Original Article

HEJ

Health Education Journal
2022, Vol. 81(3) 280–292

DOI: 10.1177/00178969211073681
journals.sagepub.com/home/hej
SAGE

Supporting vulnerable students: Staff and parents speak

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Abstract

Background: Schools are at the forefront of promoting positive mental health and wellbeing through the implementation of evidence-based actions. Few Australian studies however have explored the views and experiences of school staff and parents as to what best supports secondary school students who struggle with positive mental health.

Aims: This article describes findings from an exploratory study looking at the views and experiences of 74 staff and parents at four Melbourne Catholic Secondary schools. The study sought to understand how staff and parents experienced, offered and understood support to vulnerable secondary school students.

Methods: The review and analysis drew on data collected from four staff groups and four parent focus groups. Participants in each group shared their views as to what they considered effective support to vulnerable secondary school students.

Results: Findings indicated that the destigmatisation of mental ill-health conditions, greater attention to the transition between primary and secondary school, and the display of unconditional positive regard are critical to supporting vulnerable young students.

Conclusion: Strengthening support to vulnerable young students requires school structures that (a) mitigate against stigmatisation, (b) recognise the period between childhood and adulthood as a time of heightened risk and (c) include staff whose posture towards vulnerable young students is one of unconditional positive regard.

Keywords

Communication, COVID-19, mental health, referrals, student wellbeing

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Introduction

Research indicates that one in seven Australian adolescents will experience a diagnosed mental disorder (O'Reilly et al., 2018), and less than half of these will access mental health services (Baruch, 2001; Gulliver et al., 2010). This positions schools at the forefront of support to vulnerable youth through the implementation of evidence-based health promoting interventions (O'Reilly et al., 2018). Within this context, it is important to understand what staff and parents see as the key issues and would like young people to have by way of support.

This article reports findings from a larger study of what wellbeing leaders and parents and carers ('parents') at four Melbourne secondary schools understand as supportive for vulnerable young students ('students'). The aim of the article is to contribute to national and local perspectives on how school communities support students. These perspectives have relevance beyond the school boundaries of the four secondary schools and the potential to inform school-based student wellbeing programmes and processes.

Literature review

Adolescents and young people are exposed to a range of individual, familial and systemic factors that inform and shape their life trajectory (Magson et al., 2021; Racine et al., 2020). Promoting adolescent health and wellbeing is highlighted as a policy priority in the United Nations 2030 Sustainable Development Goals (SDGs), the World Health Organisation's guidance outlined in Global Accelerated Action for the Health of Adolescents (World Health Organization, 2017), and the recommendations of Lancet Commission on Adolescent Health and Well-Being (O'Reilly et al., 2018).

While some scholars have cautioned against the use of the term 'vulnerability' in relation to young people, arguing its use can lead to stigmatisation, social control and the disempowerment of the individual, others argue that the term can be used to draw attention to the systemic issues and external factors that create problems for the individual. Identifying the systemic and external causes of vulnerability creates opportunities to develop strategies to mitigate the effects of root causes of health inequities and social exclusion (Ashencaen Crabtree, 2017; Clark and Preto, 2018).

Throughout this article, I use the term 'vulnerable' to refer to secondary school students who have a medically diagnosed mental health issue, not to direct attention towards the student, but rather to focus on the school-based policies, procedures and practices that may hinder student wellbeing. Moreover, concern for students' lived experience highlights the school's obligation to work towards and support wellbeing by improving the school-based responses and support offered to students and their families.

Positively, when supported and validated by family, peers and school contexts, students show and develop resilience. Resilience, defined here as 'a student's capacity and ability to effectively cope with significant stressors or adverse and threatening situations' (Khawaja et al., 2017: 285), offers young people a means to combat internalised stigma (Adams et al., 2014; O'Reilly et al., 2018). Resilience is characterised by feelings of physical and emotional safety and confidence to trust school staff. It provides a context within which to develop strategies to manage and improve mental health and wellbeing (Lawrence et al., 2019) and to seek support from peers (Kataoka et al., 2018).

