

“It’s all about relationships”: The place of boarding schools in promoting and managing health and wellbeing of Aboriginal and Torres Strait Islander secondary school students

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ABSTRACT

Introduction: In recent years, Australian government policies have promoted access to secondary education through boarding schools for Aboriginal and Torres Strait Islander (hereafter respectfully termed Indigenous) students from remote communities. These students experience the poorest health of any Australian adolescent group. This exploratory study examines how boarding schools across Queensland promote and manage healthcare and wellbeing support for Indigenous students.

Methods: Qualitative grounded theory methods were used to sample and collect data from the healthcare and wellbeing support staff of eight Queensland boarding schools using semi-structured interviews. Data were coded using NVIVO software and compared to identify the context, conditions, core process, strategies and outcomes of boarding schools’ healthcare and wellbeing support. Preliminary findings were fed back to school staff and students’ family members for discussion and response at an annual Schools and Communities meeting.

Results: Boarding school health staff support Indigenous student-centred healthcare and wellbeing by *weaving a relational network* with students, families, school staff and external healthcare providers. Either through on-site or school-linked centres, they provide students with access to healthcare services, support wellbeing, and offer health education. Through these strategies, they enable students’ participation in education and learning, receive quality healthcare improvement, “move to a better head space”, and become responsible for their own healthcare. Enabling conditions are the professional and cultural capabilities of school staff, school leadership and commitment, compatibility of intersectoral systems and resourcing of healthcare and wellbeing support.

Conclusions: Boarding schools are doing considerable work to improve the promotion and management of healthcare and wellbeing support for Indigenous students, but there is considerable variation across schools, impacts are not formally monitored or reported, and there are many opportunities for improvement. Working towards a best practice framework, school staff identified a need for a multi-levelled relational model of healthcare and wellbeing support to be iteratively embedded at each stage of the school cycle: at intake; enrolment; term one; and throughout the school year (including in emergencies/crises).

1. Introduction

The responsibility for both teaching about health, and managing the health and wellbeing of students, is increasingly required of schools. Consequently, Australian state and territory education departments have developed various policies, procedures and resources regarding mental health support, general first aid and other healthcare procedures during school. These recognise that health underpins students’ ability to

engage in learning and absorb the full benefits of education (Albright & Bundy, 2018), and in corollary, schools contribute to students’ lifestyle and health behaviours that are likely to persist through adulthood and even inter-generationally (Shankar et al., 2013). However, there are currently no standard practices nor clear best practice guide/s for providing health care and wellbeing support to the approximately 21,000 students in Australia who access their secondary schooling away from home, living in boarding schools or residential accommodation

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during the 40 weeks of the school year. [Table 1](#).

In the physical absence of family members, boarding school and residential staff have a duty of care and responsibility to manage the health and wellbeing of students not only for the 7 h that students spend in the classroom, but also the other 17 h of boarding care. Aiming to advance best practice among government funded, religious or independent boarding schools, the peak Australian Boarding Schools Association promotes enhancement of the well-being of boarders and facilitates the professional development of staff ([Australian Boarding Schools Association, 2019](#); [Osborne, Rigney, Benveniste, Guenther, & Disbray, 2018](#)). Furthermore, a national boarding standard has been developed and provides a section on child protection, safety, health and wellbeing, holistic development, care and supervision, and providing for boarders with specific needs ([Standards Australia, 2015](#)). However, until this is mandated or residences are audited by external review, it is largely up to each individual institution to ensure the standards are followed. Despite the imperative, very little is documented about boarding school healthcare and wellbeing models nor the availability of support provided in Australian boarding and residential facilities.

Australian funding and resources have been increasingly directed to the implementation of programs to increase Aboriginal and Torres Strait Islander (hereafter respectfully termed Indigenous¹) students' access to secondary education through boarding schools. These arose from the disappointing progress since 2008 of Australia's *Closing the Gap* targets that aimed to achieve reductions in disparities between Indigenous and other Australians' life expectancy, health, education, training and employment through a series of funding agreements and action plans ([Department of the Prime Minister and Cabinet, \(2019\), 2019](#)). Remote-dwelling Indigenous students have lowest (but increasing) Australian rates of education attainment ([Department of the Prime Minister and Cabinet, \(2019\), 2019](#)). Educational attainment is related to access to secondary schooling options; almost half of the 5700 students accessing ABSTUDY (government funds for Indigenous students) studied away from home because they did not have secondary schools within 100 km from their home communities or chose to bypass their local school due to limited programs. For a further 20% of students, their home conditions impeded, prevented or disrupted their educational progress ([Australian Government, 2017](#)). Remote dwelling Indigenous adolescents also simultaneously experience the poorest health outcomes of any Australian adolescent group, including high levels of chronic disease and health issues ([Azzopardi et al., 2018](#); [Department of the Prime Minister and Cabinet, \(2019\), 2019](#)). Increasing support from state and territory governments has improved the access and transitioning to the boarding environment for remote-dwelling Indigenous students, with Queensland and the Northern Territory both providing transition support services to students and families wishing to access boarding ([Osborne et al., 2018](#)). However, very little is known about how boarding schools manage and support such a student cohort with poorer health, higher exposure to trauma and/or complex wellbeing needs. This exploratory study examines how boarding schools across Queensland provide healthcare and wellbeing support to Indigenous students.

Previous studies of the perspectives of staff at boarding schools suggest they are largely cognisant of and committed to a role in Indigenous student wellbeing ([Benveniste, Dawson, & Rainbird, 2015](#); [MacDonald Gringart, Ngarritjan Kessariss, & Cooper, 2018](#)). A Western Australian study in seven boarding schools, for example, found that school leaders were concerned about the effect of Indigenous students' exposure to previous social trauma and adverse life events and

Table 1

The roles, Indigeneity and gender of participants varied.

Staff role	Number	Identified as Indigenous	Identified as male
Registered and enrolled nurses	5	0	0
Indigenous student liaison/ education officers	2	2	1
Wellbeing managers	1	1	1
Assistant principals	1	0	1
Total	9	3	3

expressed their intent to support students to develop agency and make healthy lifestyle decisions concerning relationships, nutrition, sexual and mental health ([Macdonald et al., 2018](#)). Indigenous students at those schools identified that boarding education allowed them to achieve the dual aspiration of meaningful career pathways and improved health outcomes ([Macdonald et al., 2018](#)). However, this and other studies of Indigenous students' boarding experience ([Benveniste, 2018](#); [Mander, 2012](#); [O'Bryan, 2016](#); [Rogers, 2016](#); [McCalman et al., 2020](#)) also identified the complexities of transitions to and experience of boarding education, challenges in terms of student self-concept, racism, homesickness and post-school transitions, and potential impacts on their wellbeing and cultural needs. Furthermore, earlier studies, also in Western Australia, had found gaps in knowledge and cultural competence of staff who were caring for Indigenous boarders; they had limited preparation to teach and care for Indigenous students from communities about which they knew little, had pre-conceptions, or had prior prejudices ([Mander, Cohen, & Pooley, 2015](#)).

