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METHOD

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Girls, self-harm and suicide prevention in schools

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ABSTRACT

In England, as elsewhere, one response to concern about the mental health of school-aged young people has been the emergence of government policies and programming which position schools as vital settings for mental health promotion and suicide prevention work. Much of the existing research in this area has focused on programme impact and effectiveness (often using quantitative methods), with little attention so far given to the qualitative experiences of pupils with complex mental health needs who have engaged in self-harm and have attempted suicide. To address this lacuna, this paper reports semi-structured interview data on the lived experiences of nine adolescent girls (aged 14–16) from one secondary school in north-west England who were known to engage in self-harm behaviours, and some of whom had attempted suicide. Their teacher (also the school's senior mental health lead and member of its senior leadership team) was also interviewed. The article explores three key themes: (i) Education, mental health, suicide prevention and the challenge of reconciling competing priorities; (ii) School-based mental health and suicide prevention support: great expectations with limited resource; and (iii) The unintended consequences of school-based mental health and suicide prevention work. It concludes that for pupils with complex mental health problems, the policy expectation that schools will promote mental health and help prevent suicide appears to have resulted in a series of unintended and contradictory outcomes which, it seems reasonable to suggest, are neither intended nor welcomed by government, or indeed by teachers, schools, pupils and their families.

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Mental health; policy; schools; unintended outcomes; suicide

Introduction

The mental health of school-aged (typically 5–16 years old) children and young people (CYP) has become of increasing concern in many countries. In England, it was estimated that, in 2023, one in five 8–16-year-olds (20.3%) had a probable mental health disorder, with younger (aged 8–10) boys (17.7%) and girls (13.6%) being less likely to

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report doing so compared to boys (22.3%) and girls (22.9%) aged 11–16 years old (Newlove-Delgado, 2023). These rates remain above those reported before COVID-19 (Newlove-Delgado, 2023), which further exacerbated already widening inequalities in the mental health of CYP (Hartas, 2024; Kirkbride et al., 2024). The mental health impacts of COVID-19 were not uniformly experienced by all school-aged CYP. In England, declines in mental health, especially among adolescent girls and young women and those living in poverty, have accelerated further in the post-COVID-19 period (Hartas, 2024; Institute of Health Equity/Barnardo's, 2024; Jerrim, 2022; Pickett & Wilkinson, 2024) and coincided with substantial increases in mental health service use and demand and referrals to urgent emergency crisis care (Barker et al., 2023).

Alongside the effects of the COVID-19 pandemic, social media has become an increasingly important factor in shaping the mental health of adolescents, particularly girls. While concerns have been raised about exposure to harmful or triggering content, including cyberbullying, imitation, and cultivation of a suicidal identity, which appear to affect girls more strongly (Balt et al., 2023), young people themselves also describe social media as a space to find validation, community, and support when formal services are difficult to access (Robinson et al., 2015). The evidence therefore points to a complex and sometimes contradictory role of social media in young people's lives, amplifying distress for some while providing connection and informal support for others. These demands have been linked, among other things, to the increasing prevalence of depression, anxiety, self-harm, and eating difficulties (Meherali et al., 2021; Trafford et al., 2023). Engagement in non-suicidal self-harm is also increasing, often at younger ages (especially for young women) and has been associated with a growth in the number of CYP who perceive self-harm as a way of coping with stress (McManus et al., 2019). Acute medical admissions for mental health among 5–18-year-olds rose by 65% between 2012 and 2022 (Ward et al., 2025). Over half of these admissions were related to self-harm, and eating disorder admissions increased by more than 500%, particularly among girls aged 11–15 (Ward et al., 2025).

One response to these mental health concerns has been the emergence of government policies which position schools as vital settings for mental health promotion and suicide prevention (Department for Education [DfE], 2023; Goodwin et al., 2023; Hayes, 2023; Jerrim, 2022; Ma et al., 2023; Stentiford et al., 2023). For example, in its 2017 Green Paper *Transforming Children and Young People's Mental Health Provision*, the British government noted that "we want to put schools and colleges at the heart of our efforts to intervene early and prevent problems escalating" (Department for Health and Social Care [DoHSC]/DfE, 2017, p. 3). They also suggested that:

> Teachers … can achieve results comparable to those achieved by trained therapists in delivering a number of interventions addressing mild to moderate mental health problems (such as anxiety, conduct disorder, substance use disorders and post-traumatic stress disorder). (DoHSC/DfE, 2017, p. 41)

