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ARTICLE

"It's like an epidemic, we don't know what to do": The perceived need for and benefits of a suicide prevention programme in UK schools

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Abstract

Background: Despite emerging evidence for the effectiveness of school-based suicide prevention programmes worldwide, there are few being implemented in the United Kingdom, and their social validity (i.e., the feasibility, acceptability, and utility) is not yet known.

Aims: We aimed to conduct a scoping study to determine: (1) the social validity and potential benefits of school-based suicide prevention interventions, (2) the perceived need for such interventions, and (3) barriers and facilitators to implementation.

Sample and Methods: A total of 46 participants took part. Semi-structured interviews were conducted with mental health professionals ($N = 8$), school staff ($N = 8$), and parents whose children had experienced suicidal ideation/behaviours ($N = 3$) in England. Focus groups were also completed with children and young people ($N = 27$) aged 15–18 across three state secondary schools. Data were analysed using thematic framework analysis.

Results: Three themes were identified: (1) the need for and importance of suicide prevention in children and young people, (2) schools as a setting for delivery, and (3) key components of suicide prevention programmes.

Conclusions: Participants overwhelmingly agreed that there is a need for a greater and more consistent emphasis on school-based suicide prevention. School appears to be an acceptable location for suicide prevention, and participants felt discussions about suicide should begin at the start of secondary school. However, there are potential barriers that need to be considered, including tailoring for neurodiversity, challenging cultural/family beliefs and stigma,

managing personal experiences of suicidal thoughts or previous bereavement from suicide, and a lack of existing training for school staff.

KEYWORDS
children and adolescents, qualitative, school mental health, suicide prevention

INTRODUCTION

Suicide is one of the leading causes of death among children and young people (CYP) in the United Kingdom (Office for National Statistics [ONS], 2022). Alarmingly, adolescent suicide rates in England and Wales continue to rise, having increased by 7.9% annually since 2010 (Bould et al., 2019). The most recent figures have shown a further increase in young people aged 15–19 years, and women under the age of 24 years (ONS, 2022). Incidences of suicidal thoughts and behaviours (STBs) occur with increasing frequency as young people reach adolescence (van Vuuren et al., 2021), with 7.4% of 17-year-olds having previously attempted suicide (Patalay & Fitzsimons, 2021). STBs are associated with several negative outcomes for the individual, including increased risk of future suicide (Castellví et al., 2017). Additionally, suicide can have a catastrophic impact on a young person's family, friends, and the wider community, also increasing their risk of suicide (Robinson et al., 2018). This provides a strong case for both prevention and early intervention for CYP regarding suicidality.

Schools have been identified as a promising location to deliver suicide prevention, providing universal access to the majority of CYP (Calear et al., 2016). In line with World Health Organization (WHO) guidance (2018), post-primary school-based suicide prevention interventions should incorporate universal (delivered to a whole population), selective (for those with increased risk), and indicated (for those who are already experiencing suicidal thoughts or behaviours) approaches, in addition to general well-being promotion that can prevent STBs through targeting related factors (Walsh, McMahon, et al., 2022). A recent systematic review by Walsh, Herring, et al. (2022) identified 28 studies that evaluated 36 suicide prevention trials in secondary schools since 1991. Meaningful reductions in STBs were evident in around half of all trials, with some trials also identifying longer-term effects. Further work by Robinson et al. (2018) identified similar beneficial effects of suicide prevention interventions for youth across various settings, although comparatively less evidence was found for interventions delivered in educational settings. However, their results did suggest that school-based psycho-educational interventions (i.e., universal approaches) coupled with screening have the potential to be effective, although higher-quality studies are needed to confirm this.

To date, the most commonly evaluated programmes include the Signs of Suicide (SOS; Aseltine & DeMartino, 2004) intervention, Youth Aware of Mental Health (YAM; Wasserman et al., 2015), and Question, Persuade, and Refer (QPR; Walsh, Herring, et al., 2022). In particular, YAM, a brief duration (5 h across 4 weeks) classroom-based psychoeducation programme, has gained traction in recent years across Europe. One randomized controlled trial, consisting of 11,110 secondary school pupils across 10 European countries, identified significant reductions in the number of suicide attempts and severe suicidal ideation in adolescents at the 12-month follow-up stage (Wasserman et al., 2015). Similarly, a trial of the classroom-based SOS intervention with 2100 pupils in North American high schools (Aseltine & DeMartino, 2004) also evidenced reductions in suicide attempts at a three-month follow-up, although no significant effects were identified for suicidal ideation, and no longer-term follow-up was conducted.

