**Dimensions of pastoral care:
Student well-being in rural Catholic schools.**

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Abstract

This paper investigates the health and welfare needs of students ($n = 15,806$) and the current service models in Catholic schools in the Ballarat Diocese of Victoria, Australia. Catholic schools use a service model underpinned by an ethos of pastoral care; there is a strong tradition of self-reliance within the Catholic education system for meeting students' health and welfare needs. The central research questions are: What are the emerging health and welfare needs of students? How does pastoral care shape the service model to meet these needs? What model/s might better meet students' primary health care needs? The research methods involved analysis of: (1) extant databases of expressed service needs including referrals ($n = 1,248$) to Student Services over the last 2.5 years; (2) trends in the additional funding support such as special needs funding for students and the Education Maintenance Allowance for families; and (3) semi-structured individual and group interviews with 98 Diocesan and school staff responsible for meeting students' health and welfare needs. Analysis of expressed service needs revealed a marked increase in service demand, and the complexity and severity of students' needs. Thematic analysis of qualitative interview data revealed five pressing issues: the health and welfare needs of students; stressors in the school community; rural isolation; role boundaries and individualised interventions; and self-reliant networks of care. Explanations for many of these problems can be located in wider social and economic forces impacting upon the church and rural communities. It was concluded that the pastoral care model – as it is currently configured – is not equipped to meet the escalating primary health care needs of students in rural areas. This paper considers the implications for enhanced primary health care in both rural communities and in schools.

Key words: Pastoral care, Catholic education, Student well-being, Rural

Introduction

In recent years, there has been a significant decline reported in the health and welfare status of children and adolescents (Suicide Prevention Task Force, 1997), with population indicators showing an increased prevalence in anti-social behaviour, depressive symptoms, homelessness, self-harm and suicide (Bond, Thomas, Toumbourou, Patton & Catalano, 2000; Vimpani, Patton, & Hayes, 2002). One Australian study estimated that as many as 15% of children have a designated mental illness (Sawyer et al., 2000 as cited in Al-Yaman, Bryant & Sargeant, 2002).

Similar issues are evident within the Catholic education system where approximately 1 in 5 or more than 666,000 students are educated (Australian Bureau of Statistics, 2004). A recent statewide survey of principals about the nature, extent and impact of student welfare issues within Victorian Catholic schools (Cahill, Wyn & Smith, 2004) found that schools were responding to a greater number of educational and welfare problems, particularly learning problems, student mental health issues, behavioural problems, family difficulties, and staff wellbeing.

However, little is known about whether rurality affects the health and welfare needs of Catholic students or how it impacts on service delivery, especially given that people living in rural and remote Australia have been identified as having generally poorer health (National Rural Health Alliance, 2002). Moreover, there is very little published analysis about how pastoral care – the ethos underpinning student development and wellbeing in Catholic schools – might effectively inform primary health care service responses.

The pastoral care service model in Catholic schools

The central tenets of school pastoral care from a Catholic perspective are drawn from Christian-spiritual origins (Rennie, 2003) whereby the holistic care of all individuals comprising the school community (teachers, parents and students) is paramount (Treston,

1997, as cited in Rennie, 2003, p. 14). Pastoral care includes educational, religious and social dimensions that contribute to a positive, whole-school culture (Grove, 2004, p. 13).

These theological traditions are reflected in the Catholic Education Commission of Victoria's policy on pastoral care of students in Catholic schools. Some of the dimensions of pastoral care articulated in this document are:

- Responsibility entrusted to all members of the faith community. The bearing of burdens and the sharing of joys and honour is not done for others but with others.
- Building effective networks of care. In a period when schools are being asked to play a greater role in supporting the special needs of students and their families, the establishment and coordination of networks of care (within the school and wider community) represent a major priority in pastoral care programs.
- Supportive school-family relationships. Some students and their families actively seek the school's support in times of crisis and instability. Within the limits of its resources and expertise, a school committed to the total well-being of its students endeavours to provide this intensified support.

