
Social awareness, as a component of Social-Emotional Learning, represents a shift in the key competencies from concern for self to concern for others. Social awareness is largely concerned with the capacity to recognize the perspectives of, and empathize with the perspectives of, others from diverse backgrounds and cultures (Guy Cooper Research Associates, 2013; Kendziora & Yoder, 2016).

The ability to recognize, and empathize, with what others are thinking and feeling is extended to include the need to understand social and ethical norms of behaviour to

Furthermore, social awareness entails identifying family, school and community resources that offer services and support for those in need (Guyn Cooper Research Associates, 2013). This element is key as it involves a proactive awareness of specialized services and trustworthy individuals that students can confide in for personal support, or to address concerns they have regarding others.

Social awareness involves the following competency development:

- **Social Responsibility**
  This competency is concerned with developing a commitment to, and willingness to engage in civic life, contributing to the surrounding community and protecting the environment (Payton et al., 2000).

- **Respect for Others**
  Respect for others is concerned with the intention to accept and appreciate individual and group differences, and to value the rights of all individuals from a variety of diverse backgrounds and identities (Kendziora & Yoder, 2016; Payton et al., 2000).

- **Perspective Taking**
  While self-management and self-awareness require the capacity to understand self, social awareness is concerned largely with the capacity to accurately assess the perspectives, feelings, and opinions of others (Payton et al., 2000).

**Relationship Skills**

The fourth component of Social-Emotional Learning is concerned with both establishing and maintaining healthy, rewarding, and meaningful relationships with diverse individuals and groups (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016; Weissberg & O’Brien, 2004). The key to maintaining such relationships is embedded in: clear communication, active listening, the resistance of inappropriate social pressure, constructive conflict negotiation, cooperation, and the ability to seek help when deemed necessary (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016; Weissberg & O’Brien, 2004).

Consistent with the information provided above, the Social-Emotional domain of Relationship Skills demands that students develop the following key competencies:

- **Expressive Communication**
  This competency is concerned with the ability for individuals to initiate
and maintain conversations, in addition to expressing thoughts and feelings, both verbally and non-verbally, with clarity (Payton et al., 2000).

- **Active Listening**
  Actively listening is a key competency within relationship skills as individuals must be able to demonstrate both verbally and non-verbally that they understand the information communicated by others (Payton et al., 2000).

- **Cooperation**
  Cooperation is an essential component of Social-Emotional Learning as students must not only be able to engage in social situations, but they must also take turns and act fairly in group situations (2 or more) (Payton et al., 2000).

- **Negotiation**
  When engaging in social settings, individuals must be able to demonstrate and employ negotiation skills, considering the perspectives of all parties involved in the conflict, in order to find a peaceful solution that meets the satisfaction of all impacted parties (Payton et al., 2000).

- **Refusal**
  Refusal is a key competency in Social-Emotional Learning as the ability to make and follow through with “no statements”, resisting social pressure is key for personal health and well-being (Payton et al., 2000).

- **Help-Seeking**
  Lastly, but certainly, not least help-seeking is considered to be significant as individuals are must both identify when support and assistance are required and recognize how to access the appropriate resources (Payton et al., 2000).

**Responsible Decision Making**

Responsible decision-making is primarily concerned with the individual capacity to make constructive and respectful choices about personal behaviour and social interactions (Guyn Cooper Research Associates, 2013). In making constructive and respectful choices individuals are highly encouraged to factor in: ethical standards, social norms, a realistic evaluations of consequences, respect for others, and consideration for the well-being of self and other (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016). Ultimately, individual’s who demonstrate responsible decision-making are able to account for the well-being and perspectives of both self and other, while taking responsibility for personal decisions (Weissberg & O’Brien, 2004).
In order to achieve responsible decision making the following capacities are encouraged:

- **Problem Identification**
  Problem identification involves the capacity for individuals to identify situations that require decision-making or alternative solutions, while considering the associated risks, barriers, and resources (Payton et al., 2000).

- **Problem-Solving**
  Problem-solving requires that individuals are able to develop, implement, and evaluate positive and informed solutions to problems independently, in pairs and in group settings (Payton et al., 2000).

- **Social Norm Analysis**
  Individuals are not only required to identify problems and associated factors but are also encouraged to critically evaluate social, cultural, and media messages, all of which influence social norms and personal behaviour expectations (Payton et al., 2000).

**Justification**
While understanding what defines Social-Emotional Learning, and the various competencies that are significant to the implementation of this approach is essential, it is equally important to understand why this approach is identified as a recognized initiative in enhancing child and adolescent mental health and well-being and resilience within the classroom.