However, little research has been conducted into the benefits of multi-modal school-based prevention interventions that encompass universal, selected, and indicated approaches, despite tentative evidence

that they may be more effective (Robinson et al., 2018). Indeed, only one study to date is applying rigorous methodology to evaluate the short- and long-term cost-effectiveness of a multi-modal school-based intervention; Byrne et al. (2022) are currently trialling the Multimodal Approach to Preventing Suicide in Schools (MAPSS) project in secondary schools in Melbourne, Australia. MAPSS consists of a psychoeducation session on suicide for all Year 10 students (universal), screening questions to identify students at risk of suicide (selective), and an online cognitive behavioural therapy (CBT) intervention for students who disclose recent suicidal ideation (indicated). While the feasibility trial is ongoing, pilot work examining the safety and acceptability of the online CBT component demonstrated the intervention did not lead to increases in suicidal ideation or distress, and almost all participants reported finding the programme enjoyable and helpful.

The current study

Despite emerging evidence for the effectiveness of school suicide prevention programmes (Gijzen et al., 2022; Walsh, Herring, et al., 2022), there are few being implemented in the United Kingdom, and they have not been rigorously tested. Furthermore, the cultural transferability of interventions cannot be assumed (Wigelsworth et al., 2016); interventions that have worked in one setting or context too often do not work across other settings, particularly in school contexts (Joyce & Cartwright, 2020), given the wide ranging contextual and cultural factors influencing implementation (Chiodo & Kolpin, 2018). Further to this, if an intervention does not have high social validity, meaning that it is not viewed as acceptable, useful, and feasible by intervention deliverers (e.g., school staff) and/or recipients (e.g., pupils), then it is likely to fail (Lendrum & Humphrey, 2012; Wolf, 1978). However, little is currently known in the literature about the views and perceptions of gatekeepers and intended recipients of youth-focused school-based suicide prevention programmes, both in the United Kingdom and globally. Therefore, before any suicide prevention interventions are implemented and trialled in UK schools, the perceived need for and acceptability of such interventions should be established, along with any necessary cultural or contextual adaptations, in order to ensure success.

In light of this, we conducted a scoping study with professionals, parents, and CYP, with an aim of determining perceptions of: (1) the social validity and potential benefits of school suicide prevention interventions, (2) the perceived need for such interventions, and (3) the barriers and facilitators to implementation.

METHOD

Design and setting

This was a qualitative scoping study conducted in North-West England. Semi-structured interviews were conducted with mental health professionals, parents, and school staff, and focus groups were completed with CYP across three secondary schools. Ethical approval for this study was granted via the authors' University Research Ethics Committee (ref: 22/PSY/011) and the Consolidated Criteria for Reporting Qualitative Research (COREQ, see Data S1; Tong et al., 2007) was utilized when describing methods and presenting the findings.

Participants and recruitment

Eight mental health professionals (one man, seven women) and three mothers of children with experience of STBs were recruited via volunteer/opportunity sampling, using adverts shared through emails within existing networks and via social media. Professionals had roles in settings including: Child and

Adolescent Mental Health Services (CAMHS), Local Authority Public Health, NHS Mental Health Support Teams, and General Practice.

Gatekeepers from three state co-educational secondary schools were also recruited via existing contacts and local networks. They were provided with a participant information sheet and were asked to sign and return a consent form to confirm they were happy for their school to participate. Gatekeepers were asked to assist with recruitment of staff via email. A member of the research team (JT) subsequently made contact with those who had expressed interest in participating and provided them with a participant information sheet and opt-in consent form, which they returned via email. Eight members of school staff (four men and four women) were interviewed. Staff had a range of roles including Learning Mentor/Pastoral Support, Head of Year, and Assistant Headteacher.

The gatekeepers were also responsible for organizing the focus groups with CYP and were asked to recruit students from Years 10 to 13. They were advised to recruit students with an appropriate level of maturity who were unlikely to find the research distressing. Gatekeepers were asked to obtain verbal assent from CYP and written opt-in consent from their parents, who were provided with an information sheet and consent form. The researcher then visited the school and provided CYP with a participant information sheet and opt-in assent form prior to the focus groups beginning. Twenty-seven CYP aged between 14 and 17 years (nine boys, 18 girls) took part in four focus groups. Two took place in one school (nine 16- and 17-year-olds in one group, eight 14- and 15-year-olds in a second group), another in the second school (four 14- and 16-year-olds), and one in the third school (six 14- and 15-year olds).