International research has documented three types of school healthcare models: (1) basic healthcare, coordinated by a nurse and trained school health aides and entailing screenings, assessment, record reviews, and coordination of health services with parents and community agencies; (2) student wellbeing support services, coordinated by a psychologist, nurse, and social worker that emphasise health, behavioural, and learning problems, with referrals made to community providers for serious or extended problems; and (3) on-site nutritional, medical and health education services to students and families ([Allensworth et al., 1997](#)). More recent research has suggested that comprehensive school health programs incorporate 10 interrelated components: health education; physical education and physical activity; nutrition environment and services; health services; counselling, psychological, and social services; physical environment; social and emotional climate; family engagement; community involvement; and employee wellness ([Kolbe, 2019](#)). This suggests that caring for the health and wellbeing of students involves much more than activities within the school gates, but also engagement with other services, families and the broader community.

For Indigenous Australian students, an empirical study affirmed the importance of strong relationships between community and schools and suggested that schools' strengthening of culture, links with community and bilingual education were necessary to improve education outcomes ([Wilson, Quinn, Abbott, & Cairney, 2018](#)). Similarly, a systematic review of interventions for Indigenous students' mental health across Canada, Australia, New Zealand and the United States documented key strategies to improve links between schools, primary healthcare and other services to improve Indigenous students' mental health. These included involvement of community and external workers, staff and organisational capacity building, empowering families and adaption of services with a focus on strengthening culture and identity ([Lopez-Carmen et al., 2019](#)).

Indigenous students transition to boarding schools in Queensland at around the age of 12, having navigated considerable geographical distances, separation from family and community, and vast cultural differences. This exploratory study answers the following research questions: 1) How do boarding schools promote and manage the health

¹ We recognise and respect the diversity in histories, culture, language, perspectives and experiences of Aboriginal and Torres Strait Islander peoples across Australia. However, in the absence of identification of students' particular cultural or language groups, we have adopted the term Indigenous as an identifier.

and wellbeing of Indigenous secondary school students? And 2) What conditions and strategies enable successful management of Indigenous students' health and wellbeing and what are the student outcomes?

2. Methods

2.1. Research approach and ethics

This study was founded on research partnerships with Apunipima Cape York Health Council, the Indigenous community-controlled health service for the remote Cape York region of Queensland, through a research fellowship (NHMRC 1110307) and 18 Queensland boarding schools through a concurrent five-year resilience study (NHMRC 1076774) (McCalman et al., 2016). Concern about the healthcare and wellbeing support provided to Indigenous students was identified at an annual Schools and Communities meeting for the resilience study in 2017 that brought together the Indigenous students, family and remote community members, and staff members from boarding schools, Education Queensland's Transition Support Service, Apunipima and other relevant organisations.

The study itself was conducted by adopting constructivist grounded theory research methods to investigate the processes involved in providing healthcare to Indigenous boarding school students, with the specific aims stated above. Two authors of this paper are Indigenous (VS, MW); three non-Indigenous (TB, EH, JM). The study was approved by the CQUniversity Human Research Ethics Committee, approval number 20903, and Townsville Catholic Education Office Research Application Reference Number: 2018–11.

2.2. Participating schools and staff

Theoretical sampling was used to progressively identify diverse healthcare and wellbeing support models amongst the 18 resilience study partner schools at which Indigenous students were supported by the Queensland Department of Education's Transition Support Service (McCalman et al., 2016). The boarding school principals at 12 Queensland boarding and residential school sites were invited to participate in this study. Four either indicated that the school had other priority commitments or did not respond.

2.3. Data collection

Data were collected using semi-structured interviews; each

conducted by one of two non-Indigenous researchers (TB, JM). Interview questions were open-ended. Questions about their healthcare model, on-site or school-linked services and procedures and school healthcare and wellbeing support policies and processes were explored. Participants were also asked how their school healthcare model came about, and what specific services and considerations were in place for Indigenous students. Data about conditions for providing healthcare and wellbeing support were sourced from questions such as: “*what communication systems exist between healthcare providers and school health services*” and “*what are the barriers and enablers to improvement*”. Data about the strategies was sourced from questions such as “*how do you identify the needs of Indigenous students*”, “*how are health problems tracked between home and school*”, “*what mechanisms exist to ensure that identified problems are followed up and treated?*”, “*when do you refer out, and to who?*” and “*what is the process for dealing with medical emergencies at your school?*”. Interviews were audio-recorded and transcribed.

2.4. Data analysis

Transcripts were imported into NVivo 12 data analysis software and open, axial and selective coding conducted. In open coding, transcripts were scrutinised concept by concept, with text assigned to 187 progressively identified codes (concepts). In axial coding, constant comparison of new data to existing codes was used to group higher order concepts, termed categories. Selective coding involved integrating and refining the categories into a theoretical model of schools' healthcare and wellbeing support process (Birks & Mills, 2011; Charmaz, 2014; Lawrence & Tar, 2013). Initial emerging issues in the data were used to shape ongoing sampling of schools and data collection in following interviews. A preliminary model was developed and presented to boarding school staff, students' family and community members and assorted health and education services at the schools and communities meeting in 2019. School representatives provided feedback and further information, which was used to refine the analysis.

3. Results

Eight principals agreed to their school's participation in the study. The eight sites included mixed and single-sex cohorts, and two had majority Indigenous students. The principals agreed that one to two of their school's healthcare and/or management staff members could be invited to interview. Nine staff members were identified, either by school principals or through previous research relationships and all

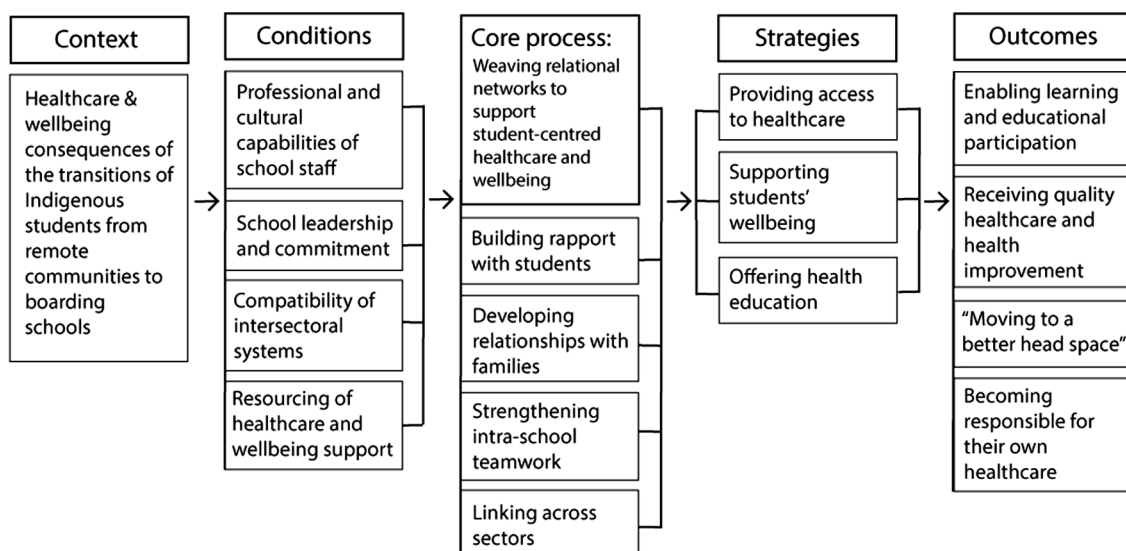


Fig. 1. Overview of results.