Before exploring the specifics of the justification for Social-Emotional Learning as a beneficial initiative for both academic success and mental health it is important to recognize that generally speaking, Social-Emotional Learning is considered to be a promotional and prevention-based approach that aid’s educators in their desire to coordinate academic performance, enhanced resilience, and improved sense of well-being (Taylor et al., 2017; Weissberg & O’Brien, 2004). The impact of Social-Emotional Learning is evidently widespread, however, it is important to note that such initiatives maintain a durable impact (as long-term results span from 56-195 weeks) within a wide range of diverse identities (including different racialized groups, socioeconomic status, ethnic and geographical backgrounds) (Domitrovich et al., 2017; Taylor et al., 2017).

**Benefits of Social-Emotional Learning in Schools**
Within the educational setting, Social-Emotional Learning involves implementing practices and policies that help students acquire and apply the knowledge, skills, attitudes, and beliefs to enhance personal development, social relationships, ethical
behaviour, and effective/productive work (Taylor et al., 2017). Social-Emotional Learning is reported to include classroom instruction that enhances student capacity to recognize and manage emotions, appreciate the perspectives of others, establish prosocial goals, solve problems, and use interpersonal skills to effectively and ethically handle developmentally appropriate tasks (Payton et al., 2000). The Social-Emotional Learning approach is favoured for its ability to transcend environmental and chronological factors, making such learning widely applicable to students beyond the context of school (Payton et al., 2000). Furthermore, this particular approach is favoured for its basic understanding that: 1) a diverse array of problems share common risk factors, and 2) optimal learning emerges from supportive and challenging relationships (Weissberg & O’Brien, 2004). This leads to the notion that although children may be recognized as at risk, it is the environmental context and relationships that surround them that often determine their outcome (Aviles et al., 2006).

**Link to Academic Success**

Recognizably, the focus of this resource is on resilience, mental health, and mental well-being, however, given that this resource is designed for elementary classrooms it is noteworthy to recognize how such suggested approaches benefit students academically. For this reason, the following justifies Social-Emotional Learning initiatives concerning academic success.

First and foremost, it is significant to recognize that schools are increasingly responsible for a broad role in the lives of children/adolescents, extending their influence and efforts beyond the traditional confine of academic success (Payton et al., 2000; Weare, 2010). It is acknowledged that both parents and educators desire for young people to experience success in their academic, personal, and social lives, requiring educators to offer and attend to more than the traditional academic criteria (Payton et al., 2000). With this goal in mind, it is important to note that Social-Emotional Learning is identified as a critical approach to building caring, engaging classroom/school milieus (Weissberg & O’Brien, 2004).

From an academic standpoint, the desire to foster future generations that are knowledgeable, responsible, healthy, caring, connected and contributing is seen as a key priority (Weissberg & O’Brien, 2004). Social-Emotional Learning is essential for this crucial priority as enhanced social and emotional competencies are reportedly associated with higher lives of well-being, increased predictions of long-term success, positive attitudes, essential skill development, and the establishment of interpersonal and intrapersonal skills which enhance both academic performance and behaviour (Kendziora & Yoder, 2016; Taylor et al., 2017). Furthermore, promoting social-emotional skill competence facilitates the establishment of cognitive skills and self-regulation, both of which are linked to enhanced learning and academic success (Guy Cooper Research Associates, 2013). Lastly, it is acknowledged that Social-Emotional Learning improves resilience when facing problems, leading to enhanced problem-solving strategies,
conflict resolution, and collaboration (Domitrovich et al., 2017; Kendziora & Yoder, 2016). Evidently, while Social-Emotional Learning is not focused on academic success, the residual effects are impactful, allowing for students to experience enhanced academic achievement, and for educators to meet the growing demands of their students (Kendziora & Yoder, 2016).

**Link to Mental Health**

It is important to recognize that the connection between Social-Emotional Learning and mental health is not rooted in the conviction that social-emotional skills, beliefs, attitudes, and understandings cure mental illness, however, Social-Emotional Learning is a substantial mental health promotion strategy that enhances resilience and life fulfillment (Guyn Cooper Research Associates, 2013; Kendziora & Yoder, 2016). It is supported that school/class-wide instruction and skill building is linked to compelling evidence indicating that Social-Emotional Learning enhances understanding of self, the ability to regulate emotions, feelings of optimism, a sense of coherence, and the ability to make relationships and empathize with others (Weare, 2010). With the increasing prevalence of mental health as a key concern within education, schools find themselves concerned with helping young people prepare for life, building social-emotional skills, and fostering mental health resilience (Weare, 2010).