Data collection

Bespoke semi-structured interview schedules were co-produced with professionals, school staff, and parents, through online consultation meetings and iterative rounds of review with the researchers' public advisory group (see Data S1). Interview schedules were designed to act as a guide to ensure specific topics were addressed, while also allowing for unanticipated responses (Galletta, 2013). The first half of the interview schedules focused on general views and perceptions of current support for CYP with STBs, whether and why a school-based suicide prevention programme is needed, how suicide prevention could be delivered in schools, and perceived barriers and facilitators. The second half then provided examples of the types of suicide prevention programmes that exist (including universal psychoeducation workshops and targeted online approaches), and asked for opinions and perceptions regarding the utility of interventions such as these in UK schools. Prompts and probes were utilized to encourage participants to elaborate on answers and clarify unclear responses. One-to-one interviews with mental health professionals, parents, and five members of school staff were conducted remotely via Microsoft Teams, and three members of school staff were interviewed in school. Interviews lasted between 19 and 62 min.

Bespoke semi-structured focus group schedules were also developed for CYP. Question topic areas were similar to those described above and did not require participants to discuss their own experiences of suicidality. To start, the researcher explained the definition of a focus group, outlined confidentiality, and facilitated an 'icebreaker' activity. A PowerPoint presentation was produced to display the questions and examples of programmes, and images and animations were included to help maintain engagement. Focus groups took place in the participants' school setting, consisted of between four and nine students, and lasted between 38 and 57 min. Only the researcher and participants were present.

All interviews and focus groups were conducted by one member of the research team, JT, who was employed as a research assistant for the study. She has received previous training in qualitative research methods, is educated to postgraduate level, and is a qualified secondary school teacher and Children and Young People's Mental Health Practitioner.

Analytic strategy

The audio recordings were transcribed verbatim using the Otter programme (www.otter.ai) and were reviewed and validated by the researchers. Framework analysis was used to analyse the data, as it is particularly suitable for identifying themes within pre-determined over-arching concepts (such as social validity). Analysis took place in NVivo 11 (https://www.qsrinternational.com/nvivo/).

The authors followed Ritchie and Spencer's (1994) five stages of thematic framework analysis: familiarization with the data, identifying a thematic framework, indexing the data, charting the data, and mapping and interpretation. To start, one researcher (JT) familiarized themselves with the dataset. Following discussions with the other two researchers (EA and PS), initial themes and codes were generated to produce a thematic framework. Both inductive and deductive approaches were used, in line with Ritchie and Spencer's (1994) recommendations, which enabled the exploration of a priori elements of social validity (e.g., feasibility, acceptability, and utility; Wolf, 1978) while also allowing emergent themes to be identified. The remaining transcripts were then coded against this framework, and themes were refined and reviewed. An iterative process was utilized, which enabled the continual revision of the thematic framework until final major themes were agreed by the team, ensuring trustworthiness and rigour. Once the final framework was agreed, each theme was defined and interpreted.

RESULTS

Three themes were identified: (1) the need for and importance of suicide prevention in CYP, (2) school as a setting for delivery, and (3) key components of suicide prevention programmes. Table 1 presents these themes and associated subthemes. Participants are referred to as SS (school staff), G (gatekeeper), HP (health professional), or P (parent).

The need for and importance of suicide prevention in CYP

Increasing demand and lack of accessible support available for CYP

Participants expressed that a large number of CYP are considered to be struggling with their mental health and voiced a perceived need for suicide prevention programmes as a result. Several participants indicated that mental health concerns are thought to be "drastically increasing" (SS1) and are starting earlier, with professionals reporting they saw CYP with STBs "most days" (HP6): "suicide attempts are not infrequent in young people… Completed suicides are much more common than we would like them to be" (HP4). Two professionals described it as an "epidemic" (SS2; HP8), and another outlined how rates of self-harm in particular appear to have risen: "I think there's definitely a need for [interventions]… self-harm is a lot more significant than it ever has been, the attempts are a lot more significant." (HP7). A range of influencing factors were proposed, including the COVID-19 pandemic:

TABLE 1 Overview of themes and subthemes.

Theme	Subthemes
The need for and importance of suicide prevention in CYP	• Increasing demand and lack of accessible support available for CYP • Stigma and myths prevail
School as a setting for delivery	• School as an appropriate setting • Challenges with delivering suicide prevention programmes in schools
Key components of suicide prevention programmes	• The content of suicide prevention interventions • Delivery of universal psychoeducation programmes • Delivery of online indicated interventions

"after COVID there was such a lot of students with low mood, anxiety, disengaged, and it was a real shock…In terms of suicide, we've had two." (G1).