Since the publication of the Green Paper, the expectation that schools will play a vital role in mental health promotion has been further reinforced in other ways. These include: the incorporation of mental health and well-being in the new Relationships Education (primary education) and Relationships and Sex Education (RSE) (secondary education) curriculum (DfE, 2018); new guidance on whole-school approaches to mental health and

well-being (DfE, 2021); a recommendation that schools appoint a senior mental health lead supported by mental health training (DfE, 2021); the expectation that schools work in partnership with Mental Health Support Teams (MHSTs) and support referrals to the Child and Adolescent Mental Health Service (DfE, 2021); and that the schools inspectorate, the Office for Standards in Education, Children's Services and Skills (Ofsted), be required to inspect how schools support pupils' personal development and knowledge of how to keep physically and mentally healthy (Ofsted, 2023). The government's *Suicide Prevention Strategy for England: 2023 to 2028*, which identifies CYP as a high-risk group for suicide, also emphasises the important role schools are expected to play in suicide prevention thus:

> Providing the right support and environment in schools and colleges is an integral part of suicide prevention. This includes ensuring pupils and learners benefit from a safe, calm and supportive learning environment with early targeted support for those who need it, as part of a whole-school or college approach to promoting health and wellbeing. (DoHSC, 2023)

Most recently, in July 2025, the DfE (2025) announced revised statutory guidance on Relationships Education, Relationships and Sex Education (RSE) and Health Education (RSHE). In relation to suicide, it was noted that "[S]econdary schools should … consider how to safely address suicide prevention" (DfE, 2025, p. 25), including through the mental well-being curriculum and by consulting mental health professionals. Secondary schools are also expected to "put in place high quality, evidence-based staff training before addressing suicide directly with secondary aged pupils, to ensure that staff have the knowledge and skills to do this safely" (DfE, 2025, p. 26). Ensuring that suicide is discussed using accurate and straightforward language and content, without reference to methods of suicide or self-harm, is an additional requirement of secondary schools, which should

> consider carefully when it is suitable to deliver suicide prevention content, taking into account the age, maturity, and personal experiences of pupils as well as the views of parents and the confidence and skills of teachers, recognising that pupils' emotional and cognitive maturity to understand this material increases across the early secondary years. (DfE, 2025, p. 26)

The revised guidance is to be implemented in September 2026, so at the time of writing its impact on teaching practice and pupils is currently unknown. Nevertheless, suicide and self-harm remain important challenges facing teachers and schools, and are often addressed in teaching about mental health and as part of pastoral support for pupils. This is particularly the case for pupils with complex mental health problems and other challenges, yet little is known about the experiences of these pupils and their teachers and what this suggests about prevailing policy commitments towards mental health and suicide prevention work in state schools.

In this paper, we begin to address this important, neglected area of research by exploring the lived experiences of nine adolescent girls who were known by their school to engage in self-harm behaviours (with or without suicidal intent) and some of whom had attempted suicide. We also report the experiences of their teacher (and school senior mental health lead) to shed original light on how the school endeavoured to meet pupils' mental health needs. In doing so, our findings raise important questions

about the degree to which pupils' complex mental health problems are being, and perhaps even can be, met as intended by government policy. Indeed, our data suggest that far from being enacted as intended, the constraints on teachers to meet government's policy goals related to school-based mental health promotion, and suicide prevention, appears – for the participants in this study at least – to have resulted in a series of unintended and contradictory outcomes which, it seems reasonable to suggest, were neither intended nor welcomed by government (Elias, 2012).

