



Factors Affecting the Implementation of a School-Based Suicide Prevention Intervention in the UK: A Qualitative Study of the MAPSS Program

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Abstract

Suicide is the leading cause of death among young people (YP) in the UK, yet few school-based prevention programs have been tested in real-world settings. Guided by international best practice, this study qualitatively explored experiences of implementing a Multi-modal Approach to Preventing Suicide in Schools (MAPSS), to understand workshop facilitators, school staff, and YP's experiences, perceived value and contextual factors influencing adoption and delivery. Qualitative data were collected through semi-structured interviews with YP (N=6), school staff (N=10), and workshop facilitators (N=2). Focus groups were also conducted with YP (N=25) following participation in the suicide prevention workshop. Thematic framework analysis was used to analyse the data. Findings were explored in relation to barriers and facilitators to implementation across multiple levels: classroom/individual, school, intervention and wider community. Themes included engagement, accessibility and relatability; implementation challenges; risk and responsibility; program design and engagement; and building awareness for early intervention and stigma. MAPSS was perceived as acceptable, safe, beneficial and feasible in school settings, though logistical challenges remain. Insights from multiple stakeholders highlight important considerations for refining and scaling school-based suicide prevention programs in the UK.

Keywords Suicide prevention · Schools · Multi-modal · Qualitative

Introduction

Suicide is the leading cause of death among young people (YP; aged 10–24 years) in England, with suicide rates increasing steadily over the past decade, including among younger adolescents aged 10 to 14 years (Office for National Statistics [ONS], 2022). Evidence from national surveys further highlights the scale of the problem, with around one quarter of 11–16-year-olds with a mental disorder reporting having self-harmed or attempted suicide (Royal College of Paediatrics and Child Health [RCPCH], 2020). Beyond this impact, the death of one YP aged 10–14 costs the UK economy at least £2.85 million (Samaritans, 2024) and has profound psychological effects for the YP's family, peers and wider community, increasing their risk of suicide (Robinson et al., 2018). Early intervention, defined as the timely identification and support of YP, is, therefore, essential to suicide prevention. By facilitating earlier access to appropriate support, early intervention has the potential to reduce

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suicide risk and improve longer-term mental health outcomes (McGorry & Mei, 2018).

Schools offer a unique and critical setting for suicide prevention, given their structured environment, daily contact with YP, and wide reach (Krantz et al., 2024; Miller et al., 2009). Although there has historically been hesitation to address suicide directly with YP, growing evidence indicates that such interventions are safe and can be beneficial (Brent & Brown, 2015; Hughes et al., 2023). This shift is reflected in UK policy, including the Suicide Prevention Strategy for England (Department of Health and Social Care [DHSC], 2023), which calls for school involvement in local prevention plans. Similarly, the new statutory Relationships, Sex and Health Education (RSHE) curriculum (Department for Education [DfE], 2025) now states high schools should consider how to safely address suicide. However, while guidance highlights the need for sensitive and safe delivery, it does not state an explicit evidence-based program or mechanisms to ensure safety. This may lead to variability in how suicide prevention content is implemented across schools, depending on staff confidence, local priorities and available resources (Nadeem et al., 2025; Walsh et al., 2023).

Importance of Implementation

The success of school-based interventions relies not only on program content but also on how effectively it is carried out (Durlak, 2020). Implementation, defined as "the process by which an intervention is put into practice" (Lendrum & Humphrey, 2012, p.635), is typically assessed through three dimensions: fidelity, or the degree to which the intervention is delivered as intended; quality, referring to how well its various components are executed; and dosage, which captures the amount of the program that participants actually receive (Durlak & DuPre, 2008). However, research consistently shows that interventions are seldom delivered exactly as intended, and that variation in implementation can significantly influence their outcomes (Lendrum & Humphrey, 2012).

Implementation is shaped by a range of interacting factors operating across multiple levels. Evidence indicates that stronger implementation, particularly in relation to fidelity and dosage, is associated with more positive intervention outcomes (Ashworth et al., 2020; Carroll et al., 2007; Combs et al., 2022). For example, Durlak and DuPre (2008) conducted a meta-analysis of 542 prevention programs and found that implementation quality was significantly associated with intervention effectiveness, with programs delivered with higher fidelity demonstrating stronger outcomes than those implemented less consistently. Similarly, Carroll et al., (2007) developed a conceptual framework of implementation, highlighting the importance of factors such

as adherence, exposure, quality of delivery, and participant responsiveness in determining whether interventions achieved their intended effects. Wider ecological influences, such as classroom climate, peer relations, school-level logistics, competing priorities, and broader community attitudes can further enable or constrain implementation (Greenberg et al., 2005).

Although school-based intervention research has demonstrated promising effects, much of the existing effectiveness evidence has been generated under researcher-supported or controlled conditions, where training, monitoring, and implementation resources may exceed those available in routine school practice (Durlak & DuPre, 2008). Consequently, it remains unclear whether these programs can be delivered with comparable quality and achieve similar outcomes when implemented under everyday school conditions. Addressing this evidence gap is particularly important for school-based suicide prevention programs, where inconsistent implementation may not only diminish program benefits but also compromise the timely identification and support of students (Kuiper et al., 2019). Therefore, implementation research represents a critical next step in understanding how school-based suicide prevention programs can be delivered safely, effectively, and sustainably in real-world contexts (McCarthy et al., 2025).

School-Based Suicide Prevention Programs

Despite issues with implementation, a growing body of evidence highlights the potential effectiveness of school-based suicide prevention interventions. A meta-analysis by Brann et al., (2021) reported improvements in suicide-related knowledge, reductions in suicidal thoughts and behaviors, and increased help-seeking among students across screening, gatekeeper and multi-component interventions. These findings are supported by individual program evaluations. For example, Aseltine et al., (2007) evaluated the universal Signs of Suicide (SOS) program using a randomised controlled trial with high school students. Students receiving the intervention demonstrated improved knowledge about depression and suicide, more adaptive attitudes towards mental health, and lower rates of suicide attempts compared with students who did not receive the program. Similarly, Gijzen et al., (2022) found significant reductions in suicidal thoughts and behaviors three months after program delivery for universal programs through a meta-analysis of 11 studies.