Professionals and parents felt that although some services exist, there were not a lot available: "after initial safeguarding… I don't feel like there's an awful lot of support and there's not really an intervention other than just escalating up to CAMHS… which there is then a big waiting list for, even if it's urgent." (HP7). Participants felt these services can also be difficult to access, "there are no clear pathways" (HP1), and waiting lists can be long: "demand is definitely outweighing the supply" (P2). Several participants also noted difficulties around the apparent high thresholds for accessing services:

> [The services] are not efficient at all. They're too hidden and support only comes in when you become someone who's chosen to take their own life by an attempt… The child can display [difficulties] and the family can request support from when it's level one… but until you're a high three or four, nobody steps in.
>
> (P1).

Stigma and myths prevail

All participant groups raised the point that there is still thought to be a stigma around suicide, with many describing it as "taboo". Some participants suggested that even the word 'suicide' carries stigma, with one participant describing it as "a word that people skirt around" (SS2). Thus, participants felt that suicide prevention strategies are "key in normalising some of this stuff" (HP8) and subsequently facilitating support: "we need to… break the taboo around mental distress and normalise the fact that we're all on a continuum somewhere and some people suffer more than others… this sort of work does that really well in a preventative way." (P8).

Participants also suggested there is a common misconception that talking about suicide "might get into the other person's head" (Y11 student). Several participants spoke about other people having this belief, and there was a small minority of participants who appeared to hold this concern themselves. One participant shared how learning that asking about suicide does not increase risk had been helpful in facilitating support for students: "that definitely gave me more confidence… I don't think that I would have asked those questions not having had that conversation" (SS2).

School as a setting for delivery

School as an appropriate setting

Most participants felt that school was a valuable setting as it provides easy access to a large population of CYP, and it enables students to receive support and education regardless of background: "because some parents are like 'oh mental health isn't real, just get on with it, it's not a big deal' then the only place they have is school." (Y10 student). However, there were some concerns about pupils missing out if they do not attend school, and that some CYP might not want their school to be involved: "when we talk to young people in the [doctor's] surgery, often they don't necessarily want to speak to school about issues… they sort of want to keep it private" (HP4). There may also be some logistical challenges when implementing a suicide prevention programme in schools, for example, deciding when and how to fit this into the curriculum, particularly with competing academic priorities: "the only issue you've got there is timetabling, it's kind of well which lessons do they miss? How many days?" (G2).

In terms of the appropriate age to begin introducing suicide prevention, there was mixed feedback from participants, with responses ranging from Year 6 to Year 11 (aged 10–16). The most common answer was to first introduce suicide prevention at Year 7 (aged 11–12), when students have just

transitioned from primary to secondary school. A number of participants suggested that suicide prevention education should be repeated and built upon every year:

> It probably could be a staggered approach so Year 7, Year 9. The transition from year 6 to year 7 is very stressful… It's making sure that those students who are not having those thoughts are aware that their friends might be and what they could do to help… and then as they get older it might be like, 'okay so if this is continuing what other mechanisms could be put in place?' So I would probably consider a staged approach.
>
> (SS1).

Some participants felt that strategies should begin early, to have a preventative effect before difficulties emerge: "[Year 11 is] far too late… behavioural patterns are well and truly embedded. They have… established their personality and how they cope with things… they should be age appropriate." (P1). However, students felt that age did not preclude CYP from having STBs: "just cause they're younger, they still have them thoughts" (Y12 student).

Finally, participants noted the perceived value of increased suicide prevention work in schools given the current heavy reliance on staff to support students with mental health difficulties, despite many lacking formal training, specialist knowledge, or confidence: "I think a lot of them [school staff] would feel very uncomfortable… they all felt like they were really, really out of their depth." (SS4). Participants felt this can increase pressure and emotional demand on school staff: "especially with no mental health training, but you're the triage for it and because the waiting lists have been so long, we end up dealing with it week after week after week which is okay, but then it's our own mental health." (SS1). Some professionals also felt that lack of teacher training can ultimately increase demand on health care services:

> There is a huge need for teachers to have a bit of an understanding around mental health and how to manage these type of thoughts as well, because… it sounds like teachers are burning out because of it. It sounds like teachers are feeling really, really anxious because of it, they don't know what to do… and it does cause unnecessary attendances to A&E.
>
> (HP2).