School-based mental health and suicide prevention programmes

One consequence of the increased political and policy commitment to supporting the mental health of CYP and preventing suicide in that group has been the substantial growth internationally of school-based mental health promotion programmes, often as part of whole-school approaches to mental health (Haycock et al., 2020; Hayes, 2023; Smith et al., 2024; Weare, 2015). There are many such programmes, which can broadly be divided into two kinds: universal programmes which are delivered to whole school groups, not defined by risk; and targeted programmes developed either for sub-groups of pupils with elevated risks of poor mental health, or for sub-groups of pupils considered at high risk as well as those with subclinical but detectable symptoms of poor mental health (Hayes, 2023). The effectiveness of these programmes varies and has been reviewed in more detail elsewhere (e.g. Haycock et al., 2020; Kirkbride et al., 2024; Smith et al., 2024; Weare, 2015). Overall, however, because of their design, universal programmes have typically engaged larger numbers of pupils and are most effective when addressing those community or society-specific determinants which positively impact pupils' mental health and willingness to seek help (Kirkbride et al., 2024). More resource-intensive targeted programmes, while often reporting greater effect sizes, can negatively impact pupil engagement by unintentionally increasing stigma and self-stigma (Kirkbride et al., 2024). School-based programmes focusing specifically on suicide prevention, including the Multi-Modal Approach to Preventing Suicide in Schools (MAPSS) (Byrne et al., 2022) and the Saving and Empowering Young Lives in Europe (SEYLE) programme (Wasserman et al., 2015), have also been developed and are most effective in reducing suicidal thoughts and suicide attempts when they are multi-faceted (Byrne et al., 2022; Kirkbride et al., 2024; Pistone et al., 2019).

Notwithstanding the substantial growth of mental health promotion and suicide prevention programmes in schools, in state schools in England there remains much variation in school-level mental health provision in curriculum time and as part of whole-school approaches (Barker et al., 2023; Kidger et al., 2010; West & Shirley, 2023). This variability has been associated, among other things, with curriculum content and priorities, school contexts and cultures (including leadership styles, teacher commitment and training), the wider competitive and regulatory environment in which schools operate (Barker et al., 2023; Hartas, 2024; Kidger et al., 2010; West & Shirley, 2023), and the structural inequalities which shape pupils' needs and backgrounds (Ashworth et al., 2023; Hartas, 2024; Kirkbride et al., 2024; Smith et al., 2024; Townsend et al., 2022). These important contextual factors can exacerbate existing difficulties schools experience in identifying and responding to pupils' mental health needs (Barker et al., 2023; Kidger et al., 2010; West & Shirley, 2023), especially for girls with complex mental health problems. For example,

one qualitative systematic review identified girls' fears for the future (including having a happy and good future life), parent/family pressures (typically expressed as "wanting the best" for children), competitive school cultures (including gendered teacher expectations, institutional performance priorities and competing with peers), and the imbalance in healthy lifestyles, gender identity constitution and personal perceptions of the importance of academic performance, as often contributing to girls' poor mental health (Stentiford et al., 2023). In this regard, it has been argued that there needs to be a better balance between academic achievement and other school priorities, including pupil mental health and well-being, and to consider pupil and teacher mental health simultaneously since teachers' ability to support pupils is closely related to their own mental health and well-being (Barker et al., 2023; Kidger et al., 2010; Stentiford et al., 2023).

In addition to their variable implementation and impact, one notable feature of existing evaluations of school-based programmes (especially those focused on suicide prevention) has been the dominant use of quantitative methods (including validated measures and instruments) to generate evidence of their effectiveness. Where qualitative approaches have been adopted, they have typically – with some notable exceptions (e.g. Garmy et al., 2015) – focused on teachers', rather than pupils', experiences. Studies involving teachers have commonly reported that teachers often lack the requisite mental health training, literacy and supervision needed to best support pupils' mental health needs (Best, 2006; Davies & Matley, 2020; Dowling & Doyle, 2016; Goldberg et al., 2019; Shelemy et al., 2019), and that their expected role in mental health promotion and suicide prevention needs to be understood in the context of the very many other, often competing, priorities of their role (Rothi et al., 2008; Rainer & Abdinasir, 2023; Soneson et al., 2020; Stoll & McLeod, 2020). These include the continued prioritisation of pupils' academic performance and school league table position (West & Shirley, 2023; Wilson et al., 2023), the pressures of which, together with their alleged role in mental health promotion, can exacerbate teacher stress and workload (Arthur & Bradley, 2023), threaten their own mental health (Barker et al., 2023; Kidger et al., 2010; Stoll & McLeod, 2020; Wilson et al., 2023), increase sickness absence and staff turnover (Barker et al., 2023), and compromise teachers' relations with pupils (Alder, 2002).