Prior to COVID-19, the United Nations (2015) estimated that some 10%–20% of children and young people, who collectively represent 16% of the world's population, will experience a mental health disorder (O'Reilly et al., 2018). In Australia, one in seven school students (aged 5–18 years)

is currently living with a mental health problem (O'Reilly et al., 2018). International research has identified factors within the family, peer and school contexts that impede the attainment of adolescent health and wellbeing. Among the key issues in this respect is lack of social support resulting in a higher incidence of more serious mental health problems, especially among school drop-outs (Ramsdal et al., 2018).

These problems link closely to social inequalities in education, family and among peers (Michelson et al., 2020). Some students experience higher levels of stigmatisation, bullying, isolation, emotional distress, cultural dislocation, discrimination and racism than their peers (Aldridge and McChesney, 2018; Bennouna et al., 2019; Huggett et al., 2018). While these may be risk factors for all adolescents, students of diverse backgrounds, students with disabilities, LGBTQI+ students and students of refugee and asylum seeker backgrounds have a heightened risk of developing mental ill health (Adams et al., 2014; Australian Institute of Health and Welfare [AIHW], 2011; Rose and Gage, 2017; Rousseau and Frounfelker, 2019).

The onset of COVID-19 and the subsequent and the unprecedented interruptions to daily life have made young people more vulnerable to mental ill health and more in need of social and emotional support. Although there is an absence of longitudinal studies, scholars anticipate that the COVID-19-related disruptions to adolescent life may be precipitators of mental health problems, including anxiety, depression and/or stress-related symptoms (Bhatia, 2020; Magson et al., 2021; Racine et al., 2020). A recent national survey of 4,065 Australian youth aged 12–25 years showed that one-third of Australian young people in 2020 reported high or very high levels of psychological distress. The same study showed that 51% of those surveyed had been unable to carry out their daily activities on at least 1 day in the previous 2 weeks, an increase from one in five when surveyed in 2018 (*headspace*: National Youth Mental Health Foundation, 2020). Recognising the negative impact of COVID-19 on young people's mental health, both Federal and State Governments in Australia have substantially increased funding to key mental providers to young people such as *headspace*, *Beyond Blue, Lifeline* and *Kids Help* (Minister for Health and Aged Care, 2021). These changes build on Federal and State governments' push, since 2014, for schools to provide more supportive, accepting and more health promoting environments for student learning.

The State of Victoria has seen an expansion of support offered to government schools through state-funded student support services. This allows schools access to area-based multi-disciplinary teams of nurses, psychologists, social workers and speech pathologists (Victorian State Government, 2018). In contrast to Government Schools, Victorian Catholic primary and secondary schools, which have no access to state government support services, allocate funds to student wellbeing positions through their own budgets and through National Consistent Collection of Data (NCCD) grants providing school support for transition to students with disability (Melbourne Archdiocese Catholic Schools [MACS], 2021) and have access to regionally based allied health workers.

The study

Against this background, three deputy principals and one student wellbeing school leader from four Victorian Catholic secondary schools came together in February 2020, to create the Western Mental Health Youth Collective (WMHYC). Three of the four schools were situated in socio-economically disadvantaged suburbs in West Melbourne and one was located in a socio-economically disadvantaged suburb in regional Victoria. The WMHYC set itself the goal of better understanding how its members' respective school-based student wellbeing policies and practices supported, or could more effectively support, young people. Members determined that they would seek the views of school staff and parents of students with a medically diagnosed mental health problem.

In March 2020, the author of this article was commissioned to develop this work on behalf of the four schools. The task was to conduct a qualitative exploratory study into how the four schools could promote positive mental health and wellbeing. This involved the author reviewing school-based policies and practices; conducting one parent and one staff focus group, in each of the four schools; analysing the collected data; and making recommendations on how to improve support to vulnerable students. The WMHYC and an employed project worker met monthly with the author to review the ongoing research and discuss, review and refine the themes emerging from the analysis. These regular meetings helped contribute to the reliability and trustworthiness of the research.

Ethical issues

The study was approved by Victoria University's Ethics Committee (HRE20-221). Participants provided informed consent and were assured of confidentiality. Acknowledging that some of the questions asked might cause distress, each school provided access to an onsite psychologist or counsellor during and following data collection sessions. A participant information form also included the telephone number of a school-nominated health care professional should participants wish to seek support afterwards.