(Catholic Education Commission of Victoria, n.d.)

However, the very foundations of pastoral care in Catholic schools may be eroding. Historically, Catholic schools and the parish community were indivisible: schools were founded, staffed and funded by local parishes, and to this day in Victoria, Catholic schools remain under the authority of parish priests. As a matter of course, parishioners sent their children to the local Catholic school, and families were closely connected to the parish. In the last couple of decades, the Catholic church and its schools have been caught up in Australia's social, economic and cultural transformations:

The church is no longer the powerful force it once was in society.

Numbers of priests and religious are diminishing and the place of the parish in people's lives, particularly those who are young, is becoming less important. At the same time, Catholic schools are

now for the most part administered and staffed by lay people.

Significant numbers of these are not involved with the church

outside of their school communities (Battams, 2002, p. xii).

These changes may have profound consequences for the capacity of Catholic schools to implement a pastoral care program. This is acknowledged in the foreword to the pastoral care policy:

While Catholic schools have always given emphasis to the Pastoral Care of students, there is today a certain urgency to its challenges and responsibilities. Rapid and complex social change is resulting in substantial uncertainty, insecurity and stress in families, in the community at large and amongst the students in our schools. The possibilities and limits of each school's response to these realities requires constant appraisal (Catholic Education Commission of Victoria, n.d.).

These changes prompt questions about the effectiveness of pastoral care in meeting the primary health care needs of students in rural communities.

The rural setting and current service model

The setting for this study is the Catholic Diocese of Ballarat which covers a vast geographic area of approximately 135,000 square kilometers across western Victoria, Australia. The Diocese spans from the southern Victorian coastline to the New South Wales border, and from the South Australian border to central Victoria. Using the Australian Standard Geographical Classification Remoteness Area Structure (based on road distance to major service centres and population size), the Diocese covers areas that are classified as 'inner regional Australia', 'outer regional Australia', and 'remote' (in the far north west of the state) (Australian Institute of Health and Welfare, 2004). The Diocesan region is also home to nine postcode areas which are among the most disadvantaged in

the State (Vinson, 2004). The Catholic Education Office Ballarat (CEOB) administers 65 schools (54 primary and 11 secondary) with a 2005 enrolment of 15,806 students (8,446 primary school students and 7,360 secondary school students). Approximately half ($n = 32$) the schools have a student population greater than 200; ten of these have a student population over 500. Twenty one primary schools have a student population of less than 100.

Consistent with the pastoral care policy, each school and parish community carries the primary responsibility for meeting the educational, health and welfare needs of its students. The CEOB also employs a Student Services team comprising psychologists, speech pathologists, special education advisors, part-time visiting teachers for hearing and vision-impaired students, one youth services officer, and one Indigenous education advisor. These staff are based in four major provincial cities or towns across the Diocese. Schools can refer students with educational, health and welfare needs to the Student Services team for assessment and professional support.

The CEOB commissioned the researchers to conduct a study into student wellbeing in the Diocese. The three central research questions guiding this project were: What are the emerging health and welfare needs of students attending Catholic schools in this rural Diocese? How does pastoral care shape the service model to meet these needs? What model/s might better meet students' needs?

Methods

Before commencing the study, approval was obtained from the CEOB and the University of Ballarat Human Research Ethics Committee. This study employed three main research methods: analysis of the database of referrals to the Student Services team; analysis of trends in additional funding support – such as special needs funding for students and the Education Maintenance Allowance for families; and semi-structured individual and group interviews with 98 staff across the Diocese who have some responsibility for meeting