Table 2
Healthcare items provided annually by 8 boarding schools – on-site or linked.

School	1	2	3	4	5	6	7	8
Routine immunisations								
First aid								
Condition-specific management and treatment								
Evaluation of emotional or behavioural problems								
Annual assessment height/weight, vision, hearing								
Annual assessment physical fitness								
Annual dental services								
Mental health counselling								
Lifestyle risk factor, cardiovascular screening and counselling								
Prenatal testing and/or care								
Alcohol and drug screenings								
Health education								

consented to be interviewed. As outlined in

The theoretical model identified from the grounded analysis of interview and workshop transcripts is presented in Fig. 1. The main process through which boarding schools promoted and managed the health and wellbeing of Indigenous secondary school students was by *weaving relational networks to support student-centred healthcare and wellbeing*. This process was implemented by school healthcare and wellbeing staff members by developing and maintaining multi-levelled relationships with students, families, intra-school and boarding house staff, and healthcare practitioners onsite or off-site at the school location, in community, and with specialist services. Speaking about relationships with students, one nurse reflected: “if you don’t build those relationships with the kids, you’ve got no hope. If [a staff member] can’t build the relationships with kids then you shouldn’t be at our school! It’s all about relationships And I think it is that personal investment”. Relationships with parents/families were also considered critical. For example, a wellbeing manager observed: “they get so homesick. And if you can’t establish contact with family ... we lose the boys.” School staff also noted the importance of intra-school teamwork and linking with healthcare practitioners. A school wellbeing staff member commented “I have a really good working relationship with our nurse so I can go to her”, and a nurse commented: “We were just blessed with [psychologist name] because everybody liked her! ... the kids just don’t want to go to [other service name].” Fig. 1 provides an overview of the interlinked context, conditions, core process, strategies and outcomes of boarding schools’ process of providing healthcare and wellbeing support to Indigenous students

3.1. Context

Challenges faced by the students, and in turn, issues for the schools in which they arrive, included students’ adjustments to the changes in culture and language (many students speak English as a second or third language), school and academic expectations. A health coordinator noted: “because English is their second language, it’s extremely hard; like we try and do the pictures and where hurts, what’s going on.” In quoting a student, a nurse highlighted how their assessment of their low academic capabilities impacted their wellbeing: “I can’t do maths. I can’t read. I can’t write. And they can’t! So ... they constantly present to me because they don’t want to be in the class.... I do think they need help at the very start.” The nurse also reflected on the impact of having to adjust to rules and expectations of boarding school that differ to those of home communities.

“I think a lot of them are healthy but ... they come down here,

where they have to go to school, every day in a uniform with shoes on. They can’t do it. So, their mental health affects their physical health.”

Schools also identified many examples of Indigenous students’ pre-existing diverse and complex physical health and social and emotional wellbeing (SEWB) issues that impacted their ability to participate in school life and learning. Issues included ear health and hearing loss, dental neglect, diabetes, rheumatic heart disease, asthma and mental health issues. An assistant principal in charge of student wellbeing considered that limited access to health services in many remote communities had meant that: “Students that arrive here have had years of neglect with their health. So many students are having root canal and teeth removed and ... ongoing ear issues that were never resolved when they were young.” He also revealed that:

“Our clientele ... have significant health and mental health concerns. Eighty per cent would be from significant trauma backgrounds. Grief and loss is a significant component in their lives, as is domestic violence, as is alcohol and substance abuse. So there’s a whole host of things that these students present with.”

Similarly, a wellbeing manager reflected: “They’re so far away from home in such a completely different environment.... And they have come from really complex sort of traumatic communities or families where they need that support even more.” He suggested that some students were further “traumatised from just being here”.

Of the eight boarding schools included in this study, four provided primary healthcare services on-site (defined as having a general practitioner available to students through a school-based clinic); the other four took students to a nearby primary healthcare service (general practitioner and/or Indigenous community-controlled health service). Both on-site and off-site boarding school healthcare models were appropriate depending on the situational circumstances of the school such as its (urban or regional) geographical location, the number of Indigenous student enrolments, the extent of their healthcare and wellbeing support needs, and the availability of local external healthcare services. There was some variation in the extent and type of services provided (Table 2). Specialist health services (including allied health specialists, cardiologists and hospital services) were accessed through referrals from a general practitioner, and as required, students were taken to see optometrists, dentists, audiologists and other specialist health services.

The logistical issues associated with coordinating care across home community and school locations proved challenging for school staff. An assistant principal noted that schools are required to coordinate care

and services across the vast distances between students' home communities and school locations *"those constraints with distance; so having students from remote areas of N-T [Northern Territory], not being able to get a hold of them to share medical records or to discuss medical concerns is obviously a detractor."* Even within the regional boarding school locations, a nurse commented that access to timely services was difficult: *"although you have services here, ... it's hard to get people seen quickly... because they are so busy."*

But despite these challenges, staff considered that boarding schools provided a useful opportunity for improving students' healthcare and wellbeing. A nurse commented: *"A few of the kids ... from like islands in the Torres Strait, they have to ... get a boat elsewhere. So logistically, it's better for us to do most of their care here."* Another nurse agreed that: *"While kids are here ... [we] try and get all their health up to date.... This is their best opportunity to get it done...."*

Hence, the combined effects of students' diverse and complex healthcare and wellbeing support needs, the challenges of supporting students through transition to boarding schools, and the issues associated with working inter-sectorally and across geographical distance created challenges for boarding schools in finding solutions for both poor educational and health outcomes for remote Indigenous students. Making the point that school systems are not designed to manage such complexity, a wellbeing manager reflected:

"They think school's a cure all.... I just think it's a bit of a disservice if you take boys down to boarding school thinking that the environment is going to fix ... it's a huge thing to ask for, to go to a system that we're aware isn't necessarily adapted to them right now."

3.2. Conditions

Broad conditions at multiple levels of the education and/or health systems enabled and constrained boarding schools' promotion and management of student healthcare and wellbeing. They were the: professional and cultural capabilities of school staff, school leadership and commitment, compatibility of inter-sectoral systems, and resourcing of healthcare delivery and wellbeing support.

3.3. Professional and cultural capabilities of school staff

Attracting and retaining professionally and culturally capable staff was considered a critical condition for promoting and managing Indigenous students' healthcare and wellbeing. A wellbeing manager reflected: *"the really little boys that come in ... they get so homesick.... you need people who know how to work with that ... adjustment stuff ... they're so vulnerable when they come down."* The benefits of having experienced and skilled healthcare staff were demonstrated relationally when students *"build a rapport with and feel safe with [them]"*.

