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Beyond PISA: Schools as Contexts for the Promotion of Children's Mental Health and Well-Being

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Abstract Over the past couple of decades, the Program for International Student Assessment (PISA) has gained an increasing role in shaping educational systems and policies across the world. PISA's measurement of a limited range of cognitive abilities across cultures, however, promotes a narrow view of education, one that focuses primarily on preparing students for the economic market. This paper argues for a broader educational agenda—namely the formation of academically, socially, and emotionally literate young people who have the skills and emotional resilience necessary to navigate the uncertain of modern life. In addition, the role schools may have in promoting the well-being of children and young people is discussed, positioning the classroom teacher as an effective and caring educator in both academic and social and emotional learning. The paper proposes a multilevel, whole school, and school-based approach to social and emotional education. The final section discusses the role of school psychologists in the implementation of this framework, particularly at the universal, preventive level.

Keywords Mental health · Schools · Social and emotional education · Prevention · Health promotion · School psychologists

The Program for International Student Assessment (PISA, OECD) has gained an influential role in shaping educational policies across the world and has become a global "benchmark of standards" in education. PISA has been instrumental in the development of an assessment system of fundamental cognitive processes to enable young people to face the global economic challenges of our time. PISA's conceptualization of education reflects a market economy model (Meyers 2013). However, this narrow focus on cognitive processes, assessment and ranking, and the consequent pressure on countries to improve their ranking and move up the league tables is compelling educational authorities and schools to invest more on what is measured by PISA, rather than an education that balances cognitive with social, emotional, and cultural education. Young people today need an education that provides for the development of the requisite cognitive, social, and emotional competencies and resilience to grow and thrive in the face of the present and future socioemotional as well as cognitive challenges (Cefai and Cavioni 2014). Such an education, however, may be considered of limited value within a culture of performance indicators and competition as educational authorities strive to climb the rankings of the international league of countries (Pring 2012). Schools may have doubts about the relevance of social and emotional processes in education, seeing them as taking precious time away from academic learning and as being secondary to the latter (Benninga, Berkowitz, Kuehn, and Smith 2006).

The evidence shows, however, that rather than being diametrically opposite, academic learning and social and emotional learning are on the "same side" and support each other (Diamond 2010). Social and emotional learning provides a foundation upon which effective learning and academic success can be built (Adelman and Taylor 2009). It serves as a meta ability for academic learning (Goleman 1996), enabling students to regulate their emotions and deal with emotional distress, cope better with classroom demands and frustration, solve problems more effectively, have healthier relationships,

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and work more collaboratively with others. In their meta-analysis of over 200 studies, Durlak et al. (2011) reported that students who participated in universal social and emotional learning programs scored significantly higher on standardized achievement tests when compared to peers not participating in such programs. This and other similar studies (e.g., Cavioni and Zanetti 2015; Sklad et al. 2012; Weissberg and Cascarino 2013; Zins, Weissberg, Wang, and Walberg 2004) underline that social and emotional education is a primary educational goal for all students.

The rise of therapeutic education and its potential labeling and stigmatization of vulnerable children (Ecclestone and Hayes 2009; Watson, Emery, and Bayliss 2012) has been a cause of concern among some educators on the broadening educational agenda. Teachers are educators and not surrogate psychologists or counselors, and schools are learning communities, not mental health centers (Craig 2009). Such a view, however, construes mental health and well-being as mental illness and psychopathology, focusing on a small percentage of students manifesting significant difficulties in their social and emotional development. In contrast, a nonmedical view of mental health in education seeks to promote the mental health, well-being, and growth of all children and young people, providing a relevant and meaningful education leading to the formation of academically, socially, and emotionally literate young people who have the skills, abilities, and emotional resilience necessary to thrive in a challenging world (Cefai and Cavioni 2014; Cooper and Cefai 2009). The goals of education are thus both cognitive and affective, and separating these two goals leads to both less skilled teachers, short-changes students, and ineffective practices in both academic learning, social and emotional learning, and mental health promotion (Greenberg et al. 2003; Spratt et al. 2006). The most recent report by the U.S. Center for Disease Control and Prevention (2013) showed that the prevalence of mental health difficulties among children and young people (20 % of all school children) has been increasing in the last 25 years. If such issues are not addressed in schools, which have most access to children and young people, children facing mental health difficulties are more likely to experience learning difficulties and fail academically.