students' health and welfare needs. The referrals database is maintained by the CEOB and records referral information (allocation, commencement and completion dates; case worker; and type of support provided) and biographical details (age, gender, school year level, and school attending) for each referral. Owing to some incomplete or missing data, analysis was restricted to referrals (total $n = 1,248$) received from the beginning of 2003 until mid-2005. De-identified referral data were supplied to the researchers, and then transferred to SPSS 11.5 for analysis, and these provided evidence of expressed needs for service. In addition, aggregated data on special funding support for students and their families from 2003-2005 were supplied by the Catholic Education Commission of Victoria and the CEOB. The data included the number of students receiving funding for literacy, numeracy and special learning needs; the number of families receiving the Education Maintenance Allowance (which offers an indication of socio-economic disadvantage); and the number of students with diagnosed social-emotional disorders. The third method involved semi-structured individual and group interviews with a stratified sample of 98 key stakeholders across the Diocese including Student Services staff, principals, secondary welfare coordinators, special needs coordinators, and CEOB office leadership group. Individual consultations were also conducted with senior staff members from the Catholic Education Office Melbourne, Centacare, and the regional Department of Education. Interviews were conducted during Term 3, 2005, and lasted between 30 – 80 minutes. Hand written notes were taken to record participants' responses. Responses were thematically analysed, initially independently by the two researchers. The thematic structures were then compared to ensure inter-rater reliability (Miles & Huberman, 1994).

Results

Expressed service needs

The data revealed a steady increase in the number of referrals to Student Services over the last two and a half years. A large majority of all referrals were for male students ($n =$

872, 70%; females: $n = 376$, 30%), and students attending primary school (primary school $n = 1113$, 89%; secondary school: $n = 127$, 10%; missing: $n = 8$, 1%). In addition, the data indicate that most referrals are for speech pathology (37%), psychology (29%) and special education (12%) services. A pie chart depicting the requests for Student Services for each service stream is presented in Figure 1.

[Insert Figure 1 here]

Primary school referrals

Table 1 presents a summary of primary school referrals since 2003. Overall, students in preparatory grade and grade one represent the largest proportion of referrals, with this number generally decreasing as grade level increases. Most referrals are for speech pathology, psychology and special education.

[Insert Table 1 here]

Secondary school referrals

Table 2 summarises the referrals for secondary school students. The largest proportion of referrals occurs in the early secondary years (particularly years seven and eight) and are for psychology, speech pathology, and special education services. Noticeably, referrals for a psychologist comprise nearly half the total number of referrals for secondary school students.

[Insert Table 2 here]

Funding for students with additional needs

Other data sources confirm a rise in students' needs across the Diocese. Since 2003, there has been a 22.6% increase in the number of students receiving funding for Literacy,

Numeracy and Special Learning Needs. Furthermore, in 2005 the families of 1,897 primary school students and 971 secondary school students received the Education Maintenance Allowance (EMA). This indicates a relatively high rate of economic disadvantage: 22.5% of all primary schools students and 13.2% of all secondary school students come from families in receipt of the Allowance. Over half of all students with disabilities in the CEOB (2003 – 2005) have a severe language disorder (51%), intellectual disabilities (24%), and social-emotional disorders (14%). From 2001 to 2005, there has been a tripling in the number of students (from 23 to 73 students) identified with social-emotional disorders. A further 20 students with this type of disorder are enrolled in 2006.

Perceived service needs

For the purposes of this paper, analysis of interview data has been clustered into five major themes: health and welfare needs of students; stressors in the school community; rural isolation; role boundaries and individualised interventions; and self-reliant networks of care.

Health and welfare needs of students

There was widespread consensus about the increasing number and complexity of students' needs. Interviewees reported an escalation in speech difficulties and language disorders; social and emotional problems (often manifesting as angry outbursts); economic hardship from the drought in rural areas; welfare issues (arising from family disharmony and separation); and behavioural problems: *"There seems to be an increase in the number of preps coming to school with speech and whole-language problems."* Among secondary school students, welfare coordinators and Student Services staff reported a marked rise in mental health issues including depression, suicidal ideation and suicide attempts: *"There are more adolescents in crisis situations nowadays."*

Interviewees expressed concerns about students presenting with high needs (literacy, numeracy and special learning) but who were ineligible for additional funding. Concerns were also raised about the increased frequency and intensity of serious, dysfunctional classroom behaviours by students:

The system doesn't provide for it, so we have to deal with it internally. Behavioural problems can be much more problematic than disability-funded students.