Ultimately, Social-Emotional Learning is recognized for its capacity to enhance mental health and well-being in the following capacities:

- Reduce emotional distress and negative conduct (Taylor et al., 2017);
- Enhance the experience of life fulfillment as a result of improved social relationships and graduation rates, and well-being (Kendziora & Yoder, 2016; Taylor et al., 2017);
- Influence the decreased prevalence of criminal activity and clinical mental illness diagnoses (Kendziora & Yoder, 2016; Taylor et al., 2017);
- Improve the capacity to flourish due to reduced social and emotional distress (Guyn Cooper Research Associates, 2013);
- Enhance the capacity to obtain higher achievement in academic and life events (Guyn Cooper Research Associates, 2013);
- Enrich resiliency, influencing the ability to counteract and overcome the negative effects of adversity (Aviles et al., 2006; Domitrovich et al., 2017);
- Provide a promotional-based, proactive approach to reducing the impact of adverse influences and circumstances (Domitrovich et al., 2017); and
- Focus on positive outcomes, fostering social and emotional skills that are rooted in positive attitudes and support the protection against negativities (Taylor et al., 2017).

**Social-Emotional Learning Classroom Implementation Strategies**

When it comes to incorporating Social-Emotional Learning into the classroom milieu two
primary approaches are recognized, direct and indirect (Domitrovich et al., 2017). Within these two primary categories four secondary approaches to implementation are recognized (Domitrovich et al., 2017; Kendziora & Yoder, 2016). It is important to note that while various approaches to implementation exist, there is little evidence to suggest one approach is more influential than the other, ultimately calling for both practices to be equally valued and included (Domitrovich et al., 2017).

The suggestions for implementing Social-Emotional Learning within the classroom and school environments are categorized and identified as followed:

1. Direct Approach
   a. Explicit instruction of competencies (Guyn Cooper Research Associates, 2004; Kendiziora & Yoder, 2016)

2. Indirect Approach
   a. The integration of Social-Emotional Learning within academic content;
   b. The development of a positive learning environment; and,
   c. The adaptation of general teaching practices that support student development, and the application of Social-Emotional Learning competencies and skills (Kendziora & Yoder, 2016).

With acknowledgement of the following categories of implementation, the following provides detail regarding each of these approaches and the best practice for incorporating Social-Emotional Learning.

Social-Emotional Learning Implementation Approaches.
Direct Approach

*Explicit skill instruction.* Teachers must dedicate instructional time to teach the five pillars of Social-Emotional Learning and the various competencies explicitly (Kendziora & Yoder, 2016). It is recommended that such instruction involve explanations, demonstrations, practice, and feedback, in addition to following a sequenced, developmentally appropriate order (Domitrovich et al., 2017).

For instance, you might explicitly dedicate time to a lesson focusing on how to identify your perspective, then on how to understand the perspectives of others, and lastly, on the importance of understanding perspectives beyond your own (Kendziora & Yoder, 2016). This example demonstrates how lessons progress from simple to more complex, and how it is essential to explain why this process is significant. It is vital to recognize that such lessons would involve demonstrations, practice, active feedback, and discussion to create an authentic learning experience and well-supported instruction/development.

Indirect Approaches

*Incorporate Social-Emotional Learning into general teaching practices.* This particular approach often involves classroom management strategies, instructional strategies, and emotionally supportive teaching practices (Domitrovich et al., 2017). Primarily concerned with how classroom dynamics and learning methods are established, this goal requires teachers to consider how Social-Emotional Learning opportunities can be authentically embedded into classroom dynamics for the benefit of behaviour, instruction, and student emotional well-being (Domitrovich et al., 2017).

A prime example of this strategy would be utilizing group work within math class to solve a math problem (Kendziora & Yoder, 2016). While 15 minutes of explicit instruction on how to efficiently work in a group setting and problem solve is a prerequisite for the success of this approach, it is a beneficial way to not only model and teach key skills, but to allow for practice (Kendziora & Yoder, 2016). Throughout such activities, students must be reminded of their individual and collective responsibility during the collaborative lesson (Kendziora & Yoder, 2016). Such reminders reinforce explicitly taught skills but also help students to understand the positive and negative consequences of the way they participate among their peers (Kendziora & Yoder, 2016).

The development of a positive learning environment.

One of the key elements of effective Social-Emotional Learning initiatives and practices within elementary classrooms is the construction of a positive learning environment (Domitrovich et al., 2017; Kendziora & Yoder, 2016). According to
Guyn Cooper Research Associates (2013), this includes safe, caring, participatory and well-managed learning environments.

The following provides a list of critical elements that contribute to the creation of a positive social-emotional classroom:

- Established behaviour norms concerning respect, diversity, and positive civic values (Domitrovich et al., 2017);
- Enriched relationships among peers, teachers, and school staff (Domitrovich et al., 2017);
- The establishment of student-teacher relationships where each student feels they have a trustworthy mentor (Kendziora & Yoder, 2016);
- Discipline policies that are inclusionary, based in restorative practice, and encourage students to exercise self-regulation skills (Kendziora & Yoder, 2016);
- Engaged students who recognize they have a voice as an active contributing member of their school community (Kendziora & Yoder, 2016);
- High behavioural and academic expectations for all students, with consideration for student differences in baseline Social-Emotional and academic competencies (Kendziora & Yoder, 2016);
- Parent engagement, with established open communication channels (Kendziora & Yoder, 2016; Payton et al., 2000); and
- Community partnerships for the enhancement of resource availability and support are vital (Payton et al., 2000).