Useful though these studies are, they tell us little about how pupils with complex mental health needs, including those who self-harm or experience suicidal behaviour, experience school-based mental health and suicide prevention provision. As we noted earlier, there remains an urgent need to better understand the qualitative experiences of pupils intended to benefit from such provision (Garmy et al., 2015; Silverio et al., 2022). This is particularly true for adolescent girls who self-harm or have attempted suicide, since their voices and experiences have been largely absent in the existing research. Next we report the findings of our study, which addresses this important gap in knowledge and has substantial implications for government policy and school practice. We pay particular attention to the unintended outcomes (Elias, 2012) which appeared to have emerged out of the policy expectation that schools will promote mental health and help prevent suicide. These outcomes are not uncommon; they are the normal result of complex processes involving the interweaving of the more-or-less goal-directed actions of large numbers of people (e.g. teachers and pupils) which cannot be explained simply in terms of the intentions of individuals, but which are a fundamentally important feature of social life (Elias, 2012).

Methods

Participants

This study was intentionally designed as an in-depth, small-scale, qualitative case study. The aim was to explore, in detail, the lived experiences of a small group of girls with complex mental health needs within a single school context. Nine adolescent (aged 14–16) girls from one secondary school in north-west England participated in the study together with their male teacher, Jack (pseudonym), aged 42, who was also the school senior mental health lead and a member of the school leadership team. All the pupils were identified by Jack as being known to engage in self-harm behaviours (with or without suicidal intent), and some were known to have previously attempted suicide associated with various adverse childhood experiences. Some pupils had experienced historical traumatic events including sexual abuse, rape and domestic violence. These events had been addressed through the relevant legal channels and were known to the pupils' school, which continued to support these in line with their safeguarding processes. Other pupils also engaged in self-starving behaviours, had been bereaved by suicide, experienced transphobic bullying, and had lived in households where their parents and siblings were alcohol dependent and users of other drugs.

All pupils thus had complex mental health needs and had been referred by the school to specialist Child and Adolescent Mental Health Services (CAMHS). At the time of the research, one pupil was receiving support from CAMHS, while the remaining eight were on a waiting list, were receiving no other specialist mental health support and had not yet received a formal mental illness diagnosis. The school which the pupils attended, and which was part of an academy trust, was based in an area ranked in the sixth decile (of ten) according to the 2019 Index of Multiple Deprivation. Around one-third of its pupils (aged 11–16 years) were eligible for free school meals.

Procedure

Prior to engaging in the research, participants engaged in eight weekly mental health intervention workshops delivered by the lead researcher, a qualified teacher, having explored pupils' mental health needs with Jack. The workshops covered a range of content (i.e. mental health literacy, self-harm, suicide, eating disorders, social media, drugs and alcohol, sexual assault) and were designed to empower the pupils by providing a safe space in which they could share their individual and collective lived experiences of mental health. The sessions were intentionally supportive and provided a consistent, familiar and non-hierarchical space in which pupils could explore and articulate their lived experiences within an established safeguarding framework and without clinical framing. The workshops were not part of the research data collection, and no data were generated from them. Their primary purpose was to provide support for pupils identified by the school as requiring additional input. However, they also served an important ethical function in relation to the research component: they established relational safety, familiarity and credibility between the pupils and the researcher. Qualitative research involving sensitive topics and vulnerable, marginalised or hard-to-reach young people often requires careful ethical and methodological preparation to support meaningful participation and disclosure (Liamputtong, 2025; Ungar, 2019). In this study,

relational safety and familiarity were particularly important given the pupils' complex mental health needs. Participation in the workshops did not oblige or presume participation in the research interviews; informed consent for the interviews was obtained separately from pupils and their parents/carers. The present article focuses solely on the interview data. A separate forthcoming manuscript will seek to report on the workshop content and outcomes in more detail.

Following receipt of ethical approval from the Department of Sport and Physical Activity Research Ethics Committee (DREC) at Edge Hill University (Reference: SPA-REC-2021-225) and approval from the school head teacher to conduct the research, all pupils who engaged in the workshops ($N = 10$) were invited to take part in a semi-structured, face-to-face interview as part of an interpretivist research design which reflected the authors' concern with better understanding the more-or-less subjective experiences participants had of their lives. All pupils and their parents/carers were provided with a detailed participant information sheet which outlined the nature and purpose of the research, processes for withdrawal up to four weeks post-interview, how anonymity would be maintained, and how any concerns about the welfare of pupils would be managed. Having read the participant information sheet and having been offered the opportunity to ask the lead author any questions about the research before deciding whether to take part, the parents/carers of all pupils provided voluntary informed written consent. Nine pupils were eventually interviewed during May 2022, having also provided written and verbal assent to do so. Although all 10 pupils consented, one pupil was absent during the research period and, as she had completed her General Certificate of Secondary Education examinations (GCSEs) and left school, it was not possible to schedule a later interview before the end of the study.