Challenges with delivering suicide prevention programmes

Participants highlighted several potential barriers that might make the implementation of suicide prevention programmes difficult in schools. For instance, there were potential perceived barriers around cultural and family beliefs, as "people from ethnic backgrounds might not believe in it" (HP2), and there were concerns that this might mean that parents would not allow their children to participate: "there is a fear I think with parents that as soon as we start talking about self-harm and suicide, they're more likely to want to engage in that kind of activity." (G2).

Several CYP also suggested that students may not want to take part in suicide prevention programmes due to concerns around peer reactions: "I mean when… you say 'oh I'm going to a suicide prevention workshop', it sounds like you're like participating because you need that support and it creates stigmas around it." (Y12 student). One parent highlighted the careful consideration needed around the way the programme is 'badged' in order to avoid this: "the more normal it is perceived to be, the more normalised the intervention is, the better in terms of the uptake. And the people who do take part I think they're gonna get less potential ridicule or less grief from their peers" (P2). Furthermore, participants felt that some CYP may find this topic area challenging, especially those who have personally experienced STBs, as well as those who have been bereaved by suicide: "If they've lost someone close to them through suicide obviously is one of the main [barriers] but then also it might be someone who is suicidal themselves or someone who's been suicidal in the past." (HP6).

Neurodiversity was another potential challenge identified regarding delivery, with particular attention drawn to autism and ADHD. In terms of universal approaches, there were concerns that sessions might be too "intense" or "overwhelming" (P1) for neurodivergent individuals or that they "might not understand it properly" (Y10 student). Participants suggested the need for advanced planning when delivering psychoeducation to CYP with additional needs: "before any workshop is done, there needs to be an assessment that takes place to see what the children's capabilities are" (HP2) and some sessions may need to be "adapted" through the provision of "easy read paperwork, things with more pictures or more videos, or some reasonable adjustments… to allow them to understand that the information" (HP4). However, one professional described how vital they thought psychoeducation could be for neurodivergent individuals, if tailored appropriately: "Children with autism are at the highest risk of completing suicide… I think [this] is a huge gap really that could be filled" (HP2). In terms of indicated interventions, all eight professionals mentioned issues with CBT and autism: "Working with a service with autism, CBT doesn't work… and autism's quite prevalent, isn't it? So it's acknowledging that is there something else to offer that student so they're not singled out." (HP1).

Key components of suicide prevention programmes

The content of suicide prevention interventions

When discussing the specific mechanisms that may help with suicide prevention, a large number of participants referred to increased education for CYP, school staff, and parents. This could include greater awareness of warning signs, where to seek support, and how to ask questions around suicidal ideation. Participants felt this would help to normalize the experience of STBs, encourage openness, and promote help-seeking and early intervention. One school staff member described this in relation to a student at their school who had previously died by suicide: "if you think back and if she was aware, if we'd have educated [her], then it may not have come to her taking her own life." (SS1).

In addition to suicidality, participants suggested that CYP may benefit from a greater understanding of mental health generally, as they felt this in turn will reduce suicide risk: "there tends to be a lot more like drug abuse and self-harming… before suicide … if you could counteract those sort of things then obviously you counteract suicide as an effect" (Y12 student). More specifically, participants also felt that education on self-care, coping strategies, and signs and symptoms of mental health difficulties could help to prevent CYP reaching the point of crisis:

> It's around education isn't it of the children themselves, to enable them to identify that there's a problem or a difficulty?… so they might feel sick every morning but they just think that they're feeling physically sick… when actually anxiety is the underlying sort of mechanism.
>
> (HP4).

Participants from all groups agreed that it is important for CYP to be aware of how to support their friends with STBs. CYP noted that they would like to know "how to spot the signs of it" (Y10 student) and professionals felt that peer support was valuable given the tendency of CYP to seek help from their friends: "I think they do sometimes tell their friends about suicidal thoughts and then sometimes their friends don't know what to do… everyone needs to be educated." (HP6). In particular, they felt it would be helpful for CYP to know where to seek advice and support if a friend disclosed STBs:

> One of the things that came out [of a suicide review] was that each of the young people had told a friend… that they were planning, and each of those friends hadn't shared that

> with anyone and they didn't know what to do… So that peer support, that's exactly what is needed.
>
> (HP8).

When discussing the content that should be incorporated into a school suicide prevention programme, numerous suggestions were raised, with coping strategies and help-seeking being the most common: "You can educate them about the importance of resilience and distraction… the importance of future planning… if someone's having suicidal thoughts but they've got goals and dreams to achieve, that reduces the risk of them completing that suicide." (HP2); "I suppose the emphasis would be on about reaching out for help and about how they can access help… if they are in crisis, or before they get to the crisis point" (HP4).