Stressors in the school community

Many interviewees observed an increase in the number of parents seeking assistance from school staff about personal issues including family and relationship problems and parenting issues:

The need for parenting support is increasing.

Parents are less able to cope with issues. There's an 'angry parents' syndrome.

Families are much busier. There's not the same time that used to be put aside for reading together or getting homework done.

Respondents speculated that these issues may be closely linked to the young age of some parents, the increasing pressures placed on single parent families, and the competing time demands when both parents work full-time. Meeting students' health and welfare needs were especially difficult for schools when parents were confrontational or had disengaged from their children's problems.

Consequently, teaching staff were under greater pressure: *"We're now dealing with more teachers who are on the brink of breakdown far more than we ever have."* Many expressed uncertainty about the practical limits of pastoral care: *"There are no boundaries around our responsibilities. It's just an elastic band that keeps stretching."* There was unanimous support for, and acknowledgement of the commitment and professionalism of

Student Services staff, but this praise was overshadowed by the concerns for their welfare given their huge workloads (working long hours and overtime), the many urgent and complex referrals, and the large distances traveled to visit schools. As one Student Services staff member remarked *“Work is full on – I feel there could be ten of me and there still wouldn’t be enough”*.

The isolation of small rural schools

Smaller, isolated primary schools in the Diocese reported an increase in the number of student welfare issues particularly in communities experiencing economic hardship because of the drought.

Families are really struggling. They’re under enormous pressure with relationships breaking down...violence. We’ve got dads on medication for depression because of the drought. Our kids are noticeably more angry because of the drought. They’re drawn into farm work and get to see the conversations at home between the parents about all the problems. The families are coming to us (for help).

The CEOB waived school fees for these families, which offered temporary reprieve. However, while many of these small country schools had *“traditionally managed (to provide pastoral care) in-house, they are now calling out for assistance”*. Primary school staff also reported an increase in the number of calls for welfare assistance from people within the wider community. They explained that, with the gradual disappearance of resident priests in some parishes, Catholic schools were now being approached by both locals and travellers passing through town:

Schools are the de facto parish point of contact for priest-less parishes. This is especially pronounced in our small rural communities.

Many of these small rural schools are under-resourced to respond to these demands. Typically, the school principal also has classroom duties and carries responsibility as the special needs coordinator. The geographical isolation also makes it difficult to access health and welfare support services for those students and families with additional needs.

Role boundaries and individualised interventions

The CEOB and schools in the Diocese have taken action to address the escalation of needs. Some school staff are completing a Graduate Diploma in Education (Student Welfare), together with ongoing professional development in special education. Some larger schools operate very effective student well-being teams which provide a comprehensive primary health care service. However, many school staff remain uncertain about the boundaries between education and welfare. Some believed that schools and the CEOB should only focus on the educational needs of students and not deliver primary health care or welfare services:

“It’s hard to know when to draw the boundaries when assisting students and their families.”

“Catholic education needs to work in a lot more closely with Centacare (the Catholic Church’s welfare arm). Schools should stick to what they do best. Anything to do with family health and welfare should be referred out, and this is where Centacare should come in.”

The reality of this was problematic for those schools located outside the major towns; parents would need to drive their children long distances to access services.

Closely linked to this issue were concerns about finding the balance between prevention and intervention. The escalating demands and the current funding model impelled schools to an interventionist service model:

“We’ve got a predominant reactionary approach. It’s a firefighter mentality. We tend to react to individual crises rather than setting up structures and processes to deal with the problems.”

There was growing recognition that this approach was neither appropriate nor effective, especially given the increasing number and complexity of student problems:

“The current approach is unsustainable. We have to change. We can’t continue with the reactive, interventionist, one-to-one approach. We have to move to a more primary prevention model.”

