FEATURE

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Supporting Mental Health and Wellness among Private School Students: A Survey of Catholic Elementary and Secondary Schools

ABSTRACT

Little systematic inquiry has focused on school-based mental health services in the Catholic education sector, which educates more than two million children annually in the United States. More than 400 Catholic elementary and secondary schools were surveyed to inform a baseline environmental scan measuring how Catholic schools nationally are serving children's mental health needs. The article sheds light on patterns of mental health staffing and resource provision, student psychosocial and mental health issues, mental health service provision, and barriers to and challenges of mental health service provision. The findings are contextualized by comparison with estimates of public school mental health service provision, consideration of funding issues pertinent to the private school sector, and the continuing need for strategic assessment and action planning to support student mental health.

Key words:student mental health; Catholic education; private schools

Introduction

Schools must ensure that children are granted the greatest opportunity for learning possible. This means not only developing students' academic capabilities, but also providing support for their emotional, behavioral and mental health needs as well. While the nature and scope of mental health service provision has been assessed and mapped in our nation's public schools, large-scale inquiry centered on Catholic education has not been conducted. As a whole, much less systematic inquiry has focused on the private education sector, which collectively educates more than six million children annually. Thus the purpose of this study was to collect information – via a confidential online survey of Catholic school principals – regarding mental health services, staffing and needs in their schools.

School mental health as a public health issue

National interest in children's mental health as a significant public health issue has increased over the last decade. For example, several reports released by federal departments indicate the national significance of preventing and addressing the mental health needs of children in the United States (New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2000; U.S. Public Health Service, 1999, 2000). In particular, the Surgeon General's seminal

reports on mental health (U.S. Public Health Service, 1999) and children's mental health (U.S. Public Health Service, 2000) intensified the focus on adult and child mental health research, practice and policy. Reports such as these documented that one in ten children and adolescents suffers from mental illness severe enough to cause some level of functional impairment (Burns *et al*, 1995; Shaffer *et al*, 1996). Addressing mental health issues among young people is a national public health imperative.

Schools are a primary connection point to address the myriad mental health issues facing children. Weist and Ghuman (2002) were clear that effective school performance depends on it.

> *If schools want to achieve desired academic outcomes, it is incumbent on them to have sufficient resources in place to develop comprehensive programs that serve to remove and reduce barriers to student learning* (p4).

National advocates stress that mental health in schools must be embedded:

> *into every school's need to address barriers to learning and teaching*

and must be fully integrated into 'school improvement policy and practice' (CMHS, 2008 p2; see also Adelman & Taylor, 2006, 2010).

Despite schools' growing centrality in any discussion of children's mental health, over a decade ago Rones and Hoagwood noted that:

> *precisely what is provided by schools under the rubric of mental health services and whether those services are effective is largely unknown* (2000 p223).

Thus, in 2002, the Substance Abuse and Mental Health Services Administration endeavored to provide:

> *the first national survey of mental health services in a representative sample of the approximately 83,000 public elementary, middle, and high schools and their associated districts in the United States (*Foster *et al*, 2005 p1*).*

Published in 2005, the *School Mental Health Services in the United States, 2002–2003* study offered a portrait of the organization, staffing, funding and coordination of mental health services in schools (see also Teich *et al*, 2007).

Private schooling in the U.S. and Catholic education

While Foster and colleagues' (2005) groundbreaking work provided descriptive insight into the landscape of mental health services in public schools, an environmental scan of such efforts in the private education sector – and Catholic schools in particular – has been lacking. Private education – namely schools that are not supported primarily by public funds – encompasses both religious (68%) and nonsectarian (32%) schools (Broughman *et al*, 2009). Private schooling in the United States involves a significant population of students and schools. According to the National Center for Education Statistics Private School Universe Survey, in 2007–08 pre-K-12 enrollment totaled just over five million students, or 11% of all U.S. students. In 2007–08 there were 33,740 private schools in the country, which amounts to 25% of all U.S. schools (Broughman *et al*, 2009).

Catholic schools are a sizable majority within the private education sector, in that Catholic schools make up about 57% of all religious schools. With 2.1 million students and 7094 schools, the mission of Catholic schools is to provide for the spiritual, intellectual, moral and social formation of students (McDonald & Schultz, 2010). ***Table 1***, opposite, provides pertinent contextual and background information concerning Catholic schooling in the United States. Notably, Catholic schools have long been recognized as strongholds of student achievement (Nuzzi *et al*, in press). A long and varied literature has parsed what has come to be known as the Catholic school effect – the fact that minority, low-income children of non-educated parents outperform students from similar backgrounds in public schools (Coleman & Hoffer, 1987; Coleman *et al*, 1982; Greeley, 1982; Neal, 1997; Sander, 1996).