All parent participants suggested that parents would benefit from knowing the information being shared with their child, as well as psychoeducation for parents: "It should be detailing what has been shared with the younger generation and then a section of how you can support as parent" (P1). Participants noted a number of perceived benefits to a parent-specific component, including enhancing their knowledge and understanding "so that they've got the skills to feel equipped and able and confident to support their child if they have… suicidal thoughts and behaviours" (HP7). However, a few participants (mainly school staff) suggested that not all parents would engage in this kind of programme: "unless the parents been through it themselves, I wouldn't necessarily say our parents would take part… unless they're going through it now and thinking they need to understand a little bit more about how their kids feeling" (SS6).

Delivery of universal psychoeducation programmes

The importance of giving pupils choice when delivering universal suicide prevention programmes was highlighted, particularly by CYP, to help increase feelings of control and comfort, and promote engagement. One of the most frequent suggestions was that they should be able to choose who is in their group: "because if you are gonna talk about stuff like that, you'd want the people who you actually know." (Y10 student).

In terms of the delivery of a suicide prevention workshop, participants were very positive about discussions, videos, and case studies. Several participants emphasized the benefits of having a mix of activities (and not just someone talking), and that students could complete some activities in smaller groups to encourage openness: "delivering to the whole group in kind of like a lecture style but then giving them the opportunity to break off into smaller groups and have them group discussions and interactions … I feel like that's the most effective way" (HP7). CYP also felt that workshops need to be interactive and engaging: "[if] it just seems like it's going to be something boring, like something you don't want to listen to… But obviously if you're not struggling it's still good to know in case you are one day, but just don't make it seem like it's a lesson." (Y10 student).

In terms of who should deliver the workshops, there were mixed responses. CYP typically felt that it should not be a teacher, either because "we all know them more personally, it might be more difficult to be open" or due to perceptions that "some teachers just don't care" (Y12 student). The exception to this was "teachers who have good relationships [with students]" (Y12 student). The most popular suggestion was a school "mentor." An established and trusting relationship with the deliverer appeared to be the most important element for CYP, although some did see the value in an external facilitator: "you might feel like you can say more stuff to them because you have to see your teachers every day" (Y10 student).

Delivery of online indicated interventions

Feedback on online delivery for indicated interventions was mixed from all groups, with some participants expressing very positive views, and others preferring face-to-face. However, most participants felt that

having an added option of in-person support with an online component would be most beneficial: "I think it really is a case of case-by-case with that one. What works for one person may not be ideal for the other, so having the two options would probably be the best." (SS3). Suggested benefits of an online intervention included the flexibility to access it as and when needed:

> I think that would be hugely beneficial and it can be done in their own time as well…. It might be 10 o'clock at night and they're sitting there and 'I'm not feeling too good so I'm gonna do the next session'. I think that's a really good, I think that's a positive move.
>
> (SS1).

CYP also thought people may find it easier to write how they are feeling:

> It's sort of easier to open up online, like when you're texting people you're more willing to say stuff because you don't have to face it and you don't have to face the person, look them in the eyes and tell them something that can be really uncomfortable.
>
> (Y10 student).

On the other hand, some participants suggested that an online intervention may feel impersonal. They also noted potential barriers such as access to the Internet and devices, and that some CYP may struggle to engage, particularly if they are experiencing low mood:

> My worry is that it sounds like 'right you've got these suicidal [thoughts]… here, sign up to this and do it yourself in your own time'. And I would worry that that wasn't enough support… Sometimes when we feel low we don't want to sit and examine those thoughts… I would worry about them having to sort of take themselves through that process.
>
> (SS2).

DISCUSSION

The current study aimed to explore professionals', parents', and CYP's perceptions of the social validity and potential benefits of school-based suicide prevention interventions, the perceived need for such interventions, and potential barriers and facilitators. A greater need for a more consistent emphasis on suicide prevention was reported and schools appeared to be an acceptable location for a suicide prevention programme, although there were some barriers that need to be considered. Participants made a range of suggestions and recommendations for the implementation of suicide prevention programmes, summarized in Table 2.