Each of these classroom characteristics are essential. The capacity to maintain a positive classroom environment enhances the establishment of a healthy, safe, supportive and challenging learning environment, producing a greater capacity for academic and school engagement, parent/community involvement, and effective classroom instruction (Domitrovich et al., 2017; Kendziora & Yoder, 2016; Weissberg & O’Brien, 2004).

The adaptation of general teaching practices that support student development, and the application of Social-Emotional Learning competencies and skills.

Training and Support must be provided to and attended by educators for the implementation of effective Social-Emotional Learning programs and practice. This element includes the necessity for educators to be provided with relevant and adequate professional development, training, and resources for programming to be efficiently implemented (Kendziora & Yoder, 2016). This is significant as proactive professional development opportunities aimed to enhance the learning environment and experience for children can enhance the likelihood that students will receive enabling support before a potential crisis unveils (Aviles et al., 2006).
In an attempt to provide educators with the support they require to work with students experiencing social-emotional challenges teachers and educational support personnel are urged to refer to CASEL for a list of evidence-based programs and support documents (Kendziora & Yoder, 2016).

Additionally, it is recognized that educators must be given authentic opportunities to personally engage in Social-Emotional Learning opportunities to enhance their competencies and skills for the support of student development (Kendziora & Yoder, 2016).

Efforts must be coordinated within all educational systems to support Social-Emotional programming/practices.

It is acknowledged that systemic cohesion, throughout schools and districts, characterized by collaboration on shared efforts, programs, and initiatives enhance the ability for programming to succeed (Kendziora & Yoder, 2016). By incorporating the pillars of Social-Emotional Learning within the classroom, school, and board visionary improvement plans, it is believed that programming is most potent (Kendziora & Yoder, 2016). While this element is considered beneficial, do not let the reluctance of colleagues, principals, and board members deter your commitment to Social-Emotional Learning, as programming is still noteworthy and may just set the bar for future educator buy-in.

Student progress must be tracked and incorporated

Much like academic assessment, the consideration for, and gathering of, consistent student feedback is necessary to inform future practice (Kendziora & Yoder, 2016). Teachers must be sensitive to and aware of where students are excelling and where further training and programming is required.

Such monitoring must always be conscious of proper assessment protocol including the purpose for tracking, the comprehensiveness of the tracking method, the practicality of assessment, the burden of implementation, and the ethics involved (Kendziora & Yoder, 2016).

Key Elements of High-Quality Programs

In addition to the previously proposed instructional approaches and elements for the effective implementation of Social-Emotional Learning within the classroom environment, key elements of high-quality programs are also noteworthy (Weare, 2010). While it is recognized that not all educators will enlist a formal program into their classroom based on various constraints, it is still beneficial to outline fundamental program conditions for those who do seek a more formalized program.
- Long-term visions are established
  This element represents the necessity for programs to run over a prolonged period of time (Weare, 2010). This stipulation is important as one-off interventions are rarely, if ever, sufficient considering social and emotional problems and development are deeply rooted constructs (Weare, 2010). Furthermore, long-term establishment is key as a spiral approach is recommended, where previously covered capacities are skills are constantly revisited and built on (Weare, 2010).

- Programming is grounded in theory and research
  It is strongly encouraged that initiatives, such as those identified by CASEL, are referenced when electing to implement a particular program as varying impacts, successful and unsuccessful, have been recognized within different programs. Note, a specific program implementation is not a mandatory requirement for building a social-emotional classroom, but it can be very helpful.

- Consistency is maintained with limited tailoring
  When utilizing a perspective program or framework of Social-Emotional Learning it is strongly suggested that programming is followed precisely and not tailored to eliminate confusion and unnecessary program barriers, while maintaining program validity (Guyn Cooper Research Associates, 2004; Weare, 2010).

- Initiatives are multi-modal
  This particular element calls for Social-Emotional Learning initiatives to be integrated across all subjects, modeled by all educators, and seamlessly included in all aspects of the school environment (Weare, 2010). This is important so that students are not sent mixed messages and consistently see the value of such learning.