Evidence also supports the effectiveness of gatekeeper training. Gould et al., (2013) demonstrated that counselors trained in Applied Suicide Intervention Skills Training (ASIST) achieved better outcomes for callers to a National Suicide Prevention Lifeline, who reported feeling less

depressed, suicidal and overwhelmed. Likewise, evaluations of the Question, Persuade, Refer (QPR) program have shown sustained improvements in suicide prevention knowledge, self-efficacy and help-giving behaviors among school staff and parents (Litteken & Sale, 2018), while more recent findings indicate that gatekeeper training can improve preparedness to respond to young people at risk of suicide, with particularly strong long-term retention among participants with lower levels of initial education on the topic (Mueller-Willians et al., 2023).

Yet, school-based interventions differ widely in scope, format, duration and target populations, with few adopting a comprehensive multi-level design. According to World Health Organisation [WHO] guidance (2018), best practice in suicide prevention in schools should integrate universal (delivered to a whole population), selective (for those with increased risk), and indicated (for those already experiencing suicidal thoughts or behaviors) approaches. One example of such integrated approaches is the Saving and Empowering Young Lives in Europe (SEYLE) project (Wasserman et al., 2015), a large-scale, multi-country study, which demonstrated that school-based interventions can reduce suicidal ideation and attempts among adolescents. Despite these advances, there remains limited research evaluating multi-modal approaches. One notable exception is Byrne et al., (2022), who examined such an approach in Australian high schools, underscoring the urgent need for similar evaluations in the UK context.

The Current Study

The Multimodal Approach to Preventing Suicide in Schools (MAPSS), is a school-based program aimed at reducing suicide risk and increasing help-seeking among high school students. MAPSS consists of three parts: a universal suicide prevention workshop for all students (delivered by an external professional), risk screening to identify those experiencing suicidal thoughts, and targeted online cognitive behavioral therapy (CBT; ‘Reframe IT-UK’) for those deemed as high-risk for suicidal ideation (see Ashworth et al., 2024a for further details). Training is also provided for up to six school staff per school and all parents of YP receiving MAPSS.

Despite growing evidence that schools are safe and effective settings for suicide prevention, most research to date has focused on outcomes (e.g., changes in knowledge, attitudes or suicidal ideation) rather than the implementation processes that determine whether and how such programs can be adopted and sustained. Very little is known about how schools navigate the delivery of more complex, multi-component models, like MAPSS, particularly in the UK policy and education landscape. Understanding these

processes is essential to identify the conditions under which MAPSS can be feasibly embedded at scale.

The current study forms part of the wider UK-based feasibility cluster-randomised controlled trial of MAPSS (Ashworth et al., 2024a). The primary aims of the feasibility trial were to evaluate the acceptability, safety, social validity and feasibility of delivering MAPSS within UK high schools, alongside preliminary assessment of changes in mental health and wellbeing outcomes to inform the design of future trials (Ashworth et al., 2024a). The present qualitative study represents the implementation component of the program, providing a detailed examination of stakeholders’ experiences of delivering and receiving MAPSS across multiple schools. By reporting the implementation-focused qualitative component separately, the current study extends the findings of the wider feasibility trial to explore the mechanisms and contextual factors that may influence future adoption, sustainability and scale-up of MAPSS.

Accordingly, the current paper explores the perspectives of workshop facilitators, school staff and YP, addressing a key gap in the literature around the real-world implementation experiences, perceived value, and contextual factors influencing adoption and delivery of school-based suicide prevention programs. Specifically, it addresses the following research questions:

1. How do key stakeholders (school staff, workshop facilitators and YP) perceive the value, acceptability, and feasibility of MAPSS?
2. What are the barriers and facilitators to implementation in a UK high school context?

Methods

MAPSS Intervention

A suicide alertness training workshop, ‘Breaking the Silence’, is a single 3-hour psychoeducation lesson developed and tested with YP. The universal workshop is designed to help YP understand suicide warning signs in themselves and others, gain knowledge about sources of support and signpost others. This session is delivered by trained professionals from Grassroots Suicide Prevention (a national charity) to classroom-sized groups of around 30 students per session (with at least one teacher present).

Screening took place in the form of self-report measures embedded into trial outcome questionnaires at each time-point (baseline, post-workshop, post-Reframe IT-UK, and 1-year follow-up). Using the Suicidal Ideation Attributes Scale (van Spijker et al., 2014) (SIDAS; a score of 21 or above), as well as the final question on the Patient Health

Questionnaire (Kroenke et al., 2001) (PHQ-9: ‘Thoughts that you would be better off dead, or of hurting yourself’) students were flagged by the research team and followed up by the school safeguarding lead.

Reframe IT-UK was offered to all YP identified as at-risk in the screening. It comprises eight 20-minute online self-guided cognitive behavioral therapy (CBT) modules. Modules include video diaries of two YP in their day-to-day life and their experiences of feeling suicidal, with each module containing two activities based on standard CBT exercises. Users progress sequentially through the content, with modules automatically unlocking when the preceding module is complete. There is also a message board where participants can communicate with a moderator (study researcher), a mood diary function in which participants state whether they have ‘no, mild, or severe suicidal thoughts at the start and end of the session, as well as an information page on local and national helplines and services.