Participants overwhelmingly reported high and rising rates of mental health difficulties among CYP in schools. Compounding this issue was a lack of appropriate support services, long waiting lists with high thresholds for referrals, and inadequate training for school staff. While the issue of poor mental health among CYP and increasing demand on health care services is well-publicized (e.g., NHS Digital, 2022), relatively less emphasis is given to ways of providing alternative avenues for support, for instance, through schools. Although the Government's recent 'Transforming Children and Young People's Mental Health Provision' Green Paper (Department of Health and Social Care [DHSC] & Department for Education [DfE], 2018) stated that every school in the country should have a Designated Senior Lead for Mental Health, and that they would be funding Mental Health Support Teams in schools, there was less focus on whole-school and universal approaches to improving mental health. Indeed, findings from the current study suggest that improving teachers' knowledge and understanding of CYP mental health could help with prevention efforts. Furthermore, enhancing CYP's own understanding of signs and symptoms of mental ill health, as well as knowledge of coping strategies and sources of support, could not only help CYP

TABLE 2 Summary of recommendations.

Recommendation	Description
Schools are an acceptable location	When delivering suicide prevention work to CYP, schools should be considered as a location for this. Implementers should liaise with school staff regarding the logistics of where this can fit in the curriculum. School staff could also help to identify and support specific CYP who may struggle with the programme.
Adaptations may be required	Consideration should be given in terms of how suicide prevention programmes can be tailored for those who are neurodivergent or have a learning disability. For example, resources could be adapted, or additional support could be provided.
The importance of sensitivity	Sensitivity should be applied when offering suicide education to CYP who have personal experience of STBs, or those who have been bereaved by suicide. These young people and their parents may benefit from a conversation with a member of school staff or the research team, and additional support should be offered during and after the programme.
Universal delivery of psychoeducation programmes	Suicide prevention education should be offered to all students and an opt-out procedure should be used to encourage as many CYP to attend as possible. This helps to normalize and break down the taboo. Small group work with friends is preferable.
Confidentiality with indicated interventions	Confidentiality should be maintained to ensure that other students are not aware of who is taking part in an indicated intervention.
Challenging suicide myths	Prior to introducing a suicide prevention programme, efforts should be taken to challenge myths that may prevent engagement, for example, the belief that talking about suicide may increase the risk. Comprehensive information should be provided to school staff, students, and parents to try to reduce stigma and encourage engagement.
Involvement of multiple stakeholders	School staff, CYP, and parents should all be involved in suicide prevention. Training should be offered to each of these groups individually, and targeted support should be offered to CYP with higher suicidal risk.
Introducing discussion about mental health early	Where possible, schools should offer education and support on mental health and suicide and encourage open discussion and help-seeking with regard to this. Education could start from Year 7 and be re-visited and built upon each year.
Promotion of help-seeking and sources of support	All students in school should be aware of how and where to seek help in relation to STBs. Students should also be taught about topics such as self-care and coping strategies. Teaching methods should be interactive and varied.

manage their own mental health, but also help them provide support to their peers, given young people's preferences to seek help from informal sources such as their friends (Radez et al., 2020). However, while many different types of interventions and staff training programmes exist (see, e.g., Mackenzie & Williams, 2018, for overview), there are few that focus on STB prevention specifically. Thus, more work is urgently needed in this area, in order to implement effective and age-appropriate suicide prevention programmes.

As previously noted, schools are often a site for the delivery of mental health interventions, as they are considered a safe environment and offer a universal access point (Calear et al., 2016). Participants in the present study agreed with this sentiment, suggesting that schools are an appropriate location for suicide prevention interventions specifically. However, there were some issues raised that would need to be addressed, in order to ensure the safe delivery of such a programme. The main concern highlighted by professionals and school staff was the appropriateness of both universal psychoeducation programmes and targeted CBT-based programmes for neurodivergent (specifically autistic) CYP. Existing evidence regarding the effectiveness of CBT for autistic individuals is mixed. For instance, several systematic reviews and meta-analyses (Sharma et al., 2021; Wang et al., 2021; Weston et al., 2016) of CBT interventions for autistic individuals have found positive effects on informant-reported, clinician-rated, and task-based outcomes, but not on self-reported outcomes. There are some suggestions that these positive

outcomes reported by informants and clinicians are simply observer-expectancy effects and, in fact, CBT is not effective for autistic individuals (Weston et al., 2016). Indeed, Sharma et al. (2021) highlight how several components of CBT may not be suited to autistic individuals, including the requirement to consider multiple possibilities such as different causes or outcomes in situations, and the need for participants to attend to internal signals such as sensations and emotions, both of which require interoceptive and introspective abilities that can be impacted in autism. However, there is some evidence to suggest that adapted CBT protocols could be effective for autistic youth (see Sharma et al., 2021, for an overview). This may be especially important given the high rates of suicidal crisis among autistic CYP (Ashworth et al., 2022).