While much attention and discourse has been devoted to the academic benefits of Catholic education, there is a relative paucity of research examining non-academic supports for students in Catholic schools. Walsh and Goldschmidt (2004) highlighted non-academic barriers to learning – including students' mental health needs – that affect student achievement and overall well-being in Catholic schools. However, basic descriptive survey data documenting the extent to which Catholic schools are serving children's mental health needs has been unavailable. Thus, while similar efforts have surveyed the landscape of mental health services in public schools, this study was an attempt to begin doing the same for our nation's Catholic schools.

The purpose of this research inquiry was to measure

TABLE 1 ***Catholic Education in the U.S.: Demographic Portrait and Key Highlights***

School demographics

- 7094 Catholic schools (5889 elementary, 1205 secondary)
- Enrollment is 2,119,341 (1,507,618 elementary/middle, 611,723 secondary)
  - Minority enrollment = 29.8%
  - Non-Catholic enrollment = 14.5%
- 154,316 full-time professional staff (96.3% laity, 3.7% religious/clergy)
- Average tuition: $3383 in elementary schools, with 93% of schools providing tuition assistance; $8182 in secondary schools, with 97% providing tuition assistance

Highlights

- The Catholic Church operates schools in order to provide a holistic education (academic, social, moral, and spiritual) that is grounded in the Christian faith.
- Enrollment in Catholic school peaked at 5.6 million in 1964–1965 and has declined since then by 3.5 million students.
- A long line of scholarship documents what has been referred to as the 'Catholic school effect'. For example:
  - In Catholic schools, the student achievement gap is smaller than in public schools. (Jeynes, 2007; Marks & Lee, 1989)
  - In Catholic schools, overall academic achievement is higher. (Coleman *et al*, 1982; Sander, 1996)
  - In Catholic schools, student math scores improve between sophomore and senior years. (Carbonaro & Covay, 2010)
  - Latino and African American students in Catholic schools are more likely to graduate from secondary school and college. (Grogger & Neal, 2000)
  - Students with multiple disadvantages benefit most from Catholic schools. (Greeley, 1982; Evans & Schwab, 1995; Neal, 1997)
  - The poorer and more at-risk a student is, the greater the relative achievement gains in Catholic schools. (York, 1996)
  - Graduates of Catholic secondary schools are more likely to vote. (Dee, 2005)
  - Graduates of Catholic secondary schools are more likely to earn higher wages. (Neal, 1997).

Note: School demographics derived from McDonald D & Schultz MM (2010) United States Catholic elementary and secondary schools 2009–2010: The annual statistical report on schools, enrollment, and staffing. Arlington, VA: National Catholic Educational Association.

the current level, type and kind of mental health services and supports that Catholic schools offer, as well as to assess the predominant mental health and psychosocial needs of students. The four guiding research questions were:

- What are the patterns of staffing and resource provision as enacted in a sample of Catholic schools?
- What are students' predominant psychosocial or mental health issues in these schools?
- What specific services are provided to students?
- What are the barriers and challenges to mental health services and staffing in Catholic schools?

Method

Participants

The participants were a convenience sample of principals (or their designee) of 414 Catholic schools from 12 dioceses (districts) across the United States. The sample consisted of both elementary (*N* = 346) and secondary (*N* = 68) schools from dioceses in California, Connecticut, Florida, Georgia, Illinois, Indiana, New York and Ohio. In keeping with the typical conventions for categorizing school levels in the Catholic sector (McDonald & Schultz, 2010), the elementary sample is composed of K–8 schools and the secondary sample contains grade levels 9–12.

Elementary schools

The average enrollment in the sampled elementary schools was 300 students (s.d. = 173). In these elementary schools, including 22% minority students, 2.9% of students were classified as limited English proficient or ELL (min–max: 0–100%), 4.1% had an Individualized Education Plan (min–max: 0–26%), and 14.4% were eligible for free and reduced price lunch (min–max: 0–97%). School location was as follows: 35% suburban, 31% urban but not inner city, 25% small town or rural, and 10% inner city.

Secondary schools

The average enrollment in the sampled secondary schools was 555 students (s.d. = 398). In these secondary schools, which included 24% minority enrollment, 4.0% of students were classified as limited English proficient or ELL (min–max: 0–100%), 4.1% had an Individualized Education Plan (min-max: 0–29%) and 10.5% were eligible for free and reduced price lunch (min–max:

0–89). School location was as follows: 43% urban but not inner city, 35% suburban, 16% small town or rural, and 6% inner city.

Instrument

Background

The survey instrument used in this inquiry, the Catholic School Mental Health and Wellness Survey, contained 41 items dispersed across six major sections (see Content, below). The survey was adapted by the first author from the Survey of the Characteristics and Funding of School Mental Health Services developed by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration and used by Foster and colleagues (2005) in their national survey of mental health services in public schools. The original survey was endorsed by the American Counseling Association, the National Association of School Psychologists, the National Association of Social Workers and the National Association of State Directors of Special Education.