Design and Setting

Data for the current study were collected as part of a qualitative implementation and process evaluation conducted within a cluster-randomised controlled trial of MAPSS for Year 10 students (aged 14–15 years; equivalent of 9th Grade in the USA) across six high schools (four intervention, two control) in North-West England (Ashworth et al., 2024a). The process evaluation was guided by the Medical Research Council (MRC) Framework for Process Evaluations of Complex Interventions (Moore et al., 2015), which emphasises understanding the implementation, mechanisms of impact and contextual factors influencing intervention delivery. Focus groups with YP in the intervention schools, as well as interviews with workshop facilitators took place following the workshop delivery. Interviews with YP were arranged for 12-weeks post-baseline, to ensure students could reflect on their experiences of using Reframe IT-UK. Interviews with school staff from both intervention and control schools occurred throughout the course of the program. Ethical approval was granted via the authors’ University Research Ethics Committee (ref: 23/PSY/003). Qualitative data were collected through semi-structured interviews with school staff and workshop facilitators. Interviews (for students participating in Reframe IT-UK) and focus groups (after the suicide prevention workshop) were also conducted with YP.

Participants and Recruitment

Six high schools were recruited (four intervention, two control) within the North West of England, covering a mixture of urban and rural contexts across Merseyside and Cheshire.

The two control schools were located in Cheshire, providing a socio-demographically comparable cohort. Based on 24/25 data, England mainstream high schools on average have 13.4% of pupils with special educational needs (SEN) support, 19.2% of pupils who first language is not English and 28.9% of pupils eligible for free school meals at any time during the past 6 years. For the recruited schools, pupils with SEN support ranged from 6.94% to 18%, pupils who first language is not English (2.3% – 13.6%) and of pupils eligible for free school meals ranged from 17.18% to 37.57%.

Ten school staff (three male, seven female) participated in semi-structured interviews. School staff roles included: Mental Health Lead ($n=4$), Medical and Wellbeing Officer ($n=1$), Head of Year 10 ($n=2$), Head of Personal, Social and Health Education (PSHE; $n=1$), Assistant Head Teacher ($n=1$) and Teaching Assistant ($n=1$). Of these, seven were staff within the intervention schools and three from control schools. School staff were recruited opportunistically by a member of the research team (MM) who contacted them via email. Participants were provided with a participant information sheet and an opt-in consent form. Staff were given the option to complete the interview either online via Microsoft Teams or in-person at their school. Six interviews were conducted online, and four took place in-person.

School staff were responsible for organising the focus groups and one-to-one interviews with YP. Staff were asked to obtain verbal assent from the YP and written opt-in consent from their parents, who were provided with an information sheet and consent form. The researchers (MM, SW) then visited the school and provided YP with a YP-specific information sheet and opt-in assent form prior to the interview/focus group. Twenty-five YP (aged 14–15 years) took part in four focus groups, one in each of the four intervention schools. Six further YP who had received Reframe IT-UK took part in one-to-one interviews. Online interviews were also conducted with the two external facilitators who delivered the workshops in schools.

Data Collection

Bespoke semi-structured interview schedules were developed with input from professionals, school staff and parents, through online consultation meetings and iterative reviews with the researchers’ public advisory group. Interviews with school staff explored their experiences and perspectives of the implementation of MAPSS. Topics included staff roles, pre-existing mental health provision, motivations for participation and barriers and facilitators to implementation. Interviews lasted between 26 and 47 min ($Mean=35$ min). Six interviews with school staff were conducted in-person, while four were conducted online via Microsoft Teams.

Bespoke schedules were also developed for interviews and focus groups with YP. The topic areas were similar to those described above and did not require participants to discuss their own experiences of suicidality. Focus groups and interviews took place in the participants' school. Focus groups lasted between 19 and 38 min ($M=27$ min), while interviews ranged from 7 to 33 min ($M=14$ min).

All interviews and focus groups were audio recorded and transcribed verbatim. In-person interviews and focus groups were transcribed using Otter (www.otter.ai), while four online staff interviews and two workshop facilitators interviews conducted via Microsoft Teams used the platform's automatic transcription function. All transcripts were subsequently reviewed against the original audio recordings by MM and SW to correct transcription errors, ensure accuracy and completeness, and remove any potentially identifiable information prior to the analysis.

Analytic Strategy

Thematic framework analysis was used to analyse the data, as it is suitable for identifying themes within pre-determined over-arching concepts, for example barriers to implementation. The authors followed Ritchie and Spencer's (1994) five stages: familiarisation, identifying a thematic framework, indexing (coding), charting the data into a framework matrix, mapping and interpretation.

To start, one researcher (MM) familiarised themselves with the dataset. Following discussions with the other researchers (EA, SW, LS 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. Data from each participant group (YP, school staff, workshop facilitators) were initially analysed separately to capture distinct experiences and perspectives of each stakeholder group. Subsequently, the thematic frameworks were compared and synthesised to identify areas of convergence and divergence, particularly regarding perceived value, barriers and facilitators to implementation. Themes were then refined and reviewed through an iterative and reflective process to ensure rigour.

Findings

Using a multi-level ecological framework (e.g., Durlak & DuPre, 2008; Greenberg et al., 2005), findings were explored in relation to barriers and facilitators to implementation at different levels within the school setting. All themes span across levels of the model, with individual factors often interacting with school-level barriers and facilitators. For

example, Program Design and Engagement reflect factors at an individual (student, staff, workshop facilitators), organisational (school culture, resources), and broader systems level (policy and community support). Figure 1 illustrates these barriers and facilitators, demonstrating the connections between them, as well as how they operate across different levels of the framework. Participants are referred to as SS (school staff), facilitator (F) and young people (YP).

Program Design and Engagement of the Workshops and Surveys

Across participants, interactive and engaging delivery was a key facilitator to supporting MAPSS. Workshop facilitators highlighted the value of group work, and utilising flip charts to get the YP moving and chatting: *"I use flipchart resources, post-it notes, whiteboards...we really need to facilitate that discussion, because it's a really difficult topic."* (F2). Staff agreed, noting that interactive tools and phone-based feedback allowed for the *"quiet"* and *"shy"* students to also involved (SS1). Videos were also described as powerful for capturing YP attention: *"They went very quiet when they were watching...short bursts that stuck in their minds"* (SS2).