Methods

A social-constructivist paradigm recognises that the creation of knowledge cannot be separated from the social environment in which it is formed (Kiger and Varpio, 2020). This research was conducted using a social-constructivist paradigm since this paradigm allowed the Chief Investigator (CI) to first, privilege the participants' social contexts of school and home as well as the wider education and health policy contexts. Second, exploration of views and experiences 'sent' and 'received' between participants and the school system had the potential to inform current and emerging student wellbeing policies, practices and procedures.

To ensure trustworthiness of the data, an assistant was employed to take notes during the focus groups. These notes were added to the audio recording taken during the focus group sessions and cross-checked during data analysis. The data produced by each focus group were analysed as a unit of analysis, that is, each group's data were not delineated by individual contributions (Ritchie et al., 2014).

Recruitment

Participants were purposefully chosen from staff and parents who could speak about student wellbeing and mental health from the perspective of their own position within the school or their parent/carer ('parent') role.

In March 2021, through scheduled weekly meetings, WMHYC members in each school informed their Wellbeing, Level Coordinator and Leadership Teams of the study, the purpose of the study and the processes being used to gather data. All attendees at the meetings received a personal invitation through the school email the week following the information session. This email included Information for Participants, a Consent Form and the details of the focus group sessions. To ensure potential participants felt no coercion to participate in the project, the Consent Form was returned directly to the CI, not the WMHYC members. In addition, it was made clear during the staff briefings that WMHYC members would not be participating in the focus group sessions.

A similar process was used to recruit parents. Information and details about the study were communicated through already timetabled general Parent Information sessions. Information for

Table 1. Focus group participants.

		School A Staff ($n = 10$), students ($n = 984$)	School B Staff ($n = 11$), students ($n = 1,438$)	School C Staff ($n = 11$), students ($n = 1,665$)	School D Staff ($n = 10$), students ($n = 920$)
School staff	Campus directors/director wellbeing/ director student diversity	1	2	3	2
	Level/house coordinators/staff mentors	5	7	4	5
	Counselling/diversity staff	2	2	4	
	Learning support staff				1
	Teaching staff/librarians	2			2
Total		10	11	11	10
Parents/carers		7	11	5	9
Total staff and parents/carers		17	22	16	19
Total participants		74			

Participants and a Consent Form were emailed to parents following the sessions and intending participants returned the Consent Form to the CI. Thirty-two parents from four schools responded to the invitation and participated in the focus group sessions held at their respective schools. Overall, recruitment yielded 74 participants (Table 1).

Focus groups

In May and June 2021, data were collected from four staff focus groups and four parent focus groups. The WMHYC requested that focus groups be held at their school site and that staff and parents had different sessions. The reasoning for this separation and location was the view that the presence of staff in the parent focus groups might influence the power dynamics and negatively impact on parents' contribution to the sessions. Each focus group was 45 minutes in length.

As with any commissioned study (Ritchie et al., 2014), the specifications of the research and the research questions were based on the sponsor's needs. The questions asked in this study were formulated over three meetings in September 2020 and were informed by WMHYC's wish to understand how their current school policies, procedures and programmes reflected (or not) student wellbeing evidence-based practice and how they could strengthen support to their students. Three steps were used to develop the focus group questions: (1) an initial brainstorming session with members of the Reference Group, (2) the subsequent development of a draft schedule of questions and (3) the sharing of these questions with the WMHYC for feedback for final approval and comment. Four open-ended questions asked participants to describe their experiences and concerns, particularly those related to student wellbeing and support to vulnerable young students (Table 2).

Analysis

QSR NVivo 10 software was used to manage the qualitative data and conduct a thematic analysis (Braun and Clarke, 2006). On becoming familiar with the data, the CI generated initial codes, searched for themes, reviewed themes and defined and renamed themes. Reliability of the coding was achieved by presenting examples of narratives to the Reference Group, inviting the members to code and then comparing the code assignments with the CI's coding. This cross coding was carried out during two WMHYC meetings (June and September 2021).