Perceived barriers to school staff capacity were high workloads, short-term contracts and inadequate cultural proficiency. One nurse reflected on the role of a wellbeing manager: *"she deals with any emergency stuff like that, so self-harming ... she sees prep to year twelve so she's got a massive job."* The challenges associated with short-term employment contracts was mentioned by a nurse who recognised: *"we really do need a psychologist – someone that the kids can trust and that's not going to be changing."* An assistant principal also reflected: *"The doctors that are on placement ... that can sometimes be a bit tricky... we would like to have someone that students could see for a year or two"*. Healthcare staff cited a need for improved professional capability, particularly in relation to mental health issues. A wellbeing manager described:

"We still have a lot of issues of boys with depression, but it seems like even if they're diagnosed, there's this thing of 'why can't they just get over it ... 'people think they're just being lazy or they're being avoidant but not understanding that's part of the illness.'"

Staff comments reflected a clear need for improved staff cultural and contextual awareness of students' remote home community norms and understanding of diverse world views and traditional practices. For example, a nurse cited concern that some parents did not prioritise Western healthcare practices, saying: *"Almost 100% don't take their medication when they go home ... ultimately a parent should make them, but I think only some are on the ball with that stuff."* Another nurse disclosed her response to a student's view that *"someone at home is jealous and they've given me black magic and I've got this abdominal pain."* And I said, *"... well I have white magic and I'm giving you two Panadol, stronger than that. Take it!"*

These examples demonstrate the complexity of relating and translating across Western and Indigenous ways of knowing, being and doing. The same nurse later acknowledged the inadequacy of her response in relation to validating the student's concern: *"So anyway she took the two Panadol, she was fine. She went back to class ... So here I was thinking yeah it worked and the next day her Grandmother died, and I was like, 'oh God. There goes that!'"* School staff recognised that providing care for Indigenous students required considerable cultural awareness and sensitivity. The nurse referred to above reflected: *"Maybe culturally wise, if I was ... a little bit more sensitive, ... but I'm quite forthright."*

One non-Indigenous staff member perceived being Indigenous to be an important quality needed in student support teams, stating: *"maybe it was because I wasn't Indigenous ... they were a bit hesitant."* The value of Indigeneity in managing such issues was noted by a Wellbeing Manager: *"I think there are certain things you just sort of get from growing up in a family that other people have to learn possibly."* Other staff members considered the critically important issue to be about ensuring capability for all staff.

3.4. School leadership and commitment

The commitment of school leaders to students' health and wellbeing was linked with the recognition that health and wellbeing underpin participation in education. An assistant principal explained: *"our school leadership team ... sees that health is a priority and will devote funds and resources into that."* Furthermore: *"Our overarching Catholic Education Services sees health as a major priority ... because of the complexities of our clientele. It must be top shelf."* In corollary, referring to the contribution of engagement in education to lifelong mental and physical health, a wellbeing manager reflected: *"it'd be nice to see that happen over the next few years... they start to look at those kids that have fully disengaged"*.

Staff also noted their school's commitment to implementing ongoing quality improvement to *"perfect the processes"*. A nurse described: *"when we first got our Indigenous kids, there was no programs, there was nothing. There was no direction of what we do, how do we do it."* In comparison, she noted that now: *"I think we're sort of on track. We've got plans and we tick boxes and we make sure everybody goes and does these things and sees these things."* Similarly, a director of Indigenous education noted: *"we're in a very lucky place ... we've got a lot of organisations that we can call on ... but that's been over years of hit and miss and saying well we need to fix that up."* All school staff were interested to learn more about the models of healthcare and wellbeing support being delivered by other boarding schools.

3.5. Compatibility of intersectoral systems

Staff members noted that the information systems of education and health sectors were generally incompatible, and that inflexible eligibility criteria or processes hampered the provision of optimal healthcare and wellbeing support. An assistant principal summarised:

"there are many, many complications that we face. There's no direct way that we electronically can communicate coz our systems are obviously very different to agency systems. And we're not a government school, so we don't have that direct ability to share files."

Barriers to accessing students' medical information had implications for students' medical care throughout the student health assessment, management, referral and follow up cycle. For example, speaking of health assessment processes, one nurse explained that the school used *"[remote community] schools and health centres ... to get that information. So it's just a medical form ... but it's a process that we haven't quite perfected as yet."* Another nurse justifiably complained about a lack of co-ordination in the management of a student's health condition: *"I haven't heard anything! The appointment's booked for next Wednesday so it's just a matter of we turn up, see if it's there – yes, no, sorry, you're here for no reason!"*

Further barriers were experienced due to services that were *"changing constantly"* in eligibility criteria or conditions of use. For example, a nurse described the services of a psychologist as: *"working really well, until they decided to drop the scheme ... from next year, we're going to have to find someone else."* Another nurse commented about optometry services: *"the schemes change all the time, so what's valid one year is not valid the next year or they cut you off half way through..."*

Difficulties also occurred during referral and follow up, with healthcare system inefficiencies such as described by a wellbeing manager in lacking capacity for *"recognising two addresses."* He continued: *"their [referral] system just doesn't understand that they're here for school; but in school holidays, they're back home. And so we'll get things like appointments being sent ... back home when they're here and vice versa."*

3.6. Resourcing healthcare delivery and wellbeing support

Schools agreed they had a duty of care to promote and manage the health and wellbeing of their students; however, several health staff highlighted that they had limited resources and capacity to do so. A nurse, for example, reflected: *"we're doing the best with what we have."* The cost of basic primary healthcare was generally not considered to be a problem. For example, one nurse said: *"most of all our doctor services are all bulk-billed. Medications and things they get cheaper with C-T-G [Closing the Gap subsidy for medications]. So there's either no cost or minimal cost."* However, an example of the barrier, caused even by low costs for healthcare, was described:

"[I] tried to get them all the flu injection but I couldn't coz they weren't eligible... most of them had to pay the fifteen dollars and they didn't have the fifteen dollars. But had they have got it out at their community centres, they would've got it for free..."

The cost of specialist healthcare was almost universally mentioned as a significant problem. A nurse explained:

"finances is a huge ... a huge thing. We can get a thousand dollars for dentists.... Once their thousand dollars is gone though, that's it! An orthodontist is non-existent!... But their eyes, they have no support ... they have to pay this thirty dollars up front and they won't - they just stand there and say, '... I haven't got the thirty dollars.' ... So it's really, really difficult. if you're going to provide the students with free glasses, give them free glasses."

Also referring to dental care, a wellbeing manager reflected: *"if it's urgent ... we'd be paying for it.... And obviously that's not sustainable when you've got 30 kids."* He also commented about the need for student wellbeing support: *"The fact that it's so difficult for securing funding – you'd think that'd be the first thing."* Even for well-resourced schools, healthcare staff and managers noted the inadequacy of healthcare resources to deal with the magnitude of students' healthcare and wellbeing concerns. An assistant principal reflected: *"I could have half of my students on counsellor case load. I just significantly don't have the resources for that"*. He continued: *"if I had more funding, I would have another psychologist or more social workers"*.