Workshops were also reported to increase both student and staff confidence in recognising and responding to concerns. Some YP disclosed feeling worried about friends as a direct result, which staff felt gave *"weight"* to their pastoral conversations (SS1). YP also left with a stronger knowledge and awareness of the signs, importance, how to support friends and the language to use. For example, one YP stated facts such as *"suicide is the biggest killer of YP...especially with men"* (YP1; FG). They valued the *"comfortable and relaxed"* atmosphere, the length and timing within the school day, and the presence of an external facilitator rather than a teacher (YP5; FG).

Although overall engagement with MAPSS was described positively, participants highlighted several barriers at the classroom and intervention levels that shaped how sessions were received. These related to classroom dynamics, accessibility of materials, and the relatability of program content. Both staff and YP noted that behavioral disruptions sometimes hindered the delivery of the workshops: *"Session two, we had a bit of an issue with behavior."* (SS1). For YP, difficulties with engagement were linked to the social dynamics of the session. Several described how being in large groups with peers they did not typically speak to created discomfort, especially when discussing sensitive topics like suicide: *"My best friend's in the form so I was just talking to her, but I didn't know anyone else, so it was a bit awkward when you're being asked to talk about suicide and self-harm"* (YP24; FG). A small number of female YP

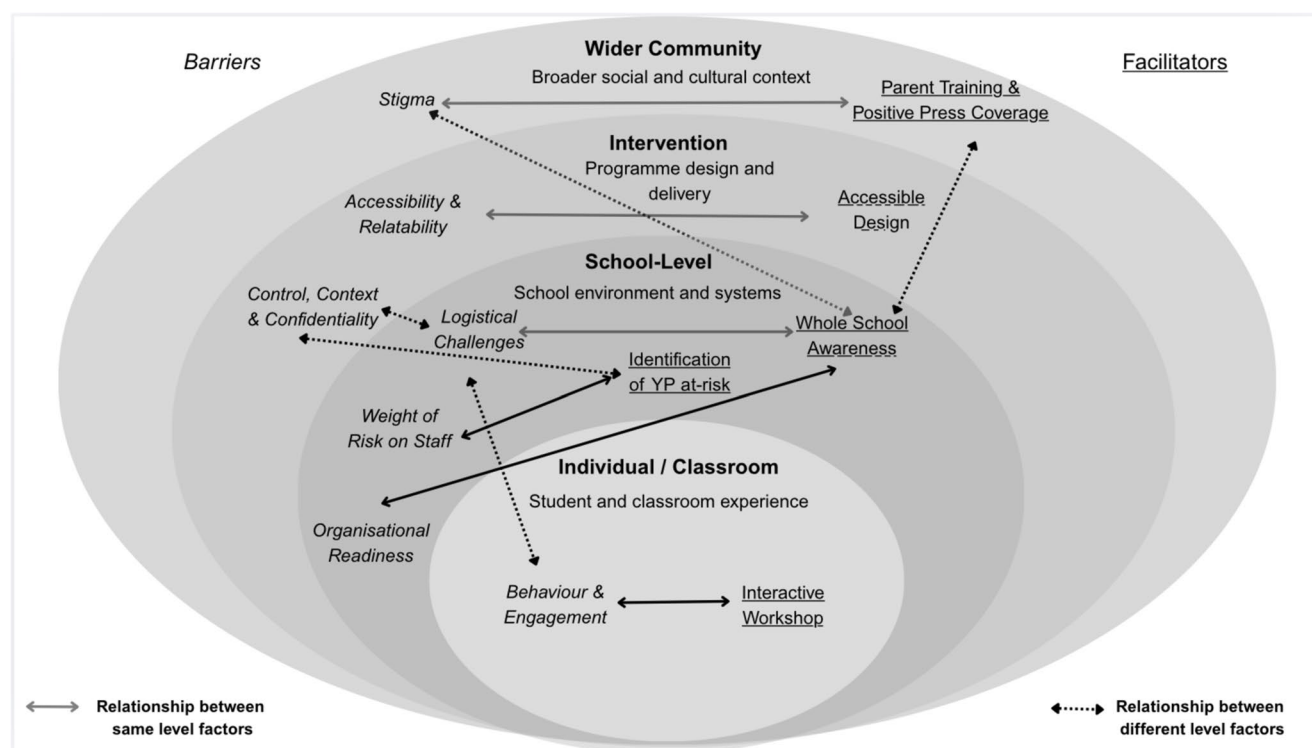


Fig. 1 Multi-level ecological framework of barriers and facilitators

also noted the challenges of mixed-gender groups, which made it harder for them to express themselves freely: “I feel like, I mean they probably couldn’t do it but, because you have like girls and boys, it’s more awkward if you had something to say and there’s all lads there.” (YP23; FG). This discomfort with group dynamics also meant that some students ended up “following the crowd” and disengaging, rather than engaging authentically (YP23; FG).

Staff and facilitators emphasised the importance of adapting sessions to meet diverse learning and behavioral needs, including ADHD and autism: “it’s managing behavior and accessibility... making sure whatever you’re delivering gives different options for people to access the materials in the most effective way for them.” (F1). Accessibility issues were also evident in the screening survey, which some YP found long and tedious. Neurodivergent students also struggled with scale-based questions: “I really struggle with that sort of thing...sometimes it feels like a yes or no...” (YP7; FG). This was mirrored by school staff who discussed how having a longer timeframe for students to complete the surveys would be beneficial: “I think for some students, especially those with autism and ADHD, they need a bit of time to complete that questionnaire.” (SS6). Language accessibility was also flagged as a barrier to engagement, with some students expressing that complex or adult-centric wording in both the survey and workshops created confusion: “Some of the wording could be quite complicated... I

couldn’t even read them, I had to ask Miss to read them out for me.” (YP2; FG).