Mental Health Promotion in School: a School-Based, School-Directed Framework

Mental health promotion in schools has shifted from the erstwhile focus on individual psychological intervention for some students, reflecting the traditional medical model, to a whole school, systemic approach targeting all students. This includes mental health promotion and prevention for all children, early identification and intervention for children considered at risk in their social and emotional development, and targeted intervention for children experiencing mental health difficulties (Adelman and Taylor 2009). A whole school approach to mental health addresses social and emotional issues in the curriculum and in the organization of teaching and learning, the development of a supportive school ethos and environment, and partnership with the wider school community (WHO 2007, 2013). It underlines multilevel and multicomponent interventions, including classroom curricula, school environment, universal and targeted interventions, and collaboration with parents and the community, making use of interpersonal, instructional, and contextual supports (Adelman and Taylor 2009; Bywater and Sharples 2012; Elias and Synder 2008; Weare and Nind 2011). The scope thus ranges from health promotion, growth, and well-being, to prevention, to targeted intervention.

This paper is focused on universal mental health promotion in school, a whole school approach integrating the development of individual social and emotional competencies such as self-awareness and management, healthy relationships, and effective problem solving, with the creation of healthy communities at classroom and whole school levels (CASEL, 2012; Cefai and Cavioni 2014). Within this perspective, the whole school community collaborates to promote the health and well-being of all its members, with culture, policies, practices, curriculum, pedagogy, and relationships contributing to a climate conducive to the development of mental health and well-being (Adelman and Taylor 2009; Bywater and Sharples 2012; Cefai and Cavioni 2014;, Furlong, Sharkey, Quirk, and Dowdy 2011). The following sections present a framework for a comprehensive, whole school and school-based approach to mental health in school, primarily focused on mental health promotion and prevention for all school children, and involving the whole school community in collaboration with the parents, the local community, and external support services (Cefai and Cavioni 2014). The framework is informed by approaches that have been found to be effective in bringing about long-term outcomes in mental health in children and young people. It consists of five components, namely multi-intervention, multidimensional, multistage, multitarget, and effective implementation.

Multi-intervention

The multi-intervention component of the framework refers to the three-tiered approach to mental health in education, namely universal, selective, and indicated interventions. The major thrust of the framework is for a universal approach to the promotion of social and emotional education for all school students (see next section), but a universal preventive approach needs to be accompanied by additional selective and indicated interventions for children at risk or with additional needs. Some students may thus receive simultaneous

universal and targeted interventions, benefitting from a complementary, additive effect (Merrell and Gueldner 2010). While universal interventions are highly beneficial for students with mental health difficulties (Cooper and Jacobs 2011), such students also need extra support in view of the risks or difficulties they are experiencing (National Institute for Health and Clinical Excellence 2008; Payton et al. 2008). The greater conceptual precision, intensity, and focus of targeted interventions may be particularly effective in this regard (Greenberg 2010). A staged, school-based approach positions the school, in partnership with professionals, parents, services, and the community, as the provider of the necessary support for students experiencing difficulties in their social and emotional development. This requires integrated, interagency working, with professionals and services working collaboratively together and with parents, school staff, and the students themselves, where possible at the school. A school-based team, including representatives of staff, students, and parents, will coordinate the targeted interventions and integrate them with the universal interventions and other whole school approaches in mental health promotion. It also ensures the provision of more intensive and transdisciplinary interventions as difficulties become more serious.

In universal and selective interventions, teachers and mental health professionals are likely to be found as partners in delivery of implementations, with more intensive interventions provided by the mental health professionals (Franklin, Kim, Ryan, Kelly, and Montgomery 2012). The latter interventions, however, would still be school based and carried out by school-based personnel or by professionals with close contact with the children and the school as much as possible.