Due to the unique milieu of private education, and Catholic education in particular, it was necessary to customize and adapt the survey somewhat. For example, one section of the original survey was dedicated to public funding (Federal, State and local), budgeting and resource allocation. Exploration of this domain was not within the scope of this study; moreover, private schools encounter a distinct constellation of issues regarding funding identification and access (Perla *et al*, 2009). Four content experts – a Catholic school principal, and three professors, of educational administration, special education and clinical psychology – then reviewed the survey. After they had suggested minor wording modifications, the final modified survey version was entered into an online data collection, management and analysis platform. Finally, to troubleshoot the online data collection link and data entry processes, the survey was pilot-tested by two Catholic school principals. Both completed the survey without difficulty and reported favorably on the soundness of the content and the navigability of the online forms.

Content

A definitional section opened the survey, seeking to clarify the use of terms such as 'mental health interventions' and 'preventive mental health programs', and to prompt respondents on the types of mental health service to consider as they completed the survey. This opening section was followed by six major sections:

- basic school characteristics
- mental health staffing in school
- psychosocial or mental health issues among students
- services provided to students
- preventive and early intervention programs
- open-ended commentary (not covered in this manuscript).

Survey items in these sections contained a mix of nominal, ordinal, Likert and open-response formats.

Procedure

Survey administration

Institutional review board approval for survey administration and data collection was received in summer 2009. At the outset of the 2009–2010 academic year, an initial letter of inquiry was directed to a convenience sample of 15 school superintendents across the United States who represented a geographic cross-section of dioceses across the country and were familiar with the University of Notre Dame's Alliance for Catholic Education Program. The letter outlined the rationale and purpose of the study, and the requirements of participation. Of the 15 contacts, 12 agreed to participate (80%). The superintendents' primary agreement was to forward the online survey link to their existing listserv of building principals. In a subsequent e-mail, superintendents were provided with the active survey link along with parameters for its distribution and completion.

When a school principal was forwarded the survey link from the superintendent or the diocesan listserv, activating the link opened an introductory page containing an invitation to participate. This invitation contained all of the elements of voluntary, informed consent, including the purpose of the study, contact information, time required to participate and disposition of data. The end of the page closed with the statement:

> *Having read the information provided above, please provide your consent to participate by clicking Next.*

Each diocese sent a second invitation asking for participation after a two-week period. Finally, each diocese was prompted to send a final reminder to potential participants, this time using a more specific prompt based on the local diocesan response rate thus far. For example:

… while individual responses remain confidential, the survey software indicates that about 55% of schools in the Diocese of [ ] have not yet responded.

In general, the online survey window in the field was approximately six weeks at each site.

Data analyses

The quantitative data were analyzed in a purely descriptive manner, calculating response frequency, percentage, mean, range and standard deviation for each questionnaire item, as appropriate.

Findings

Results from the Catholic School Mental Health and Wellness Survey are presented here in several major categories:

- patterns of mental health staffing and resource provision
- student psychosocial and mental health issues
- mental health service provision
- barriers to and challenges of mental health service provision
- prevention and early intervention services.

Patterns of staffing

Source of staffing

Principals were asked to describe the administrative locus for the delivery and coordination of mental health services in their schools. There were five response options: mental health staff are school-based (employees of the diocese or school who are assigned to this school and work only in this school), mental health staff are district-based (employees of the diocese who are assigned to and travel to various schools, spending only part of their time in this school), a community provider or organization provides the mental health staff, volunteer, and other (please describe). Principals could select multiple categories, if necessary, to describe delivery and coordination of services in their school.

As depicted in ***Table 2***, below, the source of mental health staffing in nearly four in ten elementary schools is a community provider. About a quarter of staffing is school-based and a fifth is diocesan (district) based. Catholic secondary schools, in contrast, reported a higher percentage of staffing at school level (38%), and lower levels of both community-based (22%) and diocesan-based (8%) staffing. A small percentage of Catholic schools rely on mental health services provided by volunteers (5% elementary, 8% secondary).

TABLE 2 *Sources of Mental Health Staffing in Catholic Elementary and Secondary Schools*

	Elementary % (N = 308)	Secondary % (N = 65)
Community provider	39	22
School-based	24	38
Diocese-based	19	8
Combinations	14	12
Volunteer	5	8

Mental health staff positions

To understand better the characteristics of mental health staff operating in Catholic schools, principals reported the number of staff employed in the following positions, including whether the staff were full- or part-time: school counselors, mental health counselors, school psychologists, clinical/PhD-level psychologists, social workers, substance abuse counselors and school nurses. The findings in ***Table 3***, below, show the percentage of schools that reported at least one full- or part-time staff member for each position. At elementary level, school nurses (43%), school counselors (35%) and school psychologists (28%) were the most common mental health service providers. All Catholic secondary schools reported having either a full- or part-time school counselor, 63% drew upon school nurses and 35% had school psychologists. The percentage of Catholic elementary schools reporting full-time mental health staff, across all positions, was quite low, ranging from 0% to 13%. While 88% of Catholic secondary schools have access to a full-time school coun-