Usability and Relatability of Reframe IT-UK

Reframe IT-UK was positively received for its accessibility and ease of use, enabling independent navigation. YP described session as “easy to understand” and “beneficial” (YP3), with many reporting tangible changes in coping, self-regulation and classroom behavior: “I haven’t intentionally hurt myself since starting Reframe IT-UK” (YP6). Other factors students discussed positively were: “small group sizes”, “knowing friends were beside them”, and “doing the sessions during school hours” (YP2). Knowing the “actors would do refreshers” also allowed students to feel up to date with content, allowing for good knowledge at the end of the 8-week period (YP2).

Despite this, barriers to relatability of content were also discussed by YP in relation to Reframe IT-UK, which consisted of video diaries of other YP describing their difficulties. While some students found scenarios about friendship difficulties relatable, others felt certain topics did not reflect their lived experience: “The friend one was relatable...But the other one, his dad was an alcoholic and abusive and I didn’t really find that relatable at all...” (YP6). Students recommended including more common and pressing issues for YP, like bullying, especially cyberbullying, which some

YP identified as a trigger for poor mental health: *“We’ve all got social media, and now it’s not even like you can escape the bullying at home, because it still continues online.”* (YP6).

Logistical and Practical Challenges

Despite schools’ willingness to take part in MAPSS, a number of logistical and organisational barriers at the school level that impacted on the smooth delivery. These challenges, often largely out of individual staff and facilitators’ control, emerged as a significant source of disruption and stress.

Technology was one of the most frequently cited challenges, with problems with sound, Wi-Fi connectivity and hardware interrupting session flow: *“in one school the room that was available was the assembly hall so I had to walk back and forth to the back of the hall at kind of pivotal moments, I’d have to pause the video, a really tough place emotionally and then I’d have to disappear to the back of the hall to sort of stop the clip and play the next slide.”* (F2). This was echoed by school staff, who also reported limited IT infrastructure as a key concern: *“The biggest issue is always technology. We don’t have a massive amount of IT suites and iPads, and we are also starting to have an increased problem in terms of YP getting onto the Wi-Fi.”* (SS1). Room availability and scheduling added further strain, especially during exam periods, sometimes resulting in less-than-ideal locations for MAPSS delivery, without stable internet access. In addition to space constraints, variations in school calendars also impacted the delivery of components like Reframe IT-UK, which required engagement over an 8-week period: *“Because we had half term, I didn’t do it [Reframe IT-UK] for like a week or two.”* (YP6).

While logistical challenges created practical obstacles for implementation, deeper structural and staffing issues also acted as a barrier. Many schools relied heavily on a single staff member to coordinate MAPSS, creating stress and leaving the program vulnerable to staff illness or competing responsibilities: *“Because it was just me... I’m like ringing parents on my day off”* (SS1). Staff noted that shared responsibility or a small implementation team would have eased delivery:

“if we had a team of people, like a little committee or group, it would be different. But when it’s just the one person trying to get it pushed through when you’re waiting for other people to give their approval, that’s when it gets tricky.” (SS4).

In addition to the challenges posed by individual workloads, school hierarchies also influenced the ease with which

MAPSS could be implemented. Difficulties arose both when junior staff attempted to move forward without senior leadership buy-in, and conversely, when senior leaders agreed to the program without securing buy-in from key operational staff (e.g., pastoral team) who were integral to its delivery. The success of MAPSS also relied on the involvement of many different school staff, for example form tutors. While these staff members were not always directly involved in the program; their support was essential. However, schools noted variation in confidence and commitment across these roles. For example, one senior leader explained: *“There is a dichotomy, not only in expertise and experience with the pastoral stuff, but competence and actually confidence as well.”* (SS8).

Risk and Responsibility

As discussed above, schools often had a single designated MAPSS lead, which meant that one individual had to identify the YP at-risk, speak with students, contact parents, and ensure safeguarding protocols were followed. When a high number of students were identified as at-risk, this added additional pressure to a staff member’s working day, which was already filled with full-time teaching hours: *“Well for me to do it alone was a lot, after the first survey I had to call home for nearly 30 girls”* (SS4). Staff described this responsibility as extending beyond the practical demands of follow-up, with the emotional weight of responding to students identified as at risk also contributing to feelings of pressure, worry and emotional burden: *“I just think imagine if the student has said something and we hadn’t rung home and then we get a phone call the next day to say they’d attempted [suicide]”* (SS10).

Staff consequently highlighted the importance of shared responsibility and adequate support when managing risk. The majority of staff expressed a preference for greater staff involvement to distribute the workload: *“I’ve been able to share it [workload] with the whole safeguarding team as well because we’ve really extended the team now, we’ve got nine members, and we all meet every week.”* (SS10). Others highlighted the value of supervision and preparation before engaging with students at risk, with access to safety planning resources providing reassurance: *“[Supervisor name] was able to send me over like a booklet and some different safety plans. So, I suppose for me it just kind of put my mind at ease a little bit.”* (SS4). The staff member also suggested that supervision before Time 1 sessions and guidance on how to initiate difficult conversations could help less experienced staff feel more prepared.

Nevertheless, the emotional weight of safeguarding responsibilities was also particularly evident in relation to Reframe IT-UK. Although designed to be completed

independently by the YP, the lack of real-time visibility for the mood check-ins created anxiety among staff, especially when they had no immediate insight into how students were feeling once the session ended:

“Because the sessions take about 25 minutes, as soon as they’re done, I’m like, ‘OK bye off to lesson see you later’ and actually some of our YP have been moderate and severe risk and I’ve just sent them to maths.” (SS1).