Multidimensional

The multidimensional component of the framework refers to a "taught and caught" approach, where social and emotional education is taught as a core competence in the classroom, while the classroom climate and the whole school ecology provide a context which promotes, supports, and reinforces the competencies being learnt in the classroom. The taught aspect discusses how the classroom teacher may teach social and emotional education as a core subject (set curriculum) while infusing it into the other aspects of the curriculum (cross curricular). It puts the onus on the classroom teacher and school staff for the promotion of social and emotional education. The caught aspect underlines the need for social and emotional education to be embedded in the general curriculum so as to facilitate the consolidation and transfer of learning. It discusses the key role of the classroom and the whole school climates in the promotion and consolidation of social and emotional learning throughout the whole school community.

The Taught Component

A Curricular Approach

Explicit and regular teaching of social and emotional learning as a core competence by the classroom/subject teachers is one of the key components of the framework. Direct teaching of evidence-based and developmentally and culturally appropriate social and emotional competences with application to real life situations is at the heart of mental health promotion in school. This necessitates a set curriculum and available resources to support consistency of delivery, one of the key criteria of program effectiveness. One-off, add-on, programs are unlikely to have any long-term effect on students' behavior (Durlak et al. 2011).

A Set Curriculum Cefai and Cavioni (2014) propose a social and emotional education curriculum focusing on intrapersonal and interpersonal competence and resilience skills in social, emotional, and academic domains, including such areas as understanding of self and of others, regulating emotions and enhancing positive ones, developing healthy and caring relationships, making good and responsible decisions, making use of one's own strengths, and overcoming difficulties and adversity in social and academic tasks. The curriculum draws from such fields as humanistic psychology, developmental psychology, educational psychology, positive psychology, teaching and learning perspectives, neuroscience, resilience, health promotion, prevention science, social capital, social model, and the ecosystem model of development. More specifically, it is based on the integration of six strands in the field of health and well-being in children, namely, social and emotional learning (CASEL, 2005; Mayer and Salovey 1997), positive psychology and education (Gilman, Huebner, and Furlong 2009; Seligman et al. 2009), mindfulness education (Siegel 2007), resilience in education (Bernard 2004; Masten 2011), inclusive education (Booth and Ainscow 1998), and caring community perspectives (Battistich et al. 2004; Cefai 2008; Sergiovanni 1994).

The curriculum includes two main dimensions that incorporate various skills to be learned—namely self-social (others) dimension on one side and awareness management on the other. The four areas developed from the two dimensions (self-awareness, self-management, social awareness, and social management) incorporate the five social and emotional learning areas proposed by CASEL (2005) as well as other skills from the other five perspectives. Positive emotions, optimism, persistence, self-efficacy, autonomy/agency, and sense of leadership are some of the skills from both positive psychology and resilience perspectives. Success oriented engagement underlines the requisite skills students need to maximize their learning potential, such as goal setting and achievement, planning, self-monitoring, academic regulation,

and persistence. Critical and creative thinking skills provide students with opportunities to become aware of their learning process and develop their thinking and problem-solving skills and consequently take control of their own learning.

Emotional awareness and regulation is a key feature of the CASEL framework (CASEL, 2005), but the present framework underlines awareness and regulation of one's thoughts also through positive self-talk. Another important addition to the traditional SEL framework is spiritual development, namely having a sense of meaning and purpose as a source of happiness, growth, and self-actualization. Related to this is the notion of mindfulness, the capacity to be aware of the present moment without getting caught in cognitive, emotional, or physical distractions.

The social awareness and management areas underline the role of the individual in relation to the promotion of a healthy social and physical environment, including not only the skills to relate collaboratively and meaningfully with others but also prosocial values and attitudes, responsible decision making, moral development, inclusion, diversity and children's rights, a sense of a caring classroom community, and appreciation and care for the environment. Such an approach helps to shift the focus from the well-being and health of the individual to the well-being and health of the social environment as well, thus integrating the needs of the individual with those of the collective, underlining the benefits of contributing to caring communities not only for the individual but also the communities themselves. Respecting the needs and rights of others and underlining the values of diversity and collaboration help to create caring and supportive communities and to balance the dominance of individualism and competition in Western culture, which have become a major threat to the social and emotional well-being of children and young people (Cooper and Cefai 2009).