Table 2. Focus group questions.

1. What do you see as the strengths of the teacher's, schools' or parents/carers' ability to respond to student social, emotional, psychological concerns and their impacts on teaching and learning?
2. What do you see as hindering the teacher's, schools' or parents/carers ability to respond to student social, emotional, psychological concerns and their impacts on teaching and learning?
3. Would you change the way the school responds to students who are managing social, emotional, psychological concerns in any way? How? When thinking about families supporting children and the contact with the school, have you any ideas about how they can work together to support a student social, emotional, psychological concern and their impacts on teaching and learning?
4. Are there other comments you would like to add?

Findings

Staff and parents offered insights which were organised under the following themes: school strengths and struggles; student strengths and struggles; stigma; transition – a time of risk; and unconditional positive regard. The three most discussed themes by focus group participants were stigma; transition – a time of risk; and unconditional positive regard, which are discussed here.

Stigma

Parents and staff in all eight focus groups talked of the stigma students had to navigate and saw the knowledge and skill gap of staff in schools reinforcing the stigmatisation of mental ill health. Parent focus groups referred to the stigma that resulted from lack of knowledge of the illness: 'People Googling what her condition was' (C, parent, School A) and lack of knowledge of how to respond to symptoms: 'people don't know how to handle [the behaviour] (Sn, School D). However, parent focus groups also reflected on how things had been in the past and welcomed the role that education and awareness raising had played in destigmatisation. V's (parent, School A) reflections reference this shift over time:

> I think it's maybe the older generation that don't understand because they were just taught to crack hearty and get on with it. Even though we all look the same, and that's where from a perspective of you know, different types of mental health you know, it's not, it is this big umbrella, and that's a reason that education of children, that it's, you know it's a whole, it's this massive thing.

Staff and parent groups also observed that the stigmatisation of mental ill health often has its origins in family values and culture, causing some students to ask for privacy when seeking support.

> Like, I've had students request that our sessions happen after school, or during a time when no one will know that they're accessing the space. (J, staff member, School A)

Parents noted the secondary consequences of stigma on help seeking at school.

> I think [School D] is a very warm school. From my two years' experience. But I don't know why my daughter doesn't go to the teachers about some of these issues. And she can go for weeks into semi-depression then it'll finally come out that something's bothering her. I still can't convince her to approach

> the teachers. Is there stigma though, with students going to teachers. And then other students seeing? (Sh, parent, School D)

Parents were also aware that stigma could be reinforced by school culture. One parent noted how 'stigma and culture piece go hand in hand' (V, parent, School A). There was agreement among the parents that stigma diminishes the young person's identity and has the potential to reduce them to 'a label'.

> (The diagnosis) doesn't actually have to identify them, that actually there is ways of dealing with it, and everyone has to deal with it to some degree or other because I feel like with my daughter it's become almost her identity, 'I have mental health issues, I have autism'. (J, parent, School A)

This concern was situated in their hope that their children would appreciate that the diagnosis need not define them. Parents wanted their children to come to a place where they would 'be proud of [the diagnosis because], it's part of me but not all of me' (J, parent, School A)

Cautionary comments were expressed in two parent focus groups who highlighted the damaging effects of negative and disrespectful language used by inexperienced or insensitive teachers. These parents attributed the use of this kind of language to wrongly held assumptions that mental ill health must be visible to be real:

> I think teachers need to get a better understanding. Because just because you can't see mental health doesn't mean it's . . . you know, it can be so damaging, their language. (K, parent, School C)

Parents welcomed efforts to challenge stigmatisation through education and actions to normalise students' experiences and diagnosis. For example, several parent focus groups spoke about 'normal conversations' held between staff and students and between staff and parents and the importance of these conversations occurring within a culture of safety. Parents explained that when such discussions take place, they both challenged stigma and also provided a context for students to reclaim an identity beyond diagnosis:

> I absolutely agree that people should be aware, but also that there's strategies through it, that it doesn't identify you and it doesn't keep you down. (J, parent, School A)