For YP, the way risk was managed also had unintended consequences. In schools where a senior leader, such as Deputy Headteacher, was the main MAPSS contact responsible for follow-up, some YP perceived the check-ins as disciplinary rather than supportive, in which students noted feeling “in trouble” for having to speak to this member of staff and disclose any suicidal thoughts or behaviors:

“It just feels like you’re getting punished. You get pulled out of lesson by X [Deputy Headteacher]. It doesn’t feel like you’re being rewarded for being honest, it doesn’t feel like you’re getting help, it just feels like you’re in trouble.” (YP4; FG).

The screening survey itself posed additional challenges. Central to these concerns was the issue of teacher control, with staff noting many teachers felt uneasy answering questions around the topic, without planning the content of the survey themselves. One staff member explained: *“It sets teachers nerves on edge.”* (SS6). Although some staff did note that having researchers attend the school at the time of survey completion helped to alleviate some of this stress. Staff across multiple schools also praised the efficiency of administering online surveys for screening, particularly with support by the research team. The use of QR codes was highlighted as a facilitator to implementation: *“Sharing out the QR codes made it a lot easier, in that short amount of time in form, it was much slicker.”* (SS2), as well as the use of phones to provide privacy for students: *“I think they’ve been more inclined to be honest if they’re doing it on their phones.”* (SS10). This view was also mirrored by YP who discussed having the ability to turn their screen away from peers and dim their screen brightness, helped them to respond honestly.

The inconsistency in when and where surveys were completed was also discussed as a barrier. Surveys were delivered in a variety of contexts, e.g., form time, PSHE lesson, assembly, with many schools retrospectively preferring the option they had not chosen, suggesting a persistent uncertainty about the ‘best’ environment. Anonymity and setting were also key concerns for students, who often felt exposed

completing surveys in the presence of peers. In large assembly halls or even small form groups, some feared of peers looking over their shoulder and being judged: *“I do think it’s a bit awkward because I’m sat next to my friends. So, if you put something, it’s almost like everyone’s going to know.”* (YP23; FG).

YP also discussed the fear of being flagged and identified as at-risk from survey completion, especially in environments where they lacked trust in the school safeguarding team. One student noted: *“You say something and next thing you’re in [safeguarding hub], and I don’t want to speak to them.”* (YP23; FG). At times, students even submitted fake responses, for example using friends’ details, which created follow-up difficulties for schools, particularly when high-risk indicators could not be traced back to a specific student: *“I think is the anonymity around completing the survey, we did have a lot of false positives...we also had another few situations where some students had used their mate’s details.”* (SS8). Instead, YP expressed a preference for confiding in a “safe teacher”, who is not necessarily part of the safeguarding team, friends or family.

Positive Perceptions, Early Identification and Reducing Stigma, on Implementation

Despite the noted risk above, a substantial benefit of MAPSS was its ability to identify students at risk of suicidal thoughts and/or behaviors who were previously unknown to school staff: *“I didn’t even know the YP that come up, I’d never even seen them before, I had to actually search their name and look for their picture.”* (SS1). This unexpected identification of previously “invisible” students was recognised as one of the most valuable aspects of the program. Without MAPSS, many feared these students would have gone “under the radar” and that *“they would have never been picked up on”* (SS2). Interestingly, all staff across the schools noted how these students were seen to be “introverted”, “quiet” and “undisruptive” (SS1; SS3). In some cases, MAPSS revealed other serious safeguarding issues that would have otherwise gone unnoticed:

“One of the Year 10 [students] never sought out pastoral support ever, wasn’t on anyone’s radar, and it actually transpired that they’d been [assaulted] six months before completing the survey...we wouldn’t have known had it not been for the MAPSS survey.” (SS8).

From the perspective of YP, the process was also seen as an opportunity to reach out for support in school. The programs allowed students to *“have a voice”*, *“without feeling judged”* or *“pressured into talking”* (YP6, YP8; FG).

Alongside identification, MAPSS contributed to whole-school awareness and staff capability and knowledge. Most staff noted that no formal suicide prevention training was available in their schools, with MAPSS being viewed as a significant and much-needed intervention that filled this gap. Staff described the experience as both education and empowering, enabling them to feel more confident in addressing suicide and self-harm with YP: “The training gave us the confidence in those questions with the kids, about being objectively clear and leaving no room for ambiguity.” (SS3). Crucially, training was not limited to pastoral leads; involving staff across departments helped to normalize discussion:

“It was powerful because we had curriculum leads going back to their departments talking about the training... This random maths teacher is talking about it, and I think that was really powerful.” (SS8).

However, stigma remained a barrier, with many describing the topic as “taboo”. Staff frequently cited stigma as a key reason why some parents opted their child out of participating in MAPSS, with some viewing the content as “inappropriate for their child” or fearing it would “plant the idea” of suicide in YP’s mind. Stigma was also discussed in terms of community and cultural attitudes amongst parents, particularly in more affluent areas. One staff member commented “It’s almost like ‘not in my neighbourhood, we haven’t got a problem with that’... but we do, we’ve lost kids to suicide” (SS3). This “head in the sand” attitude was said to contribute to a reluctance among parents to engage with the topic meaningfully.

YP themselves also recognised that suicide and self-harm were rarely discussed in school settings. One participant noted that it is “not really spoken about” (YP8; FG), and a workshop facilitator admitted initially feeling unsure whether it was too “heavy” a topic for students. However, they later reflected that YP were often more ready to engage than adults assumed:

“Whilst it wasn’t a comfortable topic, they’re probably a bit more ready to have this conversation than me or my generation are... I felt as though they could relate to the session and it was well received” (F2).

This underlying stigma was also found to affect the success of related aspects of the project, particularly parent-focused sessions. Staff reported that while initial responses were positive, attendance at the parent session was very low. One school noted, “We only had about three parents show up. That was frustrating especially when the feedback was so positive at first” (SS1). In some cases, this lack of follow-through surprised staff, especially in schools with generally strong parental engagement, leading them to suspect that

the topic of suicide itself may have deterred involvement: “I wonder if it’s something to do with that, the fact we are talking about suicide” (SS3).