Role of Classroom Teachers and School Staff Within a school-based, nonmedical approach to mental health, school personnel are at the center of mental health promotion. When classroom and subject teachers deliver the social and emotional curriculum themselves, they are more likely to integrate and infuse the competencies into the general curriculum and daily classroom activities, and this is more likely to have greater long-term impact (Adi et al. 2007; Diekstra 2008; Hoagwood et al. 2007). One of the issues with the limited effectiveness of the SEAL Programme in the United Kingdom (UK), for instance, is that it was not embedded directly in the formal curriculum and the classroom teachers are not directly involved in its delivery (Cooper and Jacobs 2011). Sklad et al.'s review of studies (2012) reported that classroom teachers could deliver social and emotional programs without compromising their effectiveness. Moreover, in their meta-analysis, Durlak et al. (2011) found that when classroom programs were conducted by the school staff, they were effective in both academic and social and emotional learning, and that students' academic performance only improved when school staff themselves conducted the programs.

School staff themselves believe that they should be involved in mental health promotion initiatives, particularly in teaching social and emotional competencies at universal level (Askell-Williams & Cefai 2014; Reinke et al. 2011). The staff needs to be adequately trained, however, in exercising this role, at both initial and continuing professional education. Various studies indicate that classroom teachers' sense of competence and confidence in mental health promotion is relatively poor, particularly if initial teacher education in the area was inadequate (Askell-Williams and Cefai 2014; Reinke et al. 2011; Vostanis et al. 2013). Teachers need to have competence in building health relationships with students, developing students' social and emotional learning, recognizing and responding to early signs of mental health difficulties, working collaboratively with colleagues, professionals, and parents in supporting students with mental health difficulties, as well as issues related to program implementation (Askell-Williams et al. 2010; Greenberg 2010; Humphrey, Lendrum, and Wigelsworth 2010).

Cross Curricular Approach

One of the most powerful ways to promote social and emotional education in school is by infusing it into the other areas of the curriculum in a structured way (Elias and Synder 2008). By referring and making use of social and emotional learning in the other areas of the curriculum, the teacher enables students to generalize and apply the skills across the curriculum and to integrate social and emotional learning into their daily learning and social behaviors.

The Caught Component

Classroom Climate Initiatives to promote mental health and well-being in school are more likely to be effective when they include systems level interventions at classroom and whole school levels (Adelman & Taylor 2009; Weare and Nind 2011). When classroom teachers integrate and reinforce the curriculum in their interactions and relationships with the students, and provide opportunities for students to observe and practice the skills during the day to day life in the classroom, students are more likely to catch those skills and apply them in the classroom and other different contexts (Durlak et al. 2011; National Institute for Health and Clinical Excellence 2008; Weare and Nind 2011). Learning and working in a classroom climate characterized by caring and supportive relationships and engagement in meaningful learning activities adapted to students' needs and strengths, provides an ideal context where the promotion of mental health becomes embedded in the

daily life of the classroom (Battistich, Schaps, and Wilson 2004; Cefai 2008; Pianta and Stuhlman 2004). Watson et al. (2012, p. 223) argue that in such "a relational ethics of care" based on caring relationships, choices and rights, mental health, and well-being become integrated in "positive experiences of being, becoming, and belonging."

Whole School Ecology A classroom-based approach to mental health needs to be supported by the whole school community, with all partners contributing to a climate conducive to mental health and well-being. A supportive, caring, and collaborative school climate has a complementary, value-added effect, reinforcing the work undertaken in the classrooms, and consequently influencing the relationships and behaviors of the school members (Adi et al. 2007; Payton et al. 2008; Weare and Nind 2011; Wells, Barlow, and Stewart-Brown 2003). A health-promoting school climate is characterized by members' caring relationships and meaningful and influential engagement, staff collaboration and continuing education, supportive administration, staff and student peer mentoring, active parental involvement and education, involvement of various stakeholders, and the participation of the local community (Askell-Williams et al. 2010; Battistich et al. 2004; Bond et al. 2007; Bryan and Henry 2012; Weare and Nind 2011).