- Programming is skill based
  When focusing on Social-Emotional Learning for mental health, it is widely recognized that the most effective programming includes the explicit development and practice of relevant skills that build resiliency and benefit mental health and well-being (Weare, 2010). Such practices involve more than basic discussion, calling for behavioural strategies including modeling, identification, practice, coaching, and feedback (Weare, 2010). By embedding these skills into various lessons, students can develop the capacity to apply these skills in the face of adversity, enhancing resilience.
- **Cohesion**
  As student’s lives unfold, within an array of environments, at school, at home and within the community, it is recognized that Social-Emotional Learning competencies and skills must be seen as applicable skills across all environments and domains (Weare, 2010). This alludes to the belief that students must acknowledge how such skills are beneficial within and beyond the classroom walls.

- **Includes staff development**
  Research demonstrates that the number one reason for program failure in schools is the lack of staff social-emotional skills and engagement in training practices (Weare, 2010). Heavily rooted in the belief that educators must meet their own needs before they can meet the needs of their students, this stipulation calls for educator training and practice in enhancing their own social-emotional competencies (Guyn Cooper Research Associates, 2013; Weare, 2010).

- **The SAFE model is applied**
  As a general rule of thumb, it is suggested that Social-Emotional Learning programs should follow the SAFE model, inclusive of Sequenced, Active, Focused and Explicit instruction (Domitrovich et al., 2017; Guyn Cooper Research Associates, 2013). This calls for programming to be chronologically ordered to explicitly teach skills that build on one another, in a developmentally appropriate way, with the provision of opportunities for active practice and competency application (Guyn Cooper Research Associates, 2013).
References


CHAPTER FIVE: SUMMARY, EVALUATION, IMPLICATIONS, AND CONCLUSION

This chapter provides a conclusive summary regarding the presented project. It is the intention of this chapter to provide an overview of the project, address the influence of the evaluation process, highlight the implications of this research, and explicitly identify the limitations of this project. As the research project comes to a close, it is substantial to provide this reflective commentary, ultimately offering closure for the project.

Summary of the Project

The overarching aim of this project is to equip junior grade educators in Ontario with the necessary knowledge and strategies required to promote student mental health and well-being proactively by promoting enriched resilience within students. To achieve this goal, the primary focus of this paper was the development of Promoting Resilience: A Junior-Level Educator’s Guides to Proactively Supporting Child and Adolescent Mental Health and Well-Being. This resource intends to offer an instructional resource for educators, to aid them in understanding their role and responsibility in preventatively caring for and cultivating the mental health and well-being of their students according to a Positive Psychology framework.

To achieve this goal the project initially strives to provide an enhanced understanding of fundamental concepts including, mental illness, mental health, well-being, and resilience. This explicit review is considered necessary as ambiguity often blurs perception, and as a result, educators must be provided with a comprehensive overview of what these terms constitute throughout this research. With this understanding
in mind, the current prevalence rate of mental illness and information justifying the
necessity for this resource is provided. This information is substantial as it highlights the
need for mental health and well-being to emerge as a prominent concern within
education.

With an understanding of this founding information, a focus on policy, and the
perceived role of the educator in supporting child and adolescent mental health and well-
being are explored. This review indicated that educators are in a precarious position to
actively enhance the mental health and well-being of their students. Furthermore, this
process revealed that limited information regarding universal preventative care is
provided for Ontario educators, even though policy equally informs the necessity of this
approach. It is this acknowledgment that ultimately guided the direction of this resource,
influencing the incorporation of Positive Psychology and Universal Programming.

As referenced, the theoretical framework underlying this research project is that
of Positive Psychology, initially established by Martin Seligman (2002). Positive
Psychology is fundamentally motivated by the belief that psychology, in both practice
and research, has abandoned its founding ambitions, neglecting to acknowledge the
fundamental goals of psychology equally. In response to this recognition, Positive
Psychology strives for an approach to mental health that focuses on improving individual
productivity/life fulfillment and identifying individual high talent (Chodkiewicz & Boyle,
2017; Seligman & Csikszentmihalyi, 2000). Positive Psychology strives to initiate
promotion-based initiatives that build resilience (Chodkiewicz & Boyle, 2017; Seligman
& Csikszentmihalyi, 2000). Fundamentally rooted in the belief that human strength is a
buffer against mental illness, and there is value in dealing with problems before they
emerge (O'Connor et al., 2017; Seligman, 2002). It is this belief that influences the innate desire to promote individual strengths and teach adaptive skills preventatively (Seligman, 2002; Shoshani & Steinmetz, 2013). Ultimately, mental health is about more than the absence of mental illness, and Positive psychology believes that mental health programs, initiatives, and supports must aim to nurture strong qualities and help individuals develop and invest in strategies that will allow them to build resilience for enhanced mental health and well-being (Seligman & Csikszentmihalhi, 2000).

Lastly, and perhaps most significantly, strategies for incorporating resilience into the classroom are identified. This includes the Resilience Wheel, Implicit Theory, and Social-Emotional Learning. Each approach is reviewed comprehensively, provided a detailed description of what the method entails, a justification for the approach in regards to benefiting mental health and well-being, and strategies for educators to adopt within the learning environment to incorporate each approach into the learning environment.