Interviews lasted between 45 and 60 min and were held in a quiet school classroom. Informed by the insight generated during the workshops, a personalised semi-structured interview schedule was constructed by the lead author in consultation with the other authors to generate detailed data on each participant's lived experience of mental health. Participants' relationships with family members, peers and teachers were also explored. Given the nature of pupils' mental health needs and historical experiences, and in line with approved ethical protocols, after each pupil interview the lead author fully debriefed the school's senior mental health lead and other pastoral staff of all the mental-health-related experiences raised by each pupil. This was done with pupils' full prior knowledge and consent, it having been made clear in the participant information sheet and during and after each interview. Pupils were provided with a list of relevant helplines and support resources that they could access if needed. Follow-up contact was maintained throughout the research period to address any questions and to monitor pupils' welfare and safety. No pupils disclosed any new or immediate concerns beyond those already known to the school's pastoral team and the researcher during the eight weeks of workshops and interviews. Those experiences disclosed to the lead researcher, during the workshops were also followed up by the school, and recorded and reviewed as appropriate as part of the school's in-house safeguarding monitoring processes.

The interview with Jack lasted 65 min, was held in a private school office with his prior written and verbal consent, and explored his experiences of supporting the complex mental health needs of pupils (including the other participants) and enacting the government's mental health policy expectations in his school. Jack had completed the Mental

Health Lead Intermediate Course funded by the DfE (DfE, 2021), but had not received any further specialist mental health training, and nor did he have additional protected time to undertake the senior mental health lead role alongside his normal teaching and leadership responsibilities.

Data analysis

Once complete, all interviews were transcribed verbatim by the first author, who also allocated each interviewee with a pseudonym to protect their anonymity. Each interview transcript was then subject to reflexive thematic analysis, as outlined by Braun and Clarke (2020, 2022). The first author led the data familiarisation stage by reading and re-reading the transcripts, writing familiarisation notes, and then discussed their initial analytic observations with the other authors, who acted as critical friends throughout the analytical process. Following data familiarisation, the first author conducted two iterative data coding rounds to identify key codes inductively and deductively, using these codes. Deductive codes reflected issues anticipated from existing research and the study focus on school policy and practice (e.g. workload, resources, curriculum priorities), while inductive codes captured participants' own words and meanings (e.g. "don't care", "trust", "taken seriously"). Once the initial coding was complete, the first author developed several candidate themes (i.e. "Balancing education, mental health and performance", "Delivering and resourcing school-based mental health and suicide prevention", "Expecting the unexpected: school-based mental health and suicide prevention work") before discussing these with the other authors. Given the feedback provided, the first author reviewed the candidate themes against the coded data set before the final fully realised themes were discussed with, and agreed by, the other authors (Braun & Clarke, 2020, 2022). These themes, which capture the shared meanings evident in the participants' responses, were: (i) Education, mental health, suicide prevention and the challenge of reconciling competing priorities; (ii) School-based mental health and suicide prevention support: great expectations with limited resource; and (iii) The unintended consequences of school-based mental health and suicide prevention work (Table 1).

Table 1. Thematic structure.

Theme title	Summary	Sub-theme
Education, mental health, suicide prevention and the challenge of reconciling competing priorities	Participants discussed how feeling safe, cared for and being taken seriously was important for helping to manage complex mental health problems, but this was often compromised by other competing priorities for teachers	• Feeling safe and cared for • Being taken seriously
School-based mental health and suicide prevention support: great expectations with limited resource	Participants questioned whether schools were appropriately resourced settings to support pupils' complex mental health problems, and identified many constraints impacting teachers' ability to address these in practice	• Teachers "do what they can" • Teacher training and knowledgeable empathy
The unintended consequences of school-based mental health and suicide prevention work	Participants' experiences suggested that policy expectations for school-based mental health and suicide prevention work have resulted in many unintended, and largely unwanted, outcomes which need to be better understood	• Declining trust and pupil and teacher mental health • It just feels like another thing we can fail at

Themes (i) and (ii) were shaped by deductive concerns but refined inductively, whereas theme (iii) was primarily inductive, emerging strongly from participants' accounts of their lived experiences.