TABLE 3 *Percentage of Catholic Elementary and Secondary Schools with Various Types of Staff who Provide Mental Health Services*

	Elementary %		Secondary %	
Staff positions	Full- or part-time	Full-time	Full- or part-time	Full-time
School nurses	43	13	63	30
School counselor	35	11	100	88
School psychologists	28	3	35	5
School social workers	17	1	15	14
Mental health counselors	8	2	22	12
Volunteers	8	1	12	2
Clinical/counseling psychologist (PhD)	5	1	8	3
Other staff positions	4	1	18	5
Alcohol/substance abuse counselors	4	0	21	9
Psychiatrists	1	0	2	0

selor, the percentage of schools reporting full-time staffing for other mental health providers was much smaller, ranging from 0 to 30%. Full- or part-time volunteers constituted 8% and 12%, respectively, of Catholic elementary and secondary school mental staffing.

Student psychosocial/mental health issues

The focus of this component of the survey was better understanding of the actual psychosocial and mental health problems among students in Catholic schools. Principals reviewed a list of 14 issues, originally developed by an expert study advisory panel for the Foster *et al* (2005) public school survey. The list covers a broad spectrum of concerns, from mild (such as adjustment issues) to severe (such as major psychiatric or developmental disorders). Principals indicated the three psychosocial and mental health problems – separately for males and females – that were observed most frequently at their school (***Table 4***, below).

Most commonly reported health problems
At both elementary level and secondary school levels, and for both male and female students, the mental health problem category most commonly reported was social, interpersonal or family problems. The percentage of schools identifying this issue as pre-eminent ranged from 73% (secondary school males) to 90% (elementary females). The second and third most commonly reported mental health problems differed for male and female elementary school students. For males, aggressive/disruptive behavior or bullying was reported as a top three concern by two-thirds of schools, and behavior problems associated with neurological disorders were reported by more than half (54%). For females, the second most commonly reported problem was anxiety, stress and school phobia (57%), followed by adjustment issues (55%). The elementary female pattern of common mental health problems was replicated identically at secondary school level. After social, interpersonal or family problems, the next two most common concerns among secondary school males were adjustment issues and anxiety, stress and school phobia. Notably, ***Table 4*** shows that, while aggressive/disruptive behavior or bullying was a top three concern for elementary boys (66%), it was mentioned frequently enough to rank

TABLE 4 ***Percentage of Schools Identifying the Following Mental Health Issues among their Top Three Concerns, by School Level and Gender***

	Elementary	%	Secondary	%
Females	Social, interpersonal or family problems	90	Social, interpersonal or family problems	81
	Anxiety, stress, school phobia	57	Anxiety, stress, school phobia	58
	Adjustment issues	55	Adjustment issues	54
	Aggressive/disruptive behavior, bullying	45	Depression, grief reactions	36
	Behavior problems associated with neurological disorders	34	Aggressive/disruptive behavior, bullying	20
	Depression, grief reactions	17	Alcohol/drug problems	19
	Eating disorders	7	Behavior problems associated with neurological disorders	17
	Major psychiatric or developmental disorders	6	Eating disorders	17
	Concerns about gender or sexuality	3	Concerns about gender or sexuality	10
	Delinquency and gang-related problems	3	Experience of physical or sexual abuse	10
	Sexual aggression, including harassment	3	Sexual aggression, including harassment	10
	Experience of physical or sexual abuse	3	Suicidal or homicidal thoughts or behavior	8
	Suicidal or homicidal thoughts or behavior	3	Major psychiatric or developmental disorders	8
	Alcohol/drug problems	0	Delinquency and gang-related problems	7
Males	Social, interpersonal or family problems	80	Social, interpersonal or family problems	73
	Aggressive/disruptive behavior or bullying	66	Adjustment issues	46
	Behavior problems associated with neurological disorders	54	Anxiety, stress, school phobia	44
	Adjustment issues	43	Aggressive/disruptive behavior or bullying	31
	Anxiety, stress, school phobia	40	Alcohol/drug problems	31
	Depression, grief reactions	12	Behavior problems associated with neurological disorders	29
	Major psychiatric or developmental disorders	10	Depression, grief reactions	25
	Delinquency and gang-related problems	4	Delinquency and gang-related problems	8
	Concerns about gender or sexuality	4	Eating disorders	8
	Alcohol/drug problems	3	Concerns about gender or sexuality	8
	Suicidal or homicidal thoughts or behavior	3	Sexual aggression, including harassment	8
	Experience of physical or sexual abuse	3	Suicidal or homicidal thoughts or behavior	7
	Eating disorders	3	Experience of physical or sexual abuse	7
	Sexual aggression, including harassment	3	Major psychiatric or developmental disorders	5

among the top five problems on each of the four lists.