Regarding the utility of universal psychoeducation approaches, concerns were raised regarding the potential for distress for CYP with a history of STBs or for those who have been bereaved by suicide. This highlights the importance of taking into account individual needs and circumstances when developing interventions, providing appropriate adaptations, and consulting with CYP with lived experience throughout. Furthermore, some participants expressed concern that stigma or myths surrounding suicide may be a barrier to participation. This could be at the familial level, with parents not allowing their child to take part due to cultural reasons or fear that talking about suicide may cause their child to develop STBs. It could also be at the individual level, with CYP not engaging if they feel that doing so will result in them being stigmatized by their peers. Indeed, cultural and familial stigma can still be an issue in terms of suicide prevention and mental health generally (Hawton et al., 2012; Kaushik et al., 2016), despite evidence to suggest that talking about suicide with CYP does not increase the risk (Dazzi et al., 2014). It is thus vital that suicide psychoeducation programmes include addressing myths and overcoming stigma as a core component, and that schools work with parents in order to ensure the participation of all children. Programmes including a parent psychoeducation component (e.g., Shucksmith et al., 2010) could aid with this.

Furthermore, participants suggested that suicide prevention programmes should include education around warning signs, where and how to seek support, how to ask questions about suicidal ideation, and how to support peers experiencing STBs. Additionally, CYP may benefit from a greater understanding of mental health generally, as this can in turn help to reduce suicide risk. Suggestions included covering topics such as self-care and coping strategies, drug and alcohol misuse, help-seeking, and signs and symptoms of mental health conditions. Indeed, there is evidence to suggest that promoting mental health literacy can help to improve symptoms of mental ill health (Kutcher et al., 2016).

In terms of delivery, CYP expressed a preference to be in groups with trusted peers and emphasized that it should not feel like another 'lesson'. Participants also felt that while there was no 'perfect age' to begin suicide prevention work, that timing it around the transition from primary to secondary school would be a good starting point. Some suggested that this should follow an age-appropriate stepped or staggered approach; a 'lighter touch' could be used in the earlier years of schooling to promote coping strategies and self-care, with this being built upon as the students mature and are able to handle more serious content. This may help to normalize discussions about suicide and encourage openness around the topic (Stephan et al., 2007).

Limitations

While the current study provides novel insights into the social validity of and perceived need for suicide prevention programmes in UK schools, there are some limitations that need to be addressed. Firstly, participants were all recruited from one county in England, and so experiences may not be transferable to schools and services in other areas. Secondly, participants were provided with examples of the types of suicide prevention programmes that exist during the second half of the interviews, which may have limited their ideas of what a possible programme could look like. Thirdly, while a wide range of professionals were included in the study, this may have provided a broad overview of experiences in the field as opposed to a detailed and nuanced insight into the issues specific to each vocation. Similarly,

most of the school staff had additional administrative roles and so their views may differ from those who are solely class teachers. Finally, as the recruitment strategy for this study largely relied on volunteer sampling, it may be that the professionals and schools who took part were those who already had an interest in or personal experience of STBs in CYP. Thus, the themes identified here may not necessarily be representative of all professionals' and CYP's experiences of suicide prevention in education and other health care settings.

CONCLUSIONS

The current scoping study aimed to explore professionals', parents', and young people's perceptions, including the social validity and potential benefits, of school-based suicide prevention interventions. Participants articulated a clear and urgent need for a greater and more consistent emphasis on suicide prevention in UK schools. Secondary schools were considered to be a feasible setting for delivery, whereby age-appropriate content could be delivered, re-visited, and built upon as CYP mature. Participants felt that both universal and indicated elements were important; a suicide literacy or 'curriculum-style' approach would ensure that *all* CYP access the vital knowledge and skills needed to not only help manage their own mental health, but also to reduce the likelihood of STBs in their peers. Further work and investment are needed to establish the most appropriate and effective interventions that could be implemented.

AUTHOR CONTRIBUTIONS

Emma Ashworth: Conceptualization; investigation; funding acquisition; writing – original draft; methodology; formal analysis; project administration; data curation. **Joniece Thompson:** Investigation; writing – original draft; formal analysis; resources; data curation. **Pooja Saini:** Funding acquisition; conceptualization; writing – review and editing; methodology; formal analysis.

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CONFLICT OF INTEREST STATEMENT

The authors declare they have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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