Findings

Education, mental health, suicide prevention and the challenge of reconciling competing priorities

Feeling safe and cared for

One of the central concerns girls expressed when asked about their lived experience of mental health in school was the importance they placed upon feeling safe, and cared for, by teachers and other school staff to whom their well-being had been entrusted as a feature of current government policy and guidance (DfE, 2023; DoHSC, 2023; DoHSC/DfE, 2017). The emphasis pupils placed upon the need for teachers to prioritise and care for their mental health was neatly captured by Emma, who said:

> I think they need to get their priorities straight because they need to think if people aren't coming in, it's not because they're being lazy. It's because they're dealing with their own problems, and I just wish they would care more. They say that mental health is the main thing, but they care more about the uniform.

The comments of Lillie also vividly illustrated how pupils typically interpreted whether they felt cared for by juxtaposing teachers' expectations that she attended school with instances when she was experiencing suicidal thoughts which were often associated with her eating difficulties. She said:

> I hate coming in here because I know they just don't care about mental health … I just don't want to be in school on days when I feel like I want to kill myself or when I don't want to eat. But then they're like "You have to come in", and "You have to do this", and "You have to do that". Well, I don't want to. I don't know what they expect me to do.

Other pupils, including Rylee, explained how the constraints on teachers to maximise their academic performance in forthcoming GCSEs compromised the support given for mental health (Barker et al., 2023; Stentiford et al., 2023; West & Shirley, 2023; Wilson et al., 2023). For her, however, "mental health was more important" than examination performance:

> They're more bothered about your education than about anything else … They're like "Care about education", especially with GCSEs they say: "You've got your GCSEs, just focus". And yes, but there's other things that take focus too. Like if people are struggling with their mental health and you're telling them to focus on GCSEs it's going to make them worse. I know GCSEs are important, but then mental health is more important.

The general perception that their mental health needs were not sufficiently prioritised led other pupils to be more critical of their teachers (Alder, 2002), including Robin, who felt that her teachers did not "pay any attention" to her daily engagement in self-harm behaviours. When asked whether her family had advised her school about her needs and challenging home life, Robin replied: "My dad speaks to them all the time, but they don't pay any attention. They don't care. They don't speak to you. You can speak to them, and they just go 'alright'. That's not going to help."

Being taken seriously

A related feature of girls' concerns about feeling safe and cared for was that their mental health experiences, including distressing self-harm behaviours because of suicidal thoughts, needed to be taken more seriously by others as an important feature of pupil–teacher relations in this context (Alder, 2002; Barker et al., 2023). Reflecting upon her increased engagement in self-harm and attempted suicide (including on the school premises), Elena remarked how "People shouldn't have to try and kill themselves two times to get taken seriously". Others, including Rylee, described how she had attempted to seek one-to-one support from her teachers but did not feel as if her concerns had been taken seriously:

> If you try to open-up about your mental health, they're like, "Yes we can talk about it another day, now go to your lesson" … They need to take it more seriously. They don't help … They'll sit there, one to one, and you'll open-up and if you say "Can I get help? Can I have something that will help me?". They won't acknowledge it.

It is important to note, however, that teachers' perceived failure to take pupils' mental health problems seriously was not necessarily because they were unimportant, nor because teachers lacked empathy with pupils' circumstances and needs. Indeed, Jack explained that, like his colleagues, he was empathetic with pupils and wanted to support their needs as much as possible, but that the need to balance this with supporting the needs of other pupils was particularly challenging. As noted earlier, despite being the school's mental health lead, Jack did not have any additional protected time to undertake this role alongside his other teaching responsibilities, which meant he had limited time to spend with his pupils. As he explained:

> I teach all my pupils once a week … I get an hour per week. That means I get 2 minutes per pupil, so I just don't get to know them like a primary school teacher does. We're not necessarily having those conversations where someone's opening up. I get 40 hours a year with my pupils to teach them about 140 hours' worth of content … I don't have the flexibility or capacity to deal with the meltdown of one child in my classroom when 29 others need my teaching, because I'm not a counsellor.