Issues using most mental health resources
Somewhat different patterns emerged for elementary versus secondary schools (***Table 5***, below) when participants were asked to speculate on which issues in the problem list demanded most of the school's mental health resources. At both school levels it was agreed that social, interpersonal or family problems used the most resources overall. At elementary level, aggressive/disruptive behavior or bullying followed by behavior problems associated with neurological disorders were high resource demand issues. Issues using most mental health resources at secondary schools were adjustment issues and anxiety, stress and school phobia.

Mental health service provision

Available services
To complement an understanding of who provides mental health services and the presenting conditions and needs of students, a third component of the survey focused on provision of services. Principals reported whether or not certain services were available to their students via school, diocesan or community-based resources. Delineated in ***Table 6***, overleaf, the service continuum contained 11 services such as crisis intervention, case management, substance abuse counseling, and assessment for emotional or behavioral problems.

TABLE 5 ***Mental Health Issue Using the Most School Mental Health Resources***

	Elementary % (N = 308)	**Secondary** % (N = 59)
Social, interpersonal or family problems	50	44
Aggressive/disruptive behavior, bullying	17	0
Behavior problems associated with neurological disorders	15	5
Adjustment issues	10	17
Anxiety, stress, school phobia	5	14
Other	3	0
Major psychiatric or developmental disorders	2	0
Depression, grief reactions	1	11
Delinquency and gang-related problems	0	0
Suicidal or homicidal thoughts or behavior	0	0
Alcohol/drug problems	0	3
Eating disorders	0	0
Concerns about gender or sexuality	0	2
Experience of physical or sexual abuse	0	0
Sexual aggression, including harassment	0	0

The most common mental health service (64%) provided in elementary schools was assessment for emotional and behavioral problems or disorders, which may include behavior observation, psychosocial assessment and psychological testing (***Table 6***). Three other services were provided by more than half of the elementary schools: crisis intervention (60%), behavior management consultation (57%) and referral to specialized programs or services for emotional/behavioral problems (51%). Looking at mental health services provided infrequently, fewer than 20% of elementary schools provide substance abuse counseling (16%), referral for medication management (14%) or medication for emotional and behavioral problems (11%). The most common mental health service (85%) provided in Catholic secondary schools was crisis intervention. Nearly three-quarters of secondary schools surveyed offered behavior management consultation and outside referral to specialized programs for emotional or behavioral problems. Individual counseling/therapy and assessment for emotional/behavioral problems was offered by 67% and 63% of secondary schools respectively. The mental health service provided least frequently in secondary schools was medication for emotional and behavioral problems. On average, 9.3% of Catholic school students in the schools surveyed receive some form of mental health or wellness service. In elementary schools, 7.2% of students had received one or more of the above services during the last school year. In secondary schools, 18.9% of students had.

Barriers to and challenges of mental health service provision

Degree of difficulty of providing service
Of the services provided, schools were asked to assess the degree of difficulty they encountered in providing each mental health service on a scale of 1–4, 1 being *not difficult* and 4 being *very difficult* (***Table 7***, overleaf). For elementary schools, the highest mean values were evident for medication for emotional and behavioral problems ($M = 2.79$; s.d. = 1.12), substance abuse counseling ($M = 2.70$; s.d. = 1.19), and referral for medication management ($M = 2.71$; s.d. = 1.15). For each of these three services, approximately 60% of principals said that delivery of these services was either somewhat or very difficult. Schools indicated that there was least difficulty in provision of behavior management counseling ($M = 2.10$; s.d. = 1.02) and crisis intervention ($M = 2.08$; s.d. = 1.02). For secondary schools, the

TABLE 6 ***Percentage of Schools Providing Various Mental Health Services by School Level***

Services	Elementary %	Secondary %
Assessment for emotional or behavioral problems or disorders (including behavior observation, psychosocial assessment and psychological testing)	64	63
Crisis intervention	60	85
Behavior management consultation	57	74
Referral to specialized programs/services for emotional/behavioral problems/disorders	51	74
Individual counseling/therapy	49	67
Case management (monitoring and coordination of services)	38	37
Group counseling/therapy	34	46
Family support services (child advocacy, counseling)	33	42
Substance abuse counseling	16	48
Referral for medication management	14	23
Medication for emotional and behavioral problems	11	9

most difficult services to provide were medication for emotional and behavioral problems (*M* = 2.65; s.d. = 1.16), referral for medication management (*M* = 2.47; s.d. = 1.20), case management (*M* = 2.18; s.d. = 1.07) and group counseling/therapy (*M* = 2.18; s.d. = 1.04). In contrast, provision of behavior management consultation (*M* = 1.59; s.d. = 0.87) and individual counseling/therapy (*M* = 1.48; s.d. = .74) posed the least difficulty.