3.7. Core process: Weaving relational networks to support student-centred healthcare and wellbeing

Healthcare and wellbeing support staff developed and maintained interconnected relationships with students, families, intra-school staff, and healthcare practitioners (onsite or school-linked, in community and specialist services), *weaving relational networks to support student-centred healthcare and wellbeing.*

3.8. Building rapport with students

All school-based health staff members spoke of the importance of building rapport with Indigenous students as the basis for providing healthcare and wellbeing support. A nurse explained: *"just having a good yarn and a chat.... To know it's a safe place where you can have a talk and if you need anything, just ask."* A health coordinator commented that she went *"out of my way to go and talk to those kids that fly under the radar. ... Just to try and build a relationship where they feel comfortable in coming and talking to me about stuff."*

Another nurse considered the time needed for the process of building rapport:

"When I first started here ... they were a bit hesitant... But now I have a good relationship with them all, and they'll come and chat to me ... as they get to know you and they trust you, that gets better."

Assurances of confidentiality supported the development of trust and rapport. An Indigenous student liaison officer emphasised: *"we stress to the kids as well, that everything they speak to a psychologist is confidential."* A school health coordinator also explained that gender was an important consideration in establishing rapport with some students, for example, some male students were not comfortable speaking with a female practitioner.

Rapport provided the basis for students to communicate about their health issues. A director of Indigenous education, for example, said: *"... you'd be surprised how many times they've ... just come in and talk about different stuff, and even boys that have had sexually transmitted illnesses too."* It also translates into invitations to staff members to accompany students in their healthcare consultations: *"they'll get you to - you know, '... you come with me Miss. You come with me'"*, and to support more suitable and culturally safer healthcare. A wellbeing manager, for example, noted:

"A lot of the older boys ... ask us to come in with them anyway, even if it is for something quite private.... he'll sit next to me but he takes in everything she [psychologist] says ... he's not just on his own with a strange woman being asked all this personal stuff."

Rapport also provided the basis for staff efforts to improve the quality of the services provided to students. A nurse described:

"Just having a chat with [students] and seeing how we can improve, ... if there's anything else that they need or ... is there anyone at home that I can talk to about their health needs, or do they use a clinic."

3.9. Developing relationships with families

All school-based health staff described the process of engaging with students' parents or carers as critical to students' health and wellbeing care. A nurse noted the central role of families in students' lives, stating that her goal in providing school-based healthcare was simply: *"just to get them home in one piece."* Staff noted that, as with students, this process entailed *"working across cultures"*. Communication seemed to work best when school staff drew on their informal relationships with family members. A director of Indigenous engagement reflected: *"it's been something that's [developed] over many years whenever I go up to those areas, I'll just go and talk to those different invested people anyway, so*

they can put a name to the face.” Such engagement with families required time and investment from schools, however, were key to effective student support.

Legally, schools are required to obtain the consent of parents/carers for their children to receive healthcare. Contacting parents for consent or medical information over vast geographical distances was difficult for boarding schools due to regularly changing contact details, or limited phone service in very remote areas. As described by the director of Indigenous education:

“we try and get in contact with the parents first up. But usually what happens is that the [phone] number ... changes and they forget to tell us We understand that and sometimes emails doesn’t work so ... we just go through the [remote community] councils or the schools.”

Each school implemented a different process for obtaining consent; some as part of the enrolment process and others on an as-needs basis. A nurse explained: *“those yearly forms that go out, they consent to their child being able to be seen by the school doctor, they can give consent for quite a lot of stuff.”* Other schools did not receive students’ medical information upon enrolment but rather, on an as needs basis through *“a watch and learn and pick up as and when we need to.”* School staff considered that parents’ literacy levels and aversion to text-based forms (resulting from prior experiences of intimidating government processes) were barriers to obtaining written information from families about students’ medical conditions and consent. A nurse and Indigenous student liaison officer observed: *“Some don’t even write. They’re not sure. Yeah forms are just confusing... black fellas and forms – not a good combo....”* The challenges of obtaining consent sometimes required schools to adopt the role of *in loco parentis* to keep students safe. For example, during medical emergencies, one nurse commented: *“what’s the saying, ‘it’s easier to ask for forgiveness than permission’ sometimes. Sometimes we can’t readily get hold of parents.”*

School staff described their processes for informing parents of the healthcare actions taken for their child in ways ranging from formal documentation such as: *“a letter to say ‘this is what we’ve done with your child’”*, to more informal phone calls: *“they tend to prefer for me to ring them to talk to them. So we ring and we let them know every step of the way...”* However, feedback from family members at the resilience study schools and communities meeting suggested that this communication also appeared to be somewhat ad hoc. At times, family members also struggled to attain information from schools about the results of their child’s health assessment and/or healthcare procedure.

Staff members noted several benefits when relationships were developed between schools and parents. A nurse related: *“They ring me and say, ‘... hey, this is what’s happened with my kid. Can you have a look at that?’”* Similarly, a director of Indigenous education recalled the value of parent engagement during the death of a student’s family member:

“the parents ring our office for us to tell the boys about a death ... They tell us first, and then what I tend to do then is go and talk to everyone else and say, ‘I am about to talk to this boy’ so that everybody’s ready to go before he even knows what’s going on.”

3.10. Strengthening intra-school teamwork

All staff stated that intra-school teamwork and linkages or *“keeping those lines of communication open”* were critical to meeting the needs of their school systems and students. One nurse recounted:

“the boarding supervisors ...they’ll come down usually most mornings, ... and if they’ve had a problem with the students, they share it ... and then they’ll check with me that afternoon, ‘... did such and such come and see you?”

Demonstrating an important dimension of capacity to support the complex needs of Indigenous students, school wellbeing support staff

also noted commitment by schools extended to providing support to each other across a region. A director of Indigenous education related *“... [if] someone has tried to commit suicide, the other counsellors from the school regions ... they come down to support the school and vice versa.”*

3.11. Linking across sectors

Along with the required teamwork within and between schools, coordination of Indigenous students’ healthcare and wellbeing also required intersectoral linkages across education and health sectors. School staff linked not only with extended family members in remote communities but also with primary schools, local community Councils, primary healthcare services and even Police staff to negotiate medical consent processes and access health information. A nurse noted the complexity of liaising with remote-dwelling families and services:

“It’s really hit and miss whether you get [medical notes] ... if you can talk to a carer or a parent and they have got stuff, but then you have problems coz they don’t have access to faxing and emailing stuff. So it’s easier to just go through [name of doctor at local medical clinic] and then ... they get them sent down.”

They also regularly linked with primary and specialist healthcare staff in the urban or regional school locations. One nurse provided an example: *“generally students who are identified as high risk ... We link in with the wrap-around services to make sure that they’re attending their appointments, anything we can help with”*

3.12. Strategies

Three strategies were used to promote and manage the health and wellbeing of Indigenous secondary school students. They were: providing access to healthcare, supporting students’ wellbeing, and offering health education.

3.13. Providing access to healthcare

Upon enrolment, schools sought to identify student’s health or wellbeing issues as part of their duty of care. A nurse described:

“At the start of every year we get a letter from parents with medical conditions that the child already has, and any medications that they’re currently on, whether they’re seeing doctors or so forth and that’s all put in our computer ... we then take control of that right here.”