Home school collaboration is crucial for the fulfillment of the school's goals in mental health promotion. It helps parents to develop positive attitudes towards mental health in school, overcome potential fears and resistance, and support the school's efforts in this respect (Bryan and Henry 2012; Downey and Williams 2010). Besides serving to consolidate the skills being learnt at school, this collaboration also enables the transfer of skills to different contexts such as the home. In their evaluation of the Social and Emotional Aspects of Learning program for families in the UK, Downey and Williams (2010) found that both teachers and parents reported increases in the children's social and emotional learning as a result of the home program implementation. Accessible and culture-sensitive information, resources and support, links to community services and facilities, and family learning, parenting, and personal development programs would enable schools to operate as centers for parental collaboration, education, and well-being (Cefai and Cavioni 2014).

Multistage

Like the other content areas of the curriculum, social and emotional education is characterized by increasing complexity of behavior and social contexts requiring particular skills at different developmental levels. A structured curricular approach develops basic to more complex social and emotional competences from 1 year to the other, building on what students already know, and equipping them with skills needed for different stages in their development. A spiral curriculum from the early years, to elementary school, middle school, and high school, revisits each of the main topics at developmentally appropriate levels.

The teaching of social and emotional competencies follows the SAFE approach, namely sequenced, active, focused, and explicit. Effective programs adopt a sequenced step-by-step approach, make use of experiential and participative learning, focus on skills development, and have explicit learning goals (CASEL, 2005; Durlak et al. 2011). Assessment is a crucial part of the learning process, but a performance-oriented, examination-driven curriculum may be in direct conflict with the nature of social and emotional education, potentially increasing examination stress and decreasing self-esteem, thus constituting a health hazard for students. Moreover, there is a danger of exposing children and young people to pathology labels through such assessment (Ecclestone 2012; Watson et al. 2012). Formative and continuous assessment, making use of a range of assessment modes and strategies, will ensure that assessment will become an integral part of the learning process (Cefai and Cavioni 2014). Rather than a normative, summative approach, the assessment of social and emotional education focuses on providing feedback to the students on their strengths and needs in the area. Rather than comparing students to standardized norms, a developmental assessment approach aims at supporting the students to develop their competencies according to their developmental readiness by identifying their strengths, needs, and areas for improvement. Assessment strategies may include a rubric indicating the levels of competence achieved in specific competences, teacher and student observations of, and reflections on, set tasks, teacher and student checklists, peer and classroom discussion, and a student journal outlining the student's progress and achievements.

The curriculum and its delivery needs to be culturally responsive and adapted to the diversity of backgrounds and characteristics of the students, making use of a variety of activities, instructional designs, resources, assessments, and products according to the developmental level and the socio-cultural background of the students. The SAFE pedagogical approach, including the experiential nature of the curriculum, makes it easier for the teacher to engage in individualization. The teachers also need to be self-aware of their own cultural baggage and be open-minded to adopt affirmative approaches towards their students' diverse cultures (Bartolo & Symth 2009). Adaptation, however, needs to be carried out without compromising the integrity of the curriculum, as lack of adherence to implementation guidelines may lead to ineffectiveness in terms of expected student outcomes (Bywater and Sharples 2012; Durlak 2008; Greenberg 2010; Weare 2010). This is discussed in the section on implementation in this paper.

Multitarget

The traditional conception of mental health in schools construed the student as the only recipient of mental health services. Although students remain at the center of mental health promotion in school, the health and well-being of school staff and parents is an integral part of a whole school approach to mental health (Jennings and Greenberg 2009; Weare and Nind 2011). Adults are more likely to be effective in their efforts to promote the mental health of children, if they take care of and nurture their own health and well-being. This component underlines the need to support the well-being and health of school staff and the parents themselves, in order to be more effective in improving students' health and well-being.

When teachers' own interpersonal needs are addressed, they are more likely to address the social and emotional needs of their students (Kidger et al. 2010). Teaching is considered a highly stressful career, with a high level of burnout, turnover, and attrition that may compromise the quality of teaching (Bricheno, Brown, and Lubansky 2009; Dworkin 2009; Kelchtermans 2011). A health-promoting context combined with the development of one's social and emotional resources, actively promotes the staff's mental health while reducing the risk of psychological difficulties and burnout (Jennings and Greenberg 2009; New Economics Foundation 2009). An integrated individual-context approach ensures that school staff are able to respond effectively to the cognitive and emotional challenges of working in difficult conditions, to strengthen their relationships with colleagues, students, and parents, and sustain their own motivation, efficacy, and personal agency (Cefai and Cavioni 2014).