> So even if you're having a bad day, it's all right to talk to your friends about having a bad day today, and this is why. You know, it's not saying 'I might have mental health issues', it's that understanding, and that stigma starts to go away with them, and within that group kind of balances, balances out. And it's what's been encouraged here, and it's been helpful as well. (V, parent, School B)

Notwithstanding recognition in parent focus groups that there was an ethic of care in all four schools, one parent recalled how personnel within MACS, the governing authority for Melbourne Catholic Schools, trivialised and misrepresented her child's condition by asking the school to refrain from using the correct medical diagnosis, preferring another 'non-descript' word:

> There's a lot of stigma with her diagnosis and in fact so much so that the school, when they wanted to communicate to the staff they didn't want to let . . . I think they were told by the Education Office, that it's preferred not to use that particular diagnosis, and they had another sort of 'fluffy' diagnosis, which it probably is the same thing but it's not what (my child has). (C, parent, School A)

Transition – a time of risk

School transitions are of major significance to vulnerable children. Parents reflected that effort needed to find a school with a positive culture and teachers with the skills and knowledge to respond to their child's needs at this time. For one parent, COVID-19 had posed a particular challenge for her child's transition between primary and secondary school. Lack of clarity and the disconnect between what was being communicated by the school's director of learning and the 'known' supports within the school had proved troubling:

> If I'm really honest I had a worrying Parent Support Group [meeting] last year and it was COVID, and there was a no transition, and it was really awful. I had a meeting through Zoom and I walked away thinking I need to find another school. I was really worried because I had been online to three programme directors about supporting transition with kids with anxiety or ADHD or autism into secondary schools and all the things I asked for, I was basically told no. We will see how we go when [the child gets here] and we don't offer something like that. (C, parent, School A)

> And you know the lack of understanding about medication, in that meeting I was saying, [M] has, I think there's 13 types of medications we've trialed for him throughout the years so we're off everything now, because his mental health got so bad, so now he's on nothing. But I asked to comment for example on who do I inform because I'm new to the secondary school setting. I said, for example, who do I contact if he's starting a new medication and the response was why do we need to know that? And I thought, well he's a welfare coordinator and you know, don't know that Ritalin can cause suicidal tendencies, which is where we got to so that really worried me. (J, parent, School B)

For this latter parent, it was the intervention of another parent and the parent network that eventually persuaded her to pursue the enrolment:

> [R] said wait until you meet your learning mentor. So, to be honest I was really nervous [about my son going) going from primary to high school. (J, parent, School B)

COVID-19 also disrupted information flows between school and parent during the transition between primary and secondary school. In some schools, planned awareness raising and information sessions focusing on wellbeing and mental health topics were cancelled: 'The school had planned some PDs, information sessions for parents and carers, and then Covid came' (Tn, staff member, School D).

Parents in Focus Group B were keenly aware of the need for advocacy during their children's transition. Identifying supportive key staff, working around less-understanding key staff and using past experience to leverage the necessary support were instrumental in securing (or not) a positive transition.

> . . . the transition from primary school, when we had the learning support officer, learning mentor and everything and I did raise the fact he had been seeing a counsellor in primary [school], so that was all on the table and so yep, it will happen. And the learning mentor while he was receptive, he didn't really push anything but because my older one had already been in the system and knew the social workers and everything, I knew what to do because of having been there before. (C, parent, School B)

> learning mentors are the backbone here and really, they, your child's learning mentor bats for your child. (L, parent, School D)

Recognition of a positive school culture and the student's own resilience was viewed as mitigating the risk factors during transition times:

> It's [a] really tricky one when they go from year 7 when they just kind of want to fit in and, you know, to see her much stronger now. A lot [of it is] due to the school. More open to you know, be[ing] proud of it now, it's part of me but not all of me, you know. And she's made some great friends . . ., and learned from their experience. (K, parent, School A)

A non-judgemental attitude towards the young person was also seen as important. Staff in the four schools were insistent that their adoption of such an attitude was key to mitigating stigma following transition from primary to secondary school:

> . . . as teachers we're very good at not being judgemental and not blaming the parents for their child's mental health concerns. (P, parent, School B)

However, in the four parent focus groups, there was recognition that the young person's need for personal expression and self-agency could compromise connection to their peer group. For example, one parent described her child's therapeutic need to publicly describe her personal experiences through the use of social media conflicted with the peer group's sense of personal safety:

> My daughter's an oversharer, so she actually finds it helpful to overshare, she finds it healing. So, to begin with I was very negative about it but I had to listen to her and take the stand of 'Well, if the other students are getting upset by it, well I suggest they don't read it'. This is a healing thing and an education tool my daughter believes. (C, parent, School A)

Here, parent, child and school were challenged to find a way through the school's need to follow governing body mandates, the child's need to express her views, and the parent's need to support both child and school.