Furthermore, another nurse noted: *“When a kid comes to the school, we basically assume they’ve had nothing.... So we try and cover all the bases because you just don’t know.”* The imperative to quickly identify any current medical conditions prompted all schools to attempt to have a preventive health assessment screening (Medicare Benefits Scheme rebate item number 715) administered to all Indigenous students in term one. Any health issues identified were then followed up. For example, one school nurse explained:

“they all have their yearly check-ups. Any Indigenous kids that present with fevers or throat and stiff joints automatically get seen by a doctor. It’s a risk of rheumatic heart... So we do their monthly injections..... we’ve [also] picked up things like allergies.”

Specialist health services (including allied health specialists, cardiologists and hospital services) were then arranged, and as needed, students taken to see optometrists, dentists and audiologists.

However, there was considerable variation in the breadth and sophistication of healthcare services provided. Across the four schools that provided on-site healthcare services, all had a nurse and (part-time) general practitioner available through a school-based clinic, but some also provided an on-site child psychologist, wellbeing officer, youth worker, health worker and/or links to pastoral care officers. An

assistant principal described one comprehensive service:

"We actually have a brand-new health clinic that is fully operational. We triage our students through the day through our sick bay... and then they are referred on to the clinic. Students outside of hours who are our residential boarders, they speak directly to our nurse.... having the network of support that she has access to at the drop of a hat, is ideal for us."

In contrast, a nurse at another school said:

"It would be nice if I had the time to sit with every Indigenous student that came in and did a health check. There's kind of only one and a half of me [my role] and I haven't got the time to do that...."

On-site clinics focussed mainly on minor healthcare issues and the administration of regular medications. As explained by an assistant principal: *"We predominantly deal with a lot of things that are at the minor end of the scale, so we deal with the head-lice and the boils and the cuts and abrasions and the bruises and those types of things."* However, those with more capacity also provided care for more severe medical conditions. A director of Indigenous education attested: *"there's some boys that when they get here, we realise that we need to fast track and so the health nurses, they're pretty cluey on what needs to be done."* An assistant principal spoke of students with various severe medical issues: *"Last term we dealt with a young girl that came back with a pregnancy.... We have a dozen students with heart concerns. Some are on daily medication."*

Perceived advantages to having an on-site clinic were the immediate access provided (without wait times), and time savings for students and staff from not having to take students off school grounds for medical appointments. A director of Indigenous education commented: *"some don't have their own health centre so they have to go off campus. So that comes with ... time restraints."* Four schools provided students with access to healthcare services offsite; either because of small Indigenous student numbers and/or difficulties in retaining an on-site general practitioner. For offsite services, they utilised both private and/or Indigenous community-controlled healthcare service.

3.14. Supporting students' wellbeing

All schools provided on-site social and emotional wellbeing support to students, early intervention (such as initiatives to provide real or virtual connection back to country and early referral), and access to external mental health services. Staff provided diverse support for students' wellbeing, including the informal support built through rapport. A nurse related: *"sometimes they're just sad. They're just homesick and sad and they just need someone to talk to."* Another important strategy used by school healthcare staff was to link students with familiar home and cultural supports. A nurse observed: *"sometimes when they come in and they're homesick, we Google their island or where they come from and we look at pictures."* An Indigenous student liaison officer described:

"We had an Elders morning tea in here... we'll be having a barbeque at Mum's in a couple of weeks ... all the kids come, some staff members and their families, just whoever can make it, and just have a fun day."

For other students, mental health risks were more serious; they were referred to external mental health services as appropriate. The assistant principal in charge of student wellbeing at one school explained their triage process and referral options:

"[the] Wellbeing Team ... work through a bit of a process of establishing level of risk.... then ... they go to our psychologist who does a bit of holistic health and if required, work alongside the nurse. And then we refer on...we take them to a G.P. or we present with them at Emergency... also we have linked in with the headspace organisation who visit on a regular basis.... Otherwise we have private psychologists and mental health services."

Staff members at three schools mentioned instances of student self-harm and attempted suicide. A nurse said: *"we just had a lot of mental health referrals this term ... we've had a lot of issues with um self-harm..... And then it'd be depression."* An assistant principal noted additional challenges in supporting: *"students who have phobias and are unfamiliar with working with healthcare professionals."*

3.15. Offering health education

Health and hygiene education were opportunistically or formally provided to support students to adopt health behaviours and to independently access primary healthcare and other services. A wellbeing manager noted that Indigenous students were very interested in learning about nutrition and other health issues, so long as it is explained in a way that students understand. He observed:

"All of them really take to that [health education]. They've all grown up seeing family members and community members ill from diabetes or smoking or whatever, so they're aware of what that means down the track...We've got a great doctor that ... [explains] so that they actually understand this is what is going on in your body. And they love it."

A nurse similarly observed: *"overall health and cleanliness, good hygiene – just to teach them and it makes the biggest difference."* An assistant principal described the formal health education sessions provided to students: *"We have agencies come in and run full day workshops with our students on mental health – everything from sexual abuse right through to drug and alcohol and substance abuse."*

Staff also supported students to take responsibility for their own healthcare, including learning how to access primary healthcare and other services. An assistant principal described: *"We constantly promote agencies that can help them for example Lifeline, Kids Helpline, headspace online."* A wellbeing manager added that this skill was important, particularly in the context of coming from remote communities where healthcare services have often undervalued self-efficacy in health:

"we've tried to work it so that they go in on their own ... the whole point of that is so that they learn how to access that stuff on their own when they're out of here ... and to think about their health."

Similarly, school staff encouraged students to learn how to self-manage their own healthcare. A school nurse noted: *"We try and encourage the girls to take responsibility for themselves and to listen and ask questions and answer the questions when the doctors asks them."*

3.16. Outcomes

Consistent with the strategies, four outcomes of promoting and managing Indigenous students' health and wellbeing were identified. These outcomes were: enabling learning and educational participation, accessing healthcare immediately, helping with their 'moving to a better headspace', and students becoming responsible for their own healthcare.

3.17. Enabling learning and educational participation

Schools recognised that students' health and wellbeing underpinned immediate and longer-term benefits for Indigenous students' participation in education. Immediate benefits included enhanced hearing, eyesight or wellbeing following assessments and treatment. A nurse, for example, observed:

"When we realise that he can't hear, you're not gonna learn very well. You know, if you can't see excessively well, you're not gonna learn. And also, ...if you haven't got a happy, well child then it's gonna impede in their learning somewhere. So we do what we can to make their learning as good as possible."

Similarly, a health coordinator noted:

“Even just in day-to-day school ... teachers going, ‘oh thanks for that. Now I understand that this kid can’t hear too well so let’s put them up the front or let’s face them this way so they can hear from their good ear.’”

Staff also described the longer-term aspirational benefits of engaging in learning and achieving educational goals. Staff members at two schools described the aim of their healthcare and wellbeing support as: “*anything we can do to maintain a level of wellbeing that enables students to engage in learning at the College*” and “*... looking after them physically and emotionally and mentally to see if that gives them the best chance... to complete school or whatever their goal is*”.