Each of the sections of this handbook ultimately strives to inform teachers, both those who are new and experienced, of their role in supporting student mental health and well-being. Various approaches that can be adopted into one's teaching practice and classroom to cultivate resilience are explored. It is the hope, that this research, will better equip educators with the fundamental knowledge they require to preventatively foster the positive mental health and well-being of their students.

**Feedback Process**

To enhance the reliability of *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*, a draft copy of the resource was shared with current junior grade educators who work in
Southern Ontario school boards. The teachers incorporated within the peer review process were selected based on their connection with the researcher. Participation was entirely voluntary; however, the individuals participated with eagerness.

The feedback process was intended to be primarily informal and based on personal opinion. The teachers selected were provided with a few prompts to consider; however, limited direction was provided to enrich the natural feedback process. The educators were prompted to consider and comment on elements that they found beneficial, elements they misunderstood or required more clarification on, content that captured their attention, and any other relevant feedback to enhance the impact of *Promoting Resilience*. Lastly, each educator was asked to comment on their overall opinion of the handbook, and whether or not they felt that the content included was relevant, useful, and applicable to the current teaching climate in Ontario.

Ultimately, the individuals involved in the peer review process provided valuable and overwhelmingly positive feedback. Comments throughout indicated new learning, an appreciation for descriptive content, and highlighted the practicality of the suggestions offered. It was evident that the teachers appreciated the discussion of distress in addition to the discussion on mental illness when outlining the prevalence of reduced mental health and mental illnesses among children and youth. Furthermore, it was indicated that the explicit overview of the various approaches to defining key terminology, and the provision of detail regarding the multiple policies addressed was favourable. It was noted that this information was ideal as the individuals felt they were well informed and able to make, and recognize, their assumptions and understandings, limiting researcher bias. Furthermore, the educators identified that they appreciated the provision of multiple
strategies and approaches (Resilience Wheel, Implicit Theory, and Social-Emotional Learning) as each classroom dynamic can demand a different approach. Additionally, a preference for the explicit listing of classroom strategies was noted, as this made the information accessible.

Interestingly an impactful comment was the made by a reader who recognized that this resource is not only valuable for classroom educators, but for all educators who find themselves in a variety of school-based positions working with and supporting the learning and well-being of students. This recognition was essential as it prompted the necessity to outline that this wide-scale impact was intentional. The author selected to utilize the term educators versus teachers intentionally, to recognize the role of the various individuals that work within schools (including, but not limited to: educational assistants, child and youth workers/social workers, specialized subject teachers, interdisciplinary support teams/staff, special education teachers, and principals). The reader recognizing this influenced the necessity to include commentary to explicitly outline this intention.

While praise was provided, there were also recommendations for improvement regarding content, further clarification, and adjustments to the handbook’s layout. All of the submitted suggestions were reviewed, and changes were made accordingly. This feedback was appreciated as modifications were made to eliminate the researcher’s personal bias and expert blind spots.

Electing to include the feedback of fellow educators was beneficial as it provided a new perspective on the elements of Promoting Resilience. Not only did the commentary provided support the necessity for and the practically of Promoting Resilience, but the
constructive criticism also contributed to positively, enhancing the ability to present a reliable, practical, and useful document for educators.

**Implications for Practice**

The presented handbook *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being* was created to act as both an information source and resource for teacher committed to proactively promoting the mental health and well-being of their students. Initially, *Promoting Resilience* serves as an information source, providing educators with an overview of key terminology, the current status of need among children and youth, and a review of relevant policy documents that informed the emergence of the concern for mental health and well-being within education. Based on these recognitions, the adopted approaches, Positive Psychology and Universal Programming, are explored and justified. Finally, building on this understanding the Resilience Wheel, Implicit Theory, and Social-Emotional Learning strategies are described and explored. It is the intention that this information will aid educators in understanding the necessity to take immediate steps to support the mental health and well-being of all students proactively.

It is the decision to focus on Positive Psychology and strategies for promoting mental health and well-being that make this resource unique and influential within the field of education. While an array of policy documents and recommendations are outlined, a restricted focus is evident. The most apparent restriction is the focus on a deficit approach, where the primary focus is not on prevention, but on treatment and early intervention. While these strategies and insights are beneficial, it is recognized by Positive Psychology that proactive care and initiatives focused on promoting mental
health, mental well-being and resilience are pivotal in halting the emergence of mental illnesses and distress.