Self-reliant networks of care

The final theme was that the Catholic education system was highly dependent on its own networks of care. On the one hand, this was viewed as a real strength: *“Catholic schools have a reputation for pastoral care. There’s a perception by parents that kids will be better looked after in Catholic schools.”* On the other hand, the sheer number and magnitude of problems presented by students and their families meant that school and parish support networks were not always sufficient: *“Schools must learn to work with agencies. We’ve got to work more closely with them. We’ve got to find new ways to bring them into the school.”* According to several interviewees, this self-reliant care is reinforced by some agencies that discontinue support to students moving into the “Catholic system”. School staff in small, isolated townships reported that there simply were not any other support services available. For many of the more geographically isolated schools, assistance comes solely from Student Services.

Discussion

Overall, the findings reveal escalating expressed and perceived needs of students attending Catholic schools within the rural Diocese. This is shown across a wide range of needs including speech and language difficulties, psychological distress and mental health

problems, special learning, social and emotional issues, behavioural problems and family stress and separation. These findings confirm the national and international trends about the increased incidence of anti-social behaviour (Bond et al., 2000), child and adolescent mental health problems (Sawyer et al., 2000, as cited in Al-Yaman et al., 2002), speech, language and hearing difficulties in children (American Speech-Language-Hearing Association, n.d.), and changes to the 'traditional' family unit, with an increase in single parent, step and blended families (Wise, 2003). In response, government and non-government schools are increasingly called upon to be sites for the delivery of a range of primary health and welfare initiatives. Service providers are often asked to do this with little additional resourcing or training (Kang et al., 2003). In rural areas such as the Ballarat Diocese, these problems are compounded by geographical distances and limited access to services (Bourke, 2001; Judd & Humphreys, 2001; National Rural Health Alliance, 2002). The prolonged drought has also resulted in severe financial hardship and psychological distress for families (Crosby, 1998; Munro & Lembit, 1997). The gradual disappearance of resident priests in some rural parishes places further pressure on school principals for pastoral care (Australian Catholic Primary Principals Association, 2005). It appears that the current service model can not adequately meet the burgeoning primary health care needs of students in rural Catholic schools. The remainder of this paper considers how schools can play an enhanced primary health role in rural areas.

Enhanced primary health care role for schools in rural communities

Through the establishment of the global school health initiative, the World Health Organisation recognizes that schools play a vital role in promoting the physical, social and psychological health of students and the wider school community (World Health Organisation, 2005). Recent initiatives across Australia and internationally can be grouped into four key strategies for enhancing schools' primary health care role.

The first is a focus on primary prevention and early intervention. Primary prevention aims to promote students' wellbeing and minimize factors that may lead to risk or vulnerability. Early intervention aims to modify the school environment and provide a targeted approach to groups of students for whom there is an increased likelihood of risk (Department of Education, 1998; Power, 2003). There is good evidence emerging about the effectiveness of this strategy (Prior and Paris, 2005), despite the challenges involved in shifting from a system which is primarily geared to intervention and crisis-response (McDonald and Hayes, 2001). The second strategy is the adoption of a whole-school approach. This engages all key learning areas in all year levels. It is informed by a positive school ethos and environment, and draws upon links with the wider community to promote health (Hawkins and Catalano, 1990; McBride, Midford & Cameron, 1999). The third strategy extends the whole-school approach by constructing stronger school-community-family connections. This is based upon the idea that students' health problems can be traced to disadvantages within communities and families: schools need to engage with these stakeholders to address the issues (Power, 2003). Community-based intervention programs such as Communities that Care are one example of this broad strategy (Crow et al., 2004; Prior and Paris, 2005). The final strategy is inter-sectoral collaboration between schools and local health and welfare agencies. This may involve formalizing referral pathways, or agencies delivering primary health programs at the school, or innovative service models to provide a school-based point of contact to address parents' welfare needs. Implementing this strategy in Catholic schools will require a revision of the pastoral care approach which has, to date, largely relied upon the school and parish community's resources.