3.18. Receiving quality healthcare and health improvement

Staff noted that boarding schools were able to coordinate students’ immediate access to quality healthcare services. A nurse commented: “*it’s available here ... they’ve got someone sort of pushing them to go ... where I think at home ... they would just sort of deal with it and hope it got better by itself*.” An assistant principal noted:

“We feel that we are offering the highest quality health care for our students possible. The main impact is that we have students who can easily access health care immediately. There’s no wait time. There’s many things that we have that we can do straight away to alleviate pain and alleviate discomfort ...”

School staff considered that in general, students were satisfied with the healthcare and wellbeing support services they received. A health coordinator said: “*...they would tell me pretty fast, yep. ...They’d voice it. Even if they’re not in the mood to go to the health service, they will voice it.*” An assistant principal noted that students’ satisfaction could be gauged by their increased demand for healthcare services: “*Our number of walk-ins this year has increased ten-fold. So students just going to the clinic and asking to see the nurse ...they’re not avoiding us. They’re not hiding health concerns.*”

Health gains achieved due to the coordination of healthcare by boarding schools included; identification and treatment of students’ allergies, hearing loss, poor eyesight, dental problems, head lice, boils, mumps, sexually transmitted diseases, pregnancy, depression, self-harm, suicide attempts, and the administration of regular medication for rheumatic heart disease and other heart conditions, vitamin D deficiency, and surgery for injuries. A director of Indigenous education also attributed the school’s on-site clinic to preventing an escalated spread of mumps: “*we were able to get on that very quickly and isolate them from the rest of the boarding house. If we didn’t have that on campus, I think it could’ve been wider spread.*”

However, the limited scope of boarding schools’ healthcare practice was importantly noted by a health coordinator. She observed:

“I do think there are some students that are missing out. Just because there are a lot of kids that fly under the radar. So they’re the extremely well behaved kids in class. They’re the ones that are always doing the right things. They’re the ones that do not bring any attention to themselves at all.”

Furthermore, healthcare and wellbeing staff were concerned that there was no system in place to ensure continued healthcare in their remote home communities once students returned (for holidays or on school completion). A nurse reflected: “*here, I think they get all that they need.... We can only do so much whilst they’re here and then we try our most to make sure things are continued when they go home.*” Another nurse concurred: “*I think we’re doing a pretty good job at getting them checked ... while they’re here, yeah. But that’s only while they’re here. I don’t know what happens when they go back home.*” Staff members therefore focussed on such outcomes as were within their control while students were attending the boarding school.

3.19. “Moving to a better head space”

School staff considered that wellbeing support saw students growing happily and healthily. A health coordinator observed: “*They come less. They don’t visit you as often. They’re happier. And they look better. And they’ve grown.*” An assistant principal noted:

“we determine whether we’re making a difference by I guess the amount of significant [issues] or emergencies that we may have that relate to student wellbeing, so if we’re having less self-harm, if we’re having less suicide ideation. Or if we’re having students that present with those conditions but are receiving the right level of support and are able to move themselves into a better head space.”

Most schools did not keep records to quantify gains. Rather, they observed the broader effects of improved health and provided anecdotal narratives of individual students who had gained benefit. An Indigenous student liaison officer explained: “*I can tell how they’re going by how settled everyone is, what issues we’re having, what issues the boarding house is having, yeah. It all tends to have a flow-on effect.*” A nurse narrated her role in one student’s journey:

“slowly over time as we’ve gotten to know each other, we’ve spoken about it [previous heart surgery] and she’s become really open and she’s into talking to her friends now about it, and we’ve Googled images of what’s happened and how her heart is now..... It’s things like that you know that you’re making a difference.”

However, as with healthcare, school staff were concerned that they did not have adequate resourcing to address the wellbeing needs of all students. An assistant principal said:

“We’ve got a lot of students who suffer depression and I don’t believe we’re getting to them all... We are managing to deal with the concerns that present themselves. It’s the hidden ones that we’re not yet getting or hitting the target with I think.”

3.20. Becoming responsible for their own healthcare

Finally, by educating students about healthcare and wellbeing, school staff considered that students were becoming more responsible for their own healthcare, an outcome with sustained benefits throughout the lifespan. An example of a student’s improved health awareness was related by the wellbeing manager: “*he’ll come and say... ‘I had unprotected sex. I need to go’. I think that’s brilliant. I think if they get comfortable in the knowledge of how to access ... an appointment ... that’s a great outcome.*” An assistant principal elaborated:

“we determine success by those students that are now accessing support, utilising the strategies they’ve been given, going to the right people or the health professionals...whether or not the students are able to self-regulate, identify, speak to people, utilise strategies, access agencies and resources – online resources, physical resources. If they’re able to do those things, and they are more and more at the moment, that tells us that we’re on the right track.”

Promoting self-responsibility for healthcare strengthened the promotion of a culture of student health and wellbeing at boarding schools and reinforced preventive health strategies. An assistant principal reflected: “*we’re creating a culture that ... health is just what we do.... it’s not this thing to avoid ... making it something that we do coz it’s beneficial to them.*” This appeared to produce health outcomes beyond the school gate, to supporting students to manage their healthcare back in their home communities during school holidays or beyond school.

4. Discussion

The provision of healthcare and wellbeing support for Indigenous students is a crucial component of their engagement in education at

boarding schools. Schools have a responsibility to take care of the health and wellbeing of Indigenous students while in education and are doing their best to improve their responses to students' health and wellbeing issues. This is a complex context, which requires specific conditions and strategies to enable the intended outcomes of boarding school healthcare. There is considerable value in locating the provision of student healthcare and wellbeing support within boarding schools.

Healthcare and wellbeing support at boarding schools resulted in both educational and health outcomes, including learning and educational participation, receiving quality healthcare and health improvement, "moving to a better head space", and becoming responsible for their own healthcare. These results are consistent with recent international evidence that school healthcare improves student attendance, school engagement, classroom behaviour, mood, concentration, memory, test scores, and high school completion, as well as health outcomes such as vaccinations and other recommended preventive services, and decreases in asthma morbidity and emergency department and hospital admission rates (Community Preventive Services Task, F, 2016). Teaching students to have agency over their own healthcare is also an important outcome, particularly in the context of remote Indigenous communities which have often been exposed to a paternalistic approach to healthcare that has undervalued self-efficacy in health.

Despite the positive outcomes identified, however, boarding schools currently have limited capacity to provide the streamlined healthcare and wellbeing approach needed to manage the often-complex health and wellbeing issues of Indigenous students. Some schools experienced challenges in retaining healthcare staff, identifying and responding appropriately to mental health conditions, and practicing in culturally sensitive ways. Staff members from all schools identified persistent challenges in navigating across the education and health sectors to obtain students' medical records at enrolment, parental/guardian consent, funding to provide needed specialist care (particularly for dental and optical work), and for ensuring continuation of medication and care once students returned to their home communities for holidays or at school completion. Efforts are hampered by the absence of a standard best practice guide or protocol for promoting and managing Indigenous students' healthcare and wellbeing support, limited awareness of other boarding schools' processes, and lack of formal monitoring of their own processes and outcomes. There is, therefore, a huge opportunity to improve the coordination and implementation of healthcare and wellbeing support to Indigenous students through boarding schools.