Barriers to providing service

Schools were asked to assess the degree to which several factors were a barrier to providing mental health and wellness services to their students. Examples of barriers include transportation difficulties, student confidentiality, stigma, inadequate school resources, competing priorities, gaining parental cooperation and the like. The assessments were based on a scale ranging from 1-4, 1 being *not a barrier* and 4 being *significant barrier* (***Table 8***, opposite). Elementary and secondary schools identified the same three barriers as most prominent. The greatest barrier, indicated by both elementary and secondary schools, centered on the financial constraints of families. The second and third most highly rated barriers were that school mental health resources are inadequate to meet student needs, and the stigma associated with receiving mental health services. For each of these barriers, however, elementary schools rated the barrier as more serious (higher mean values) than the secondary schools did. At the other end of the continuum, the least serious barriers to providing mental health services in elementary schools were the language and cultural barriers of students/families, and protecting student confidentiality. Secondary schools reported that lack of coordination/collaboration between school staff and community providers and protecting student confidentiality were among the least daunting barriers to mental health service provision.

TABLE 7 ***Degree of Difficulty Encountered in Providing Mental Health Services***

Services	Elementary *M* (s.d.)	Elementary % expressing Somewhat or Very Difficult	Secondary *M* (s.d.)	Secondary % expressing Somewhat or Very Difficult
Medication for emotional and behavioral problems	2.79 (1.12)	60	2.65 (1.16)	50
Substance abuse counseling	2.70 (1.19)	59	2.11 (1.16)	37
Referral for medication management	2.71 (1.15)	58	2.47 (1.20)	50
Case management (monitoring and coordination of services)	2.44 (1.06)	47	2.18 (1.07)	36
Family support services (child advocacy, counseling)	2.43 (1.11)	47	2.08 (1.05)	31
Referral to specialized programs/services for emotional/behavioral problems/disorders	2.38 (1.11)	46	1.76 (.88)	24
Assessment for emotional or behavioral problems or disorders (including behavior observation, psychosocial assessment, and psychological testing)	2.37 (1.08)	45	1.95 (1.02)	30
Group counseling/therapy	2.34 (1.17)	43	2.18 (1.04)	37
Individual counseling/therapy	2.20 (1.11)	38	1.48 (.74)	10
Behavior management consultation	2.10 (1.06)	36	1.59 (.87)	11
Crisis intervention	2.08 (1.02)	32	1.61 (.75)	11

TABLE 8 Barriers Encountered When Providing Mental Health Services

Services	Elementary M (s.d.)	Elementary % reporting Somewhat or Serious Barrier	Secondary M (s.d.)	Secondary % reporting Somewhat or Serious Barrier
Financial constraints of familes	2.71 (1.05)	57	2.27 (.97)	40
School mental health resources are inadequate to meet student needs	2.59 (1.16)	55	2.15 (1.18)	38
Stigma associated with student receiving mental health services	2.43 (2.43)	48	2.10 (.80)	25
Competing priorities take precedence over mental health services	2.42 (1.14)	49	1.83 (1.08)	27
Community mental health resources inadequate to meet student needs	2.09 (1.05)	33	1.77 (.89)	22
Transportation difficulties for students to travel to service providers	2.06 (1.11)	32	1.56 (.78)	10
Gaining parental cooperation and consent	1.98 (.86)	24	1.64 (.66)	10
Inadequate coordination/collaboration between school staff and community providers	1.98 (1.02)	28	1.48 (.73)	10
Language and cultural barriers of students or families	1.61 (.91)	17	1.52 (.92)	13
Protecting student confidentiality	1.44 (.77)	14	1.25 (.52)	4

Prevention and early intervention

Although the survey focused predominantly on mental health services, personnel and identified needs among students, one item elicited principals' input on prevention and early intervention programming in their schools. ***Table 9***, below, indicates that 85% of elementary and 88% of secondary schools employ school-wide strategies to promote safe, drug-free schools. The next most highly rated category was school-wide programming to prevent alcohol, tobacco or drug use, reported by 66% and 80% of elementary and secondary schools respectively. Only 7% of elementary schools and 12% of secondary schools indicated that they conduct school-wide screening for behavioral and emotional problems. Grade-level contrasts were evident, in that more than twice as many secondary schools (50%) provide outreach to parents regarding student mental health as elementary schools (22%). Similarly, whereas 40% of secondary schools use peer counseling/mediation and support groups, only 2% of elementary schools do.