Finally, participants acknowledged that challenging stigma requires cultural change, and that avoiding the topic will do more harm than good. As one staff member stated: “If we don’t [talk about it], then I think people are more at risk... if it saves one life, it’s worth it.” (SS5). All participants advocated for more timely delivery of MAPSS, with the need for suicide prevention in schools to be delivered from Year 7. YP stressed that earlier education could help them recognise the signs of distress in themselves and others, potentially preventing issues from escalating: “If you only learn about it from year 10 you could realise that someone has been in pain for a few years now.” (YP3). YP also reflected on key stress points in Year 7, during the transition to high school, and again in Year 9 with the pressure of choosing General Certificate of Secondary Education (GCSE) options. School staff also emphasised the need for MAPSS to be delivered earlier and noted a growing complexity in younger years:

“The YP that are coming into our schools, they’re very different YP from 10 years ago. I’m currently having transition meetings with primary school and they’re telling us that year five and sixes are bad but wait till the year fours come.” (SS1).

Discussion

Implementation of MAPSS was influenced by interacting factors across individual/classroom, school, intervention, and wider community levels. Findings highlighted the importance of student engagement, and program accessibility and relatability, while also identifying key challenges relating to the implementation processes, staff responsibility, and managing risk within school contexts. Facilitators included an interactive workshop design, increased awareness of suicide prevention, and opportunities for early identification and support for YP. However, effective delivery required consideration of school readiness, logistical constraints, and the wider stigma surrounding suicide. By capturing perspectives from workshop facilitators, high school staff, and YP across six schools in the UK, this study provides a multi-stakeholder understanding of the acceptability, feasibility, and refinement of MAPSS for Year 10 students. Importantly, the findings extend previous implementation research by demonstrating how barriers and facilitators interact across multiple ecological levels, highlighting that successful implementation is shaped not

by any single factor but by the dynamic interplay between program design, school systems, staff capacity, and student engagement.

A unique contribution of MAPSS is the multi-modal approach, incorporating universal (workshops), selective (risk screening), and indicated (Reframe IT-UK) approaches to suicide prevention. Whereas some previous programs have focused on gatekeeper training to identify, intervene and make referrals, or on postvention approaches (Brann et al., 2021), MAPSS is the first to examine a multi-modal approach within a UK school context (Ashworth et al., 2024a, Ashworth et al., 2026). Feedback from YP indicated that the different components of MAPSS created multiple avenues for seeking help, although some expressed lingering uncertainty about disclosing suicidal thoughts and how these might be received, highlighting the importance of trust-building and follow-up mechanisms to sustain help-seeking in schools. Similarly, school staff described how the varied elements helped them feel more confident in engaging in conversations about suicide, but they also acknowledged the discomfort and emotional burden that such discussions can bring. This is particularly notable given that previous research has shown staff often feel uncomfortable or underprepared to discuss suicidal thoughts and behaviors with students (Ashworth et al., 2024a, b; Bridge et al., 2007; Walsh et al., 2013). In line with Brann et al., (2021), these findings suggest that schools may benefit from adopting multi-modal programs; however, further work is needed to advance the evidence base and to ensure that such programs are safely adapted to the specific needs and challenges of UK schools.

As previously discussed, schools are generally recognised as safe and appropriate environments for suicide prevention and intervention, providing a universal access point to a large number of YP (Robinson et al., 2013; Walsh et al., 2023). Evidence further suggests that it is safe for schools to ask students directly about suicidal thoughts and behaviors, with Ayer and Colpe (2023) emphasising that such conversations not only reduce stigma, but also create opportunities to save lives. Within this, safety is a crucial aspect to consider for any suicide prevention program. In the school context, safety operates on multiple levels, including for YP, for staff who hold and manage risk information, and for researchers involved in the process. While a clear strength of such programs is that YP at risk are being appropriately flagged, it is vital that these YP are then offered appropriate and effective care, with schools having the knowledge of how to manage this effectively. It is equally important to prioritise the safety and wellbeing of staff who hold this sensitive knowledge and are responsible for responding. While no significant safety concerns were identified in the present study, further research is needed to evaluate and ensure the safety

of YP, staff and the wider school community. These findings broaden existing conceptualisations of safety in school-based research by suggesting safety should be understood not only in terms of avoiding harm to students, but also in relation to organisational preparedness, staff wellbeing, and schools' capacity to respond appropriately when suicide risk is identified (McCarthy et al., 2025).

Furthermore, stakeholders consistently highlighted the need to introduce suicide prevention earlier than Year 10, with many advocating for provision from Year 7 or even in primary schools. This recommendation aligns with a growing evidence base supporting the value of early, school-based prevention approaches, particularly in a UK higher education setting (e.g., Ashworth et al., 2024a, b; McDonald & Pervez, 2025). This is particularly pertinent given the increasing policy focus on mental health within schools, with suicide prevention now explicitly embedded in the statutory RSHE curriculum in England (DfE, 2025). Embedding programs at an earlier stage could, therefore, not only align with existing statutory requirements but also capitalise on the school environment as a protective and accessible setting, ensuring that YP are equipped with knowledge and support pathways before going through the multiple stressful periods (e.g., Year 7 transition, Year 9 options) of high school. This raises crucial questions relating to implementation on how we can ensure such provisions can be delivered across a whole population, and what infrastructure would be required to sustain it sustainably. International evidence offers useful lessons; in the USA and Australia, student mental health is prioritised from pre-school onwards, with strong governmental backing, suicide prevention training for all school staff, and expanded in-school mental health teams (Smith, 2024). In contrast, England's RSHE curriculum remains guidance-led without a mandated program (DfE, 2025). This suggests that, while schools are increasingly expected to contribute to suicide prevention, clearer national policy, implementation guidance, and system-level support may be required to ensure that programs are delivered consistently, safely, and sustainably across education settings. Given evidence of implementation variability and challenges around risk management, this context strengthens the case for structured, evidence-based delivery, rather than ad-hoc teacher-led sessions. By adopting these evidence-based recommendations, UK schools can create safer, more supportive environments that help to prevent suicide, supporting both students and staff and alleviating pressure on Child and Adolescent Mental Health Services (CAMHS) (Smith, 2024). Notably, stakeholders' support for earlier delivery was motivated not only by increasing awareness of suicide risk but also by a desire to normalize conversations around mental health before YP experience distress. This shifts the emphasis from reactive intervention towards

proactive prevention, reinforcing the value of embedding suicide prevention within a whole-school approach.