For educators, this restricted focus is represented in one of the most influential documents designed for educators titled *Supporting Minds: An Educator’s Guide to Promoting Student Mental Health and Well-Being* as released by the Ontario Ministry of Education in 2013. While this information provided regarding the current context of child/adolescent mental health and the description of and strategies for eight common mental illnesses are helpful, the information provided is mostly reactive. It is this limitation that enticed *Promoting Resilience* to adopt a prevention-based approach, focused on elevating mental health/wellbeing, life fulfillment, and positive experiences through the promotion of resilience. This distinct focus, intended to balance the limited focus of *Supporting Minds*, is impactful as it requests educators to recognize and accept their role in acting preventatively. This approach strives to create a trend in education where educators, experienced and new to the field, feel equipped to, and capable of, proactively benefiting the mental health and well-being of their students. It is hopeful that this shift will promote the enhancement of child and adolescent mental health and well-being, reducing the prevalence of mental illnesses and experiences of prolonged distress.

**Implications for Policy**

From a comprehensive policy review, as provided in the literature review, it is evident that the Ontario Ministry of Education has recognized the necessity for student mental health and well-being to be addressed within education. The release of *Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and Well-Being* in 2013, and the revision of Ontario’s goals for education as demonstrated in *Achieving*
Excellence: A Renewed Vision for Education in Ontario in 2014 illustrates the Ontario Ministry of Education’s commitment to addressing the mental health and well-being of their students. While these documents represent substantial strives in education, there are also recognized limitations. The constricted focus on mental illness and reactive intervention and treatment strategies is a notable shortcoming as this approach neglects to acknowledge proactive approaches educators can adopt within the classroom. As a result of this recognition, Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being was created to bridge the gap in the existing literature, and provide a complementary resource to the existing material readily available to educators and the goals of education. It is the intention of this research not to replace the current literature available, but to further equip educators with strategies to benefit the mental health and well-being of children and youth. Ultimately, the Promoting Resilience handbook strives to support the existing ambitions as established by the Ontario Ministry of Education, yet the intention is to reduce the current literature gap.

Implications for Further Research

It is evident throughout this research that a concern for child and adolescent mental health and well-being is prominent within society. It is recognized that 15-20% of children and youth will experience a diagnosed mental illness, while many more will also suffer severe distress, suffering, and impairments in day-to-day function caused by an undiagnosed mental illness or reduced mental health and well-being (MHCC, 2013; Millar et al., 2013; O’Mara & Lind, 2013; Ontario Ministry of Education, 2013; Schwean & Rodger, 2013). It is this recognition, in combination with the necessity for educators to
act immediately, which enticed the need to create this resource. While *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being* aims to reduce gaps in understanding by promoting a comprehensive understanding of fundamental concepts, the prevalence of mental illness/reduced well-being, existing policy implications, and promotion-based approaches to enhancing mental health, well-being, and resilience it is recognized that these suggestions promote further research questions. The main consequence of this research is to understand the benefits and limitations of Positive Psychology approaches in junior grade classrooms further.

While the literature recommends and justifies this approach to mental health, and each of the supported strategies is rooted in supportive literature, it would be enticing to complete further a research study to demonstrate the impact of such programming form a student, teacher, and parent/guardian standpoint. Furthermore, it is recognized that a limitation exists regarding research surrounding preventative approaches to enhancing resilience, mental health, and mental well-being. By exploring the impact and implications of the recommended strategies researchers would be further able to pinpoint strategies for educators to utilize, and approaches to do so efficiently. It is recognized that the method adopted throughout this research is mainly uncharted in Ontario education. While the suggestions provided are rooted in research, it is understood that a research study examining the implication of this approach would be beneficial to further justifying the impact of Positive Psychology as a means of promoting resilience to enhance child/adolescent mental health and well-being.
Limitations

While it is essential to recognize the potential impacts of *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*, it is also important to highlight the limitations associated with this research project. Ultimately, to provide the reader with a comprehensive overview, it is essential also to highlight the pending limitations. As a result of this belief, the following section will address the research limitations.

The most easily recognized and most severe limitation of this research is the decision to provide a resource intended for junior grade level educators and classrooms. While it is known that students of all ages and grade levels require mental health and well-being support, this resource elected to focus on the provision of proactive mental health and well-being initiatives to enhance resilience among the junior grades (grades 4-6 and approximately 9 to 12 years of age in Ontario). The decision to focus on junior grade level initiatives is founded on the recognition that 50% of mental illnesses diagnosed in adulthood are traceable to an onset age before 14 years of age (Manion et al., 2013; MHCC, 2013; Santor et al., 2009). This statistic was imperative in the decision to focus on junior grade levels, as the hope is to provide preventative care, focused on allowing students to build resilience, to reduce the onset of mental illness. If 50% of adult mental illness diagnosis is linked with an onset age before 14 years of age, and 15-20% of children and adolescents experience a mental illness at any given time than there is substantial evidence supporting the necessity for care during the early stages of life. The Ontario Ministry of Education (2015) Health and Physical Education curriculum further support the necessity for mental health initiatives during the early stages of life. It is
acknowledged within the Health and Physical Education curriculum that the junior grades mark a substantial shift in childhood, as peer relationships increase in significance and the development of a sense of self is essential (Ontario Ministry of Education, 2015). Aligned with curriculum implications, it is evident that this age group is critical to the development of self-awareness capacities including stress management, self-management, coping skills, and adaptive skills (Ontario Ministry of Education, 2015). Furthermore, it is acknowledged that the junior grades mark a transitional period in childhood/adolescent development, as puberty is approaching/beginning (Ontario Ministry of Education, 2015). The precarious nature of this developmental stage in life course is essential, as development is rapid, and therefore early intervention is recommended to promote healthy development as adolescence progresses. Ultimately, the vulnerability of this age group and the necessity for further self-management and awareness capacities influenced the decision to focus primarily on the junior grade level population.