TABLE 9 Percentage of Catholic Elementary and Secondary Schools Offering Various Prevention and Early Intervention Programs/ Services

	Elementary % (N = 308)	Secondary % (N = 59)
School-wide strategies to promote safe, drug-free schools (for example Safe Schools/Healthy Students Initiative)	85	88
School-wide program to prevent alcohol, tobacco or drug use	66	80
Curriculum-based programs to enhance social and emotional functioning and reduce barriers to learning	54	62
Prevention and pre-referral interventions for mild problems	46	60
Outreach to parents regarding student mental health (for example workshops, support groups, lectures)	22	50
Peer counseling/mediation, support groups	2	40
School-wide screening for behavioral or emotional problems	7	12
Other programs or strategies	6	4

Discussion

These descriptive data represent one of the first attempts to chart Catholic schools' current efforts to meet the psychosocial and mental health needs of students. The following discussion frames these findings by reviewing several germane contextual considerations.

Comparison with public schools

This investigation was not cast as an exercise to compare public and private education. However, using public schools as a reference point for understanding the nature of mental health services in Catholic schools is useful. A few differences and similarities were striking. First, in assessing staff positions that deal with mental health issues in schools, nine positions were listed, and for every staff position a higher proportion of public schools than Catholic schools listed at least one staff member who filled that position. These differences were not slight, public schools reporting the presence

of the staff position at levels ranging from one percentage point to 39 percentage points higher than Catholic schools. For example, across all grade levels there were stark differences between public school and Catholic school staffing rates for school nurses (69% vs. 47%), school counselors (77% vs. 45%), school psychologists (68% vs. 29%) and school social workers (44% vs. 16%) (Foster *et al*, 2005, Appendix C, School Table 9). Similarly, schools were asked to report whether or not they provided a range of mental health services. Eleven services were listed, and in every instance a higher proportion of public schools than of Catholic schools offered the given service. In a similar vein, schools were asked whether or not they provided certain prevention and early intervention programs. Seven programs were listed, as well as a self-reported 'other' category. Of the seven listed programs, a higher proportion of public schools than Catholic schools offered the program in every case.

Second, while Catholic vs. public school staffing patterns were markedly different in some cases, there was great consonance between Catholic schools and public schools in describing the types of student psychosocial/mental health issue that were most common (Foster *et al*, 2005, Exhibit 6.2, p52). Three issues were the most commonly dealt with for male students (social, interpersonal or family problems, aggressive/disruptive behavior, bullying, and behavior problems associated with neurological disorders). Public and Catholic schools also reported the same three issues as among the most commonly dealt with for female students (social, interpersonal or family problems, anxiety, stress, school phobia, and adjustment issues).

Third, an interesting pattern emerged regarding the series of items probing both the degree of difficulty in providing services and the barriers to providing services. When describing the degree of difficulty in providing mental health services, 11 categories were listed, and in 10 of them Catholic schools found providing each service more difficult than public schools (Foster *et al*, 2005, Exhibit 2.7, p22). The one exception was 'referral to specialized programs/services for emotional/behavioral problems/disorders'. Schools were asked to assess the degree to which certain factors were a barrier to providing mental health and wellness services to their students. In this case, ten categories were listed, and nine of them were bigger barriers for public schools than they were for Catholic schools. The one exception was 'stigma associated with student receiving mental health services'.

Funding of mental health services and supports

In the public school sector issues of funding, fiscal capacity and budgetary priorities come to the forefront in any discussion of delivering school-based mental health service for students. The same is true in private schools. Often, amidst competing school improvement priorities, coupled with a funding model in which tuition only partly covers the cost of educating a student, Catholic schools face considerable challenges in financing mental health services and staffing. There appear to be clear capacity differences in mental health service provision between the public and private education sectors.

The relatively diminished focus on mental health staffing and services in Catholic schools relative to public schools is no doubt linked to the funding model of these schools. Drawing on National Catholic Educational Association statistics (McDonald & Schultz, 2010), scholars have noted the growing gap between the funds that private school tuition generates and the actual costs to operate the school. For example:

> *In 2000, the average tuition charge at a Catholic elementary school was $1,787 while the national average cost to educate a child was $2,823, meaning that tuition covered 63% of the total cost to educate. In 2009, the average tuition charged at a Catholic elementary school had increased to $3,159, but the average cost to educate a child had more than doubled to reach $5,870, meaning that current tuition covered only 54% of the total cost to educate* (Nuzzi *et al*, in press).

So in private schools, where administrators and other interested stakeholders must turn to development, institutional advancement, fundraising and benefaction, student support needs may be treated as marginal – as a useful but ultimately non-essential add-on. Faced with the demands of meeting a constrained school budget, one apparent observation is that Catholic schools meet instructional needs first (teachers, educational aides and other faculty) and are less likely to have dedicated funding for student support services. Given the harsh reality of limited school finances, Catholic school administrators' budgetary triage often treats student support and mental health services as a less critical component of school vitality. Drawing on the framework of Adelman and Taylor (2006, 2010), in many cases Catholic schools attend primarily to their instructional and managerial needs, and provide a secondary/marginalized focus on addressing barriers

to learning and teaching (a learning supports component).