Healthy parents make for healthy children, and this framework proposes that an important way in which schools may promote students' mental health and well-being is to support the parents' own well-being (Bryan and Henry 2012; Weare and Nind 2011). In a meta-analytic review of studies, Kaminski et al. (2008) reported that the provision of additional support systems to address the needs of the parents themselves was a key factor of successful parenting. The school thus needs to provide opportunities for parents for their own education and well-being, particularly empowering and supporting them to organize their own activities according to their own needs both at school and in the community. In doing so, however, schools need to be sensitive to the circumstances and needs of the parents and the community and to be inclusive, respectful, and empowering rather than paternalistic or judgmental. This entails considering parents as equal partners contributing actively to the school's efforts in mental health promotion (Cooper and Jacobs 2011).

Effective Implementation

Mental health initiatives that are not adequately planned, monitored, and evaluated are unlikely to work in the long term (CASEL, 2008; Greenberg 2010). Planning involves a needs assessment to match the intervention to the needs of the school, identifying and incorporating existing good practices, resources, and expertise at the school. The absence of such an assessment is likely to lead to underutilization of the school's strengths and to barriers and resistance along the way (Askell-Williams, Lawson, and Slee 2010). Organizational supports and policies to safeguard the success and sustainability of the initiative include supportive management, involvement of the whole school community, including parents and local community, in planning and implementation, education and mentoring of staff, provision of adequate resources, and alignment with regional and school policies (CASEL, 2005, 2008). Finally, any initiative needs to be regularly monitored and evaluated. Pre-intervention and post-intervention student outcomes help to determine the effectiveness of the intervention in terms of students' mental health and well-being.

A major issue in implementation is program adaptation and integrity. One of the conclusions in Blank et al.'s (2009) review was that even if programs were found to be effective, they would still need some adaptation before being implemented in different cultural contexts. When they are responsive and sensitive to the social, cultural, linguistic, and economic contexts where they are being implemented, the programs become more meaningful and relevant to the lives of the students, facilitating the internalization and generalization of competences to real life contexts (Elias 2010; Merrell and Gueldner 2010). Moreover, when school personnel appreciate the program's relevance for their classrooms, they are more likely to deliver and adhere to the program (Askell-Williams et al. 2010; Jennings & Greenberg 2009).

Any adaptations in the material, resources, language, examples, or activities, however, first needs to be planned and agreed collaboratively by the school community following a needs analysis of the school. Secondly, any changes need to be in line with the program's implementation guidelines, remaining as faithful as possible to the key principles on which the program is built and expected to be implemented. This is necessary for programs to achieve the expected outcomes; "too much tailoring to local needs and circumstances can lead to dilution and confusion" (Weare 2010, p. 11). Lack of structure and consistency in program implementation, such as teachers using only parts of the program or using the program only for a short period of time, is set to lead to ineffectiveness in terms of student outcomes (Humphrey et al. 2008, 2010). Program integrity in terms of high-quality implementation, fidelity, and evaluation is a key indicator of program effectiveness (Greenberg 2010).

Role of School Psychologists

The role of the school psychologist in the traditional mental health provision in school was primarily focused on undertaking individual assessment and psychological interventions with a small group of children experiencing more serious and chronic difficulties. In line with the paradigm shift in mental health provision in schools as outlined above, school psychologists are now expected to take a broad-based approach focusing on both individuals and systems (Adelman and Taylor 2009; Christner, Mennuti, and Whitaker 2009). Besides supporting students experiencing mental health difficulties, they are expected to work with school staff, students, parents, and other stakeholders in planning, implementing, and evaluating mental health services in schools at individual, classroom, and whole school levels and at both universal and targeted interventions. The client is thus the whole school community rather than just individual students (Wilczenski and Cook 2014).