Peer groups were seen as key in hindering or supporting wellbeing. In Focus Group C, too much visibility was seen as a contributing factor to vulnerability:

> I'm thinking of [daughter] right now . . . of being uncomfortable, of not wanting to be seen. There's a difference between wanting to be heard and not wanting to be seen, I think. I know for [daughter], when she's in that space, the idea of everyone staring at her, you know sitting around others, she's assuming everyone's staring at her. (Anh, Parent, School C)

Parents stressed that peer-to-peer connection required a level of reciprocity:

> And I wonder whether she often feels not heard, or the [peer] group is just not listening. (T, parent, School D)

An antidote to students' feelings of visibility was team sport. Parents were of the view that team sports could build peer-to-peer connections without the young person feeling conspicuous:

> . . . my daughter is quite active and physical . . . and they started a rugby thing at lunchtime, that the kids started. And she just loved it. It gave her a focus at lunchtime. And she was physical, so you know, using all those hormones and burning the energy. And I think a couple of the teachers, she really connected with and has a strong relationship with where they're supervising, and that was brilliant. (Anb, parent, School D)

Unconditional positive regard

All the focus groups highlighted the importance of positive relationships in promoting and sustaining wellbeing and fostering resilience among students. Describing what these relationships 'looked like in action' enabled the identification of the theme unconditional positive regard and its link to school ethos and culture.

Responding to the question 'What is the skill you are most proud of when you're interacting with vulnerable students?', staff in the four schools were clear about the importance of 'perseverance', 'care', 'patience', 'being forgiving', 'being hopeful', 'having empathy', 'building rapport and having patience', 'recognising of their individuality' and 'calmness'. Together, these factors contributed to the unconditional positive regard that characterised their relationship skills. Staff emphasised genuineness, non-judgemental care and empathy as central to their relationships and interactions. Furthermore, staff acknowledged that relationship building with students took time.

> But also remembering that they need time and space to process what they're hearing and what they're thinking, what they're feeling. So, giving them that time and space is important. (J, staff member, School B)

Similarly, parents in the four focus groups highlighted the importance of quality of interaction between themselves and the school, with staff members influencing and strengthening the young person and the family's engagement with school staff. Across all eight focus groups, parents and staff agreed that students would seek out the staff member they felt most 'connected to' with this connection-enabled constructive and timely support. Connection was often a consequence of history:

> I think that the older students already have existing relationships with past teachers, and they often go to a past teacher or they will go to their coordinator rather than go to their nominated class coordinator. (L, staff member, School D)

Sh, a parent at School B, is also related to readiness:

> . . . [pupils have] certain teachers who their 'go-to's' are. And that comes with maturity and learning who the people are. And I don't think . . . So, my year 9 at the moment, she's struggling . . . and there's a couple of people who she's okay with, and she'll go to them. (Sh, parent, School B)

Regardless of how the relationship was built, all focus group participants stressed the importance of connectedness to at least one staff member as a factor protecting against isolation and providing support to the vulnerable young person.

Discussion

Findings from this study align with those from other research (Blignault et al., 2010; Bryan et al., 2020; Ford et al., 2011; Sawrikar and Katz, 2014) highlighting the link between limited staff skills and knowledge, low levels of health literacy, cultural and family beliefs, and positive and supportive interventions. Data indicated that where there was (1) limited understanding of mental ill health and (2) negative cultural beliefs, norms and values towards mental ill health, there was a greater likelihood of stigmatisation and alienation from mental health services and support. This could expose the young person to the 'secondary impacts of mental ill health' (Huggett et al., 2018: 381). Mitigating this negative stigmatisation were staff–student relationships. Consistent with other research (Aldridge and McChesney, 2018), schools and teachers who worked proactively and intentionally to understand mental health strengthened and contributed to a consistent ethos of care. Similarly, data confirmed the link between staff skills and knowledge and a decrease in stigmatising views towards students.