While the case for earlier intervention is strong, it is also important to recognise the logistical challenges that have been consistently highlighted in the current study, as well as in the academic literature (Mayeux & Kraft, 2017; McCarthy et al., 2025). What is interesting about the present findings is the way that facilitators and barriers were often described as interdependent, rather than separate. For example, while staff acknowledged that time constraints and staff capacity posed a challenge, they also emphasised that a whole school approach allowed for more shared responsibility by embedding suicide prevention into existing structures. This suggests that successful implementation may depend less on removing the barriers entirely and more on enhancing the facilitators. This extends previous implementation research, which has often conceptualised barriers and facilitators as distinct influences (Nilsen, 2026). Instead, our findings suggest they operate dynamically, with strong facilitators helping schools to overcome or minimise barriers. This highlights the importance of strengthening implementation facilitators rather than focusing solely on eliminating barriers.

Furthermore, the barriers and facilitators highlighted in the present study are also consistent with other school-based implementation research across a range of domains, for example, mental health programs (Chisholm et al., 2012), healthy-lifestyle programs (e.g., Day et al., 2019), and substance abuse prevention (Giannotta et al., 2014), across both primary and high schools. For example, Langley et al., (2010), in their work implementing a CBT intervention for trauma in schools in the United States, found that all 35 sites reported similar barriers, including competing staff responsibilities, logistical challenges, and variable levels of support from administrators and teachers. At the same time, facilitators closely align with those reported in the present study, particularly having a wider professional team within schools that allowed staff to share the workload and collaboratively problem-solve. Together, findings suggest that barriers can be mitigated through proactive strategies such as ensuring dedicated time and resources, strengthening safety structures within schools, as well as fostering a supporting school culture where staff collaboration is prioritised to support implementation (McCarthy et al., 2025). However, many of these conditions extend beyond the influence of individual schools. Participants' accounts suggest that successful implementation also depends on wider system-level support, including sustained funding, sufficient workforce capacity, access to specialist mental health services, and clear national guidance regarding schools' role and responsibilities in suicide prevention. Without these broader structural supports, schools may struggle to implement and

sustain interventions, regardless of their motivation or commitment. Consequently, implementation should also be viewed as a shared responsibility across schools, policy-makers, health services, and education systems, rather than as the sole responsibility of individual schools.

Limitations

While the current study provides novel qualitative insights into experiences and implementation of school-based suicide prevention programs, there are some limitations that need to be considered. Firstly, participants were recruited from the North West of England. As such, experiences and specific logistical challenges may not be transferable to other schools across the UK and internationally. Although rates of SEN support and pupils eligible for free school meals in the recruited schools were comparable to England high school averages, the percentage of students whose first language is not English was lower in the current schools, which may reflect a lack of cultural diversity. Secondly, the study focused exclusively on publicly funded schools, which may limit the transferability of findings to private education settings. This is important to note due to the points raised above in relation to stigma within more affluent areas. Furthermore, staff were recruited primarily through existing networks with schools, which suggests that participants may have had a pre-existing interest in suicide prevention. This could limit the diversity of perspectives represented. Future research would, therefore, benefit from engaging a wider range of school staff, e.g., form tutors, to ensure findings more accurately capture the breadth of views and experiences within school settings. Finally, although the sample included participants from multiple stakeholder groups, it is important to note that this is not evenly distributed across these groups. Only two workshop facilitators were interviewed; however, this reflected the full population of facilitators involved in program delivery rather than a sampling limitation. Similarly, the number of YP interviewed individually was relatively small as these participants were recruited from the Reframe IT-UK component, which involved fewer students. The representation of YP has been enhanced via focus groups. Nevertheless, the imbalance in stakeholder representation may have influenced the breadth of perspectives captured.

Conclusion

The present study highlights that the successful implementation of school-based suicide prevention programs requires more than an evidence-based intervention; it requires the

capacity, infrastructure and support to deliver that intervention safely within the realities of school life. MAPSS was perceived as a valuable and acceptable approach for supporting help-seeking and increasing suicide prevention awareness among YP and school staff; however, findings also highlighted important challenges relating to student engagement, risk management, staff workload and wellbeing and the practical constraints of embedding suicide prevention within existing school systems. Importantly, these findings demonstrate that school-based suicide prevention cannot be considered in isolation from the wider systems in which it is delivered. Effective implementation requires clear and trusted pathways for responding to risk, sufficient staff capacity, shared responsibility for safeguarding, and appropriate levels of training and support for those involved. For YP, this must be accompanied by approaches that are accessible, relatable and able to foster trust, creating an environment in which they feel able to engage openly with suicide prevention. Given the continuing need for effective youth suicide prevention, policy and practice should prioritise the infrastructure and implementation support required to deliver them safely and sustainably. The perspectives of YP, school staff and workshop facilitators in this study provide important insights into these requirements. Future implementation of school-based suicide prevention should therefore place equal emphasis on intervention effectiveness, implementation readiness and the safety and wellbeing of both YP and the staff supporting them.

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restrictions, but is available upon reasonable request from the authors.

Declarations

Ethical Approval Ethical approval has been obtained from Liverpool John Moores University ethics committee (REC/ 23/ PSY/003). All participants will be given a participant information sheet and consent form prior to taking part.

Conflicts of Interest The authors have declared that no competing interests exist.

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