This exploratory study found that effective support for Indigenous students' healthcare and wellbeing requires a multi-levelled relational approach. Those schools that are doing well have actively invested in developing and maintaining relationships with students and families as well as partnerships with key health services in remote communities and their own region. These relationships facilitate attainment of the required medical histories and consent and effective healthcare provision; however, they are also vulnerable to changes in staff and systems. An articulation is needed for how remote community and school healthcare services can be systematically integrated, including processes for obtaining parent consent to access health records, and student consent for those old enough. Additionally, there is likely to be value in connecting boarding schools across Queensland to learn from each other and share healthcare and wellbeing support practices.

This study was based on a very small sample size and was not designed to inform the development of best practice interventions. But the narratives of boarding school healthcare and wellbeing support staff suggest some potential "better practice". Working towards such a framework, school staff identified a need for models of school-based health services to feature: access to primary and specialist healthcare, support for students' wellbeing and mental health, and health education. Models should involve the student themselves, their family/caregivers, the boarding school, and on-site or linked healthcare services. Each strategy ideally should be iteratively embedded at each stage of the school cycle: pre-enrolment, at the time of enrolment/

intake, in term one (or the students' first term at the school), ongoing throughout the school year, and in emergencies/crises (Table 3). Further research is needed with a larger sample size and specific aim to identify best practice healthcare and wellbeing support for Indigenous boarding students.

Underpinning these strategies, interrelated enabling conditions can be strengthened: cultural capabilities and capacity of school staff, school leadership and commitment, the compatibility of intersectoral systems, and resourcing healthcare and wellbeing support. In boarding school environments, staff cultural competence workforce training needs to be tailored to the school situation. It is crucial that schools recruit and retain experienced, committed and relationally skilled staff, and that training be provided in trauma informed approaches to increase awareness of the effects of prior exposure to adverse childhood experiences on stress, behaviour and health issues (Berger et al., 2017). Cultural competency training can assist in alerting boarding school staff to processes that counter institutional racism, enhance the cultural safety of school environments, and address paternalistic attitudes towards Indigenous families. A systematic review found staff cultural competence training improved health practitioners' knowledge, attitudes and beliefs, skills, confidence and behaviours, but only one out of 16 studies reported improvements in client satisfaction (Jongen, McCalman, & Bainbridge, 2018). Approaches to enhance student satisfaction need to be tailored to focus on the tensions in cross cultural and intergenerational communication - issues that are clearly complex and require a certain level skill and experience as well as sensitivity and the ability to critically reflect to ensure that the wellbeing of students isn't lost in translation. Examples include engagement with Indigenous students to codesign activities, programs and spaces, and to encourage ownership of their healthcare and wellbeing.

Importantly, the study findings also suggested a critical need for training of school staff in social and emotional wellbeing and mental health issues that underpin a holistic approach to educational engagement. The linked wellbeing issues for students include homesickness, sadness and stress, and a potential under-recognition of depression. The feasibility of training school staff to better support students' mental health and wellbeing is demonstrated by our earlier study that found that a staff training program was both appropriate and effective in building the capacity of education support staff to support the wellbeing of Indigenous students through transitions to boarding schools (Heyeres et al., 2018).

The value of school leadership and commitment was suggested by active partnerships and funding sought from health grants/ providers by those schools that were doing well in providing healthcare and wellbeing support to their students. School staff were proactive in establishing rapport with students, family members, other school staff and healthcare services, and in identifying and managing healthcare issues. Strategies for improving the capacity of schools could include the targeting of specific health areas, such as hearing, dental and optical services which are more accessible in the urban and regional locations of boarding schools than in remote communities, as core school-based health programs for best practice. Strengthening connections with local remote communities and their health services would enable schools to target their healthcare programs more effectively.

Improved systems, such as an E-linked health system, are also needed for recording and sharing students' healthcare and wellbeing information and improving intersectoral team approaches to coordinate care with culturally relevant primary healthcare services in remote communities during term breaks and school-linked healthcare services during terms. The home clinic model available through Medicare could be utilised to underscore and promote such integrated care, approaching healthcare from a holistic worldview that is consistent with the needs and cultural values of Indigenous students, families and communities. Ultimately, the ethical principle of beneficence, or doing good in healthcare, should guide the improvement of boarding schools' healthcare and wellbeing support for Indigenous students.

Table 3
Embedding healthcare and wellbeing support throughout the school year.

	Pre-enrolment	Enrolment	Term 1	Ongoing
Students	Complete social and emotional wellbeing assessment	Cope with transition challenges	Adjust to boarding school environment	Learn self-responsibility for healthcare and wellbeing
Families	Establish contact with schools, discuss family situation and student's academic and medical history	Provide students' medical histories and consent for healthcare procedures	Maintain contact with students and schools	Obtain information from schools about students' medical care, follow up at home
Boarding school	Assess health issues and gauge risk	Liaise with students, families and home community clinics	Support students' wellbeing, engage with students and families	Maintain partnerships with families, support students' wellbeing, provide health education
Onsite or linked healthcare services		Record students' medical records in school database	Liaise with healthcare services, update medical records, conduct full health assessments, treat, refer and follow up	Assess, treat, refer and follow up

5. Conclusion

This study contributes to the limited knowledge of how boarding schools promote and manage the health and wellbeing needs of Indigenous students and highlights many opportunities to improve co-ordination of their health assessment and care. Exploratory findings suggest that boarding schools are doing considerable work towards improving the ways they manage and promote Indigenous students' health and wellbeing. However, because the impact of their models are not formally monitored/reported, they are rendered invisible. There is also considerable variation in the models of healthcare and wellbeing support provided by boarding schools. This variation is the result of both pragmatic, situational or externally-bound decisions across school settings, and from factors that are internally controlled and could be improved by schools and/or their interactions with students, families and the health sector.

It is in the best interests of both the health and education sectors to enhance healthcare and wellbeing support for Indigenous students who need to access secondary schooling away from home, but there are currently no best practice guidelines to support school efforts. Both on-site and boarding school-linked healthcare models are appropriate for supporting Indigenous students, depending on the circumstances. In either case, the identification of conditions and strategies that enabled positive outcomes provides something of a baseline from which best practice guidelines can be developed and implemented to ensure a minimum standard of healthcare and wellbeing support for Indigenous boarding students, which should be resourced through state and/or federal funding. A relationally focussed, ecological and cross-sectoral model of health and wellbeing support and linkages is needed that proactively involves students, families, school staff and remote and school-based or school-linked healthcare services. As noted by a school staff member at the schools and communities meeting “*it's all about relationships.*”

CRedit authorship contribution statement

Janya McCalman: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Writing - original draft, Writing - review & editing. **Tessa Benveniste:** Investigation, Project administration, Writing - original draft, Writing - review & editing. **Mark Wenitong:** Validation, Writing - review & editing. **Vicki Saunders:** Validation, Writing - review & editing. **Ernest Hunter:** Validation, Writing - review & editing.

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Appendix A. Supplementary data

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