Similar to other research, findings corroborated that staff who adopted a posture of unconditional positive regard towards the vulnerable young person were key to mitigating the young person's stigmatising experiences and were considered partners to parents in the management of the young

vulnerable student (Aldridge and McChesney, 2018; Lawrence et al., 2019). Unconditional positive regard allowed the young person (and their parents) the opportunity to identify and question any internalised stigma, to 'normalise' the diagnosis, to build trust in staff and to feel safe within the school space. It could be argued that these staff–student relationships went some way to deconstructing the perception of the young person as being 'vulnerable' and reconstructed them as resilient and 'whole'. In addition, they enabled wellbeing staff to educate the whole school community, including staff, governing bodies and parents on the impact of stigmatisation and conversely, on how to develop positive, non-judgemental relationships with young vulnerable students.

Findings also supported evidence (Brown et al., 2016; Morton and Berardi, 2018; O'Reilly et al., 2018) showing that students expect their schools to allow flexibility in how and when vulnerable students engage in their studies. In particular, schools need to pay attention to the student's (and family's) vulnerability during times of transition from primary to secondary school, and from secondary to tertiary studies and beyond. This has been particularly important during the COVID-19 epidemic when students have had the stress of adapting to rapidly changing circumstances (Magson et al., 2021) and when the mental health of some students has been reported to deteriorate compared to pre-pandemic levels.

Limitations

One key limitation of this study was that the fact that the young person's voice was not present within the data. Including young people's own views and experiences would have enabled a more in-depth understanding of how school-based policies and programmes impact young people and provide them with agency, and how Catholic secondary schools can improve and implement school-based student wellbeing policies and programmes.

A second limitation regards the generalisation (transferability) of the findings to other Catholic secondary schools. This must remain limited both because of sample choice (which was determined purposively, not with a view to generalising) and also because of variations in how schools, parents and others involved in the study understood concepts such as 'support', 'vulnerability', 'stigma' and 'transition' and 'unconditional positive regard'. The relevance of these findings to other secondary schools needs testing if the propositions and findings from this study are to have a wider application.

Finally, it is important to recognise that the WMHYC commissioned the study because they wanted knowledge to address a specific concern: namely, how could *their* schools improve support to vulnerable young people? In this sense, the author and the WMHYC needed to be aware of competing interests. The four schools wanted feedback on current processes as well as outcomes. The author wanted to frame the commissioned work as qualitative research that would have external validity. Addressing this limitation required a commitment from both the researcher and the WMHYC reference group to ongoing conversation about the credibility and generalisability of the findings.

Conclusion

In this study, data from eight focus groups explored staff and parents' views on how best to support vulnerable young students in school. Results indicate that support for students was strengthened by three factors: destigmatising mental ill health, careful attention to the student's (and the family's) heightened vulnerability during times of transition, and the display of unconditional positive regard towards the student. Results from the study have important implications for educators, welfare workers and policymakers working to support students.

Participants in the study recognised that all students possess skills of resilience that drive their engagement with, and connection to, school, staff and peers. However, mental health problems can place the young person at risk of disengaging and disconnecting with schooling, staff and peers. School practices can affect this process. Schools that act to prevent the stigmatisation of students, which help students navigate the transition from primary to secondary school, which strengthen teacher understanding and skills regarding mental health issues, and which promote unconditional positive regard are best placed to support vulnerable students.

Beyond this, schools can act to strengthen culturally sensitive health literacy among parents to provide support and address issues of stigma. They can also promote better understanding of ways in which parents can become 'companions' to other parents in a similar situation. Together these actions lay the foundation for the better support of vulnerable students – in COVID-19 times and beyond.

Acknowledgements

The author thanks the staff and parents of the four schools that participated in the research.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship and/or publication of this article. Funding from the Western Health Youth Alliance Group in Melbourne supported the research.

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