One domain of financing student mental health and wellness efforts in schools that holds promise for Catholic schools is accessing federal funding to support such efforts. Recent scholarship (Perla *et al*, 2009) has shed light on this issue, noting that among Catholic schools:

> *more than 51 percent of schools serve children who qualify for services under ESEA's Title I program* (p7).

Moreover:

> *[t]he current authorization of ESEA, known as the No Child Left Behind Act, maintains the long-standing policy that children and teachers in private schools must be provided with equitable participation in most programs authorized under* ESEA (p7).

> *Focus groups with Catholic school superintendents around the country, however, portrayed the challenges and elusive equity that Catholic schools face in tapping their share of federal funds, which must be accessed via the local public education agency. In fact, the findings indicated that, despite the clear intent of Congress that private school students and teachers should participate equitably in many ESEA programs, equitable participation has not been experienced by most Catholic schools* […] *Despite the law's intent for these programs to be student-centered, collaborative, and transparent, nearly every Catholic school superintendent who participated in the listening sessions reported that this is not the case in practice* (Perla *et al*, 2009 p6).

Thus, one critical avenue through which Catholic education can serve students' educational needs and mental health better is by sustained and systematic determination to identify and access their equitable share of federal services.

Strategic assessment and action planning

Diocesan- and/or school-level strategic assessment and action planning – expressly focused on student behavioral health as part of overall school improvement – is sorely needed in the Catholic education sector. Given the constraining financial climate in which many Catholic schools operate, administrators and school leaders have to be selective, targeted and supremely strategic in discerning how best to meet the needs of the children and families they serve. It is a fiscal reality that Catholic schools, on the whole, may never be able to offer staffing and mental health services to the breadth and depth of the public sector. For that very reason, schools must examine student needs carefully and devise staffing patterns that can meet those identified needs most efficaciously.

Catholic institutions of higher education have an especially important role to play in any revitalization efforts in Catholic schools, and certainly those that address strategic planning and action to support student mental health and wellness. For example, the Center for Catholic School Effectiveness at Loyola University Chicago already partners with the Archdiocese of Chicago to implement Response to Intervention (RtI) strategies and Positive Behavior Interventions and Supports (PBIS) at several schools. The University of Notre Dame has assisted in training and consultation for Catholic schools seeking to establish Strategic Intervention Teams, small groups of faculty and staff collaborating to address student learning and socio-emotional needs holistically. They are but a few examples; more higher education outreach and engagement with Catholic schools indeed exist but, as the survey data has shown, there is great need. Catholic institutions of higher education may be poised to provide not only even more strategic assistance to increase the effectiveness schools' efforts to support mental health and wellness, but also concomitant willingness to 'meet them where they are' in doing so.

Limitations and future directions

A few study limitations – and their direct implications for future research directions – are noted here. First, much like the original survey of public schools, this baseline survey of private schools was not intended:

> *to assess unmet need for services, nor was it intended to address the quality, adequacy, or appropriateness of services, or to capture the number and intensity of services delivered* (Teich *et al*, 2007 p15).

Thus, while this investigation provided a descriptive overview of mental health services offered in Catholic schools and the various staff who provide mental health services, further research should tease apart which specific services are provided by which staff members – and with what intensity, duration and quality. Second, while the convenience sample used in this study tracked closely the national demographic portrait of Catholic schools (McDonald & Schultz, 2010), future investigations might either draw on a purely random national sample

or examine variation within a single diocese in more depth. Third, the current study is descriptively oriented, providing a necessary first step in articulating the state of play regarding mental health services and supports in Catholic schools. Future research should employ inferential analyses to examine variation in services, staffing, barriers and needs, based on various school and student demographic categories (such as enrollment of students eligible for free and reduced-price lunch, enrollment of minority students or urbanicity of the school). Fourth, only one survey item in this study quantitatively assessed Catholic schools' efforts to provide preventative approaches for supporting children's mental health and wellness. Discerning whether and to what extent Catholic schools employ whole-school discipline programs, safe and drug-free school strategies, parent outreach, faculty professional development regarding student mental health, social and emotional learning curricula, and the like is a fertile area for additional research.

Conclusion

Catholic schools have a long and storied history of providing a sound private educational option in the United States. These schools strive to provide an integrative, faith-based approach to education that is steadfastly committed to education of the whole child. Without question, a commitment to holistic education requires acknowledgment that students cannot reach their full academic potential when their social, emotional and psychological needs remain unmet. This study provided deeper insight into who is dedicated to providing mental health services in Catholic schools and what services they provide. In addition, the study gauged the barriers and challenges inherent in the delivery of such services. However, as this investigation has demonstrated, there is great variability in the scope and degree to which Catholic schools are explicitly meeting the mental health and wellness needs of students. Continued focus on the necessity of providing these services, strategically planning for and implementing them, and a dogged effort to surmount the barriers – financial and otherwise – that impede them is necessary.

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