School psychologists are trained in child and adolescent development, learning and motivation, individual and group assessment as well as in organizational and systems change and are specialists in both academic and social and emotional learning. Moreover, they have different levels of knowledge about education systems, curricula, methods of instruction and assessment, student grouping, and school and classroom organization. They have also advanced theoretical understanding of human development, particularly children's holistic development and learning processes, as well as advanced skills in the assessment of, and interventions in, cognitive and socioemotional development (Bartolo 2015). They are thus very well placed to work with both children and adults in improving learning, motivation, behavior, and well-being, linking mental health to learning and behavior (NASP, 2008, 2014). Among others, this includes working with schools in designing and evaluating the social and emotional curriculum at both school and regional and national levels and in training school staff in the implementation of the curriculum, the social and emotional needs of the students, building healthy relationships, positive classroom management, skills development, and collaborative working. They may also provide their expertise in enhancing the teaching and learning processes, helping to design and implement learning environments, which facilitate students' active engagement. As already discussed, academic engagement is directly related to the social and emotional well-being of the students. As they are trained in systemic interventions, school psychologists may be very effective in facilitating and supporting change at the whole school level (Leadbetter 2010), working with schools in building collaborative learning communities at classroom and at whole school levels, which promote healthy relationships, connectedness, caring, collaboration, and inclusion, while preventing abuse, violence, bullying, exclusion, and other forms of inappropriate behaviors. They are well placed to facilitate home school collaboration and interprofessional networking. They also work with school staff on ways to nurture the staff's own well-being, health and resilience, and with parents to promote mental health at home and the parents' own well-being. The framework proposed in this study construes the role of school psychologists as one of empowerment and facilitation, making use of their expertise in both psychology and education to empower school communities to engage in mental health promotion both in the classroom and within the whole school community. They exercise their role through curriculum design, assessment, and evaluation and through education, consultation, and mentoring.

School psychologists may find the emphasis on prevention and health promotion daunting and difficult to achieve in organizations and services with limited resources and with a focus on individual casework. More awareness and appreciation of the role of school psychologists at preventive, systems, and transdisciplinary levels in schools and services, particularly among heads of services and schools, would make it more possible for school psychologists to engage in effective systems practice in this respect. About 20 % of school children experience mental health problems during the course of any given year and may need the use of mental health services (Center for Disease Control and Prevention 2013; WHO 2013) The prevalence of mental health difficulties among children and young people in the USA has been increasing in the last 25 years, and related services are costing the country about US$247 billion a year (Center for Disease Control and Prevention 2013). Students manifesting mental health difficulties are more at risk of learning difficulties, behavior problems, substance abuse, juvenile delinquency, school failure, and poor employability opportunities (Bradley et al. 2008; Colman et al. 2009; Miles and Stipek 2006), thus ending up as an economic burden on the country's resources. Targeted interventions for such students, however, even if they are effective, do not necessarily reduce the incidence of mental health difficulties in children (Greenberg 2010). In contrast, universal interventions promote students' mental health, prevent the development of more serious difficulties later on, and often reduce multiple problem areas because many of these have overlapping risk factors and comorbidity (Bowers et al. 2013; Diekstra 2008; Sklad et al. 2012). This is particularly relevant in childhood and adolescence when personality is still developing and serious behavior problems may not have been manifested yet (Domitrovich et al. 2007; Lane and Menzies 2003). There is consistent evidence that programs to promote mental health and well-being in schools are effective with children and young people from diverse cultures, at all school levels, and in both academic learning and social and emotional health. Various reviews of studies have found a significant impact of such programs on students' behavior, including enhanced social and emotional learning, mental health and

academic achievement, and reduced internalized and externalized conditions, such as anxiety, depression, substance use, violence, and antisocial behavior (Durlak et al. 2011; Payton et al. 2008; Sklad et al. 2012; Slee et al. 2012; Weare and Nind 2011).

Conclusion

As mental health professionals trained in both the cognitive and affective domains, school psychologists are ideally placed to contribute to a continuum of mental health services in school, from the traditional individual interventions for children with mental health difficulties to preventive universal interventions for all school children as well as for school staff and parents as well. The framework outlined in this paper calls for a nonmedical paradigm for addressing mental health in schools, positioning school staff as key players in the promotion of children's mental health and well-being, and school psychologists as change agents, empowering school staff and parents to take responsibility for the promotion of the mental health of all school children as well as their own well-being, through a school-based, multilevel, whole school approach.

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