Pastoral care models developed overseas may prove transferable to isolated rural school communities in Australia. For example, in the United States of America and Canada 'congregational nurse' and 'parish nurse' programs aim to provide a link between spirituality and health science. These nurses provide holistic care (physical, spiritual and

mental) to individuals or groups within the faith community. Nurses provide a range of primary health services that may include health assessments, health education, advocacy and referral, health promotion and community wellness programs (Buijs and Olson, 2001). Primary health care in rural communities must also be built upon more flexible approaches to funding and service delivery (National Rural Health Alliance, 2002). A cluster of small rural schools and local agencies could, for example, jointly fund the salary of a speech therapist or psychologist. In the context of the Catholic education system, this may help reduce some of the pressure placed on individual schools teams while at the same time building broader and more effective primary health care networks.

Conclusion

This research confirms that broader socio-economic changes are driving an escalation in the needs of students and their families. The health disadvantages of people in rural areas are being compounded by prolonged drought conditions. The existing student support system is largely locked into a model that responds to individual requests for assessment or assistance, often in times of crisis. Moreover, the connection of people to their parish has waned, and the number of parishes without resident priests has increased. The consequence is that pastoral care – as it is currently configured – can not adequately meet the burgeoning primary health care needs of students in rural Catholic schools. The solution lies in developing new primary health models of pastoral care in schools that focus on primary prevention and early intervention, embrace whole-school approaches, and extend partnerships with families, communities and the health and welfare sectors.

Future research in this area could be directed at investigating service system changes: research is needed to better understand the barriers and enablers in shifting student support services from a model geared to intervention to one with a greater focus on primary prevention and early intervention. Evaluative research could also help to

assess the effectiveness of different models of pastoral care, including the transferability of parish nurse programs to a rural Australian context.

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Figure 1: Referral requests for support (per stream)

Table 1

Primary school referrals for gender, year level at time of referral and support service (stream) for primary school referrals since 2003

Referral Information		2003 – 2005 Referrals (<i>n</i> = 1113)*	
		<i>n</i>	%
Gender:	Male	776	69.7
	Female	337	30.3
Year Level (at time of referral)			
	Prep	310	27.9
	Grade 1	116	10.4
	Grade 2	94	8.5
	Grade 3	94	8.5
	Grade 4	107	9.7
	Grade 5	97	8.8
	Grade 6	71	6.4
	Missing	224	19.8
Referral Support Services (Stream)			
	Speech Pathology	441	39.6
	Psychology	301	27
	Special Education	135	12.2
	Missing	236	21.2

* Note. The number of primary and secondary school referrals since 2003 is 1248. The smaller *n* for 2003 – 2005 for primary and secondary school referrals is due to missing referral data about the school. These cases (*n* = 8) have been excluded from the analysis.

Table 2

Secondary school referrals for gender, year level at time of referral and support service (stream) for secondary school referrals since 2003.

Referral Information		2003 – 2005 Referrals (<i>n</i> = 127)*	
Gender:		<i>n</i>	%
	Male	90	70.1
	Female	37	29.9
Year Level (at time of referral)			
	Year 7	38	29.9
	Year 8	22	17.4
	Year 9	11	9
	Year 10	7	5.5
	Year 11	10	7.9
	Year 12	6	4.7
	Missing	33	25.6
Referral Support Services (Stream)			
	Speech Pathology	20	15
	Psychology	58	45.6
	Special Education	17	13.4
	Visiting Teacher	2	1.6
	Youth Services	3	2.4
	Missing	27	22

* Note. The number of primary and secondary school referrals since 2003 is 1248. The smaller *n* for 2003 – 2005 for primary and secondary school referrals is due to missing referral data about the school. These cases (*n* = 8) have been excluded from the analysis.

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