Beyond the limited intended audience, it is also essential to acknowledge that the proposed approach provides a limitation for the influence of this resource. While it is recognized that a balanced provision, of both proactive and reactive initiatives, are required to meet the needs of all children and youth, this project elected to solely focus on proactive measures intended to build resilience and promote mental health and well-being universally. Although Promoting Resilience concentrates only on promotion-based initiatives, this decision was made based on the prior unbalanced representation of treatment and intervention efforts in the existing resource guide for educators titled Supporting Minds: An Educator’s Guide to Promoting Students’ Mental Health and
Well-Being (Ontario Ministry of Education, 2013). While this restricted scope is a limitation of this singular document, a broader review of the key literature indicates that Promoting Resilience completes an existing gap in the literature.

The decision to base this resource in the fundamental beliefs of Positive Psychology also represents a limitation of this research. Initially, it is recognized that an array of approaches to mental health and well-being exist beyond Positive Psychology, including, but not limited to, the medical model, social-emotional learning, mindfulness, interpersonal approach, critical approach, and trauma approach. While each of these approaches offers a distinct influence on concepts of mental health, mental illness, and treatment, this project elected to focus on and align with the beliefs of Positive Psychology, only incorporating educational approaches that reflected such fundamental beliefs. For some, this limitation might represent neglect to acknowledge and appreciate other approaches to mental health, however, for the author this approach was elected for its sole focus on positive attributes, prevention efforts, and drive to further enhance life fulfillment through the establishment of resilience (Seligman, 2002). This refreshing approach focused on prevention, resilience, and returning to the fundamental goals of psychology is substantial as it encourages society to refrain from depending on the medical model, a deficit based approach which has recently been widely adopted, and embrace an approach to mental health that is instinctually positive and focused on benefiting individuals proactively.

Within the subject of mental health and well-being, research is continually evolving, as new studies are released, and new approaches are endorsed. When completing a research project on a topic of this magnitude, it is essential to recognize that
certain restrictions must be negotiated to provide a direction for the resource produced. Within this context of this research project a junior grade level restriction, a focus on prevention, and the fundamental incorporation of Positive Psychology were selected to provide the necessary direction required to develop Promoting Resilience. It is important to note that Promoting Resilience offers substantial insight regarding avenues for the promotion of resilience within children and adolescents to enhance mental health and well-being, while reducing the development of mental illness.

**Conclusion**

Growing concern regarding mental health and well-being continues to emerge, as concern for mental illness and mental well-being emerges from the shadows. With this shift, there is an enhanced focus on the necessity for the mental health needs of children and adolescents to be addressed, highlighting the essential contributions of the education system. As a result, this project is founded on the ambition to equip junior grade educator’s, in Ontario schools, with the necessary knowledge and strategies required to promote student mental health and well-being proactively, through the establishment of resilience. Recognition that educators must be adequately prepared to meet the mental health needs of their students, and the necessity for promotion-based initiatives, prompted the creation of a resource guide for educators titled, *Promoting Resilience: A Junior-Level Educator’s Guide to Proactively Supporting Child and Adolescent Mental Health and Well-Being*. Previously established documentation for educators promotes intervention and treatment strategies for teachers, focused on mental illness, however, *Promoting Resilience* intends to reduce this limitation and offer prevention and promotion based techniques. Adopting a Positive Psychology approach to proactively
promoting resilience, mental health, and well-being is essential as educators must understanding that their ability to contribute positively and proactively. Ultimately, if educators are expected and trusted to invest time and effort towards enhancing the mental health and well-being of their students, it is essential to ensure that educators are prepared to, and equipped to embrace such initiatives and expectations. It is hopeful that *Promoting Resilience* will aid educators in addressing the mental health needs of their students, allowing children and youth to experience enhanced resilience and limited experiences of reduced mental health and well-being.
References


Bibliography


doi:10.3389/fpsyg.2016.01873