School-based mental health and suicide prevention support: great expectations with limited resource

Teachers "do what they can"

Although girls were often critical of the school-based mental health support they received, they nevertheless often recognised the significant constraints on teachers' practice which prevented them from providing the specialist support their complex mental health needs really required (Rainer & Abdinasir, 2023; Soneson et al., 2020; Stoll & McLeod, 2020; West & Shirley, 2023; Wilson et al., 2023), and which is expected by government (DfE, 2023; DoHSC, 2023; DoHSC/DfE, 2017). Delilah, for example, suggested that schools are not settings which are particularly conducive to supporting her poor mental health, and that teachers often do not have the required time and knowledge to support pupils as they wished:

> They do what they can. Just give pupils 5 minutes. But at the end of the day it's a school, it's not like a place for helping mental health. They can do what they can with their limited

> knowledge on it. You can't ask them to do everything because they're not built for that. They're not made for that.

The demands placed on teachers were recognised by other pupils, including Rebecca, who emphasised how the needs of large numbers of students exceeded the time teachers had available to offer personalised support:

> Because there's a lot of students struggling, they don't have time for everyone. If they were to not send you back to lesson, they would have to not send loads of others. That's a problem in itself because each one matters as much as the next person. There's not someone who is less important so I don't think they should just be sent back but, I mean, what are you going to do? There's so many pupils with problems.

Beyond the time-related constraints on teachers, Jack also emphasised how, despite being a senior school mental health lead, he did not have a dedicated ring-fenced budget to provide mental health support for pupils despite its prioritisation in government policy and guidance (DfE, 2021). Accordingly, the support offered was often the result of teachers providing their time for free to support pupils as much as possible:

> I don't have a budget for mental health. All the things we do, we do for free. You know, I have no paid staff. I don't get paid any extra for mental health stuff. We're just doing it. We're just doing it because it's the right thing to do … We desperately want to do well for them. We desperately want them to be well, and we refer to every service that you can be referred to.

Teacher training and knowledgeable empathy

The lack of training teachers typically receive to enable them to meet pupils' mental health needs (Best, 2006; Davies & Matley, 2020; Dowling & Doyle, 2016; Goldberg et al., 2019; Shelemy et al., 2019), especially when these are particularly complex, was acknowledged by all participants in the study. Jack, for example, explained how mental health was often a "bolt-on" feature of teacher training, which meant that it was not always the focus of their (or others') practice:

> They've started to train teachers when they go into teacher training to do more in terms of mental health. But even then, it's very much a bolt-on. It's an add-on to what we do and therefore isn't the focus and will never be the focus.

The lack of appropriate training was especially problematic for pupils, who felt they could trust and seek support from teachers for their mental health. This was brought out particularly clearly by Robin, who said:

> When you become a teacher, you need to know everything because you're going to have to put up with a lot. But if someone trusts you, then they're going to tell you everything and you should be trained to know how to deal with it.

Other pupils, including Delilah, similarly recognised that while teachers endeavoured to support pupils as best as they can, the lack of training they often receive in relation to mental health and suicidal thinking could result in things becoming "awkward" between them and their pupils. As she expressed it:

> When you go for a teaching degree you go to teach. You don't have a separate thing about students who want to kill themselves. It's just so awkward when they think they're doing the best thing for you, but really you just want to tell them to piss off.

Some pupils also noted that well-intentioned support from teachers did not match the intensity of their distress, as Lillie explained:

> They'll go "why do you feel like this, what can you do to feel better? Go through the rest of the day and see if you feel better bla bla bla". And it's like well it's not going to fix anything. That thought is still going to be in my head. You can't just go "bada bing bada boom … poof all of it's gone".

The potential unintended consequences of teachers who wished to support pupils, but who perhaps lacked sufficient "knowledgeable empathy" (Jack) about their circumstances and needs, was also recognised by Jack. Speaking in relation to the potential problems of having insufficient training and thus acting in well-intentioned ways based on limited knowledge and understanding, Jack emphasised how "We need to be careful what we expect of teachers, as people with a little bit of knowledge could do a lot of damage".

Next, we explore some of the other unintended consequences of school-based mental health and suicide prevention work, which has grown substantially in response to current government policy expectations (Goodwin et al., 2023; Hayes, 2023; Jerrim, 2022; Ma et al., 2023; Stentiford et al., 2023.)

The unintended consequences of school-based mental health and suicide prevention work

Declining trust and pupil and teacher mental health

One important unintended consequence (Elias, 2012) which was perceived to result from teachers' lack of mental health training was a gradual erosion of trust between pupils and their teachers which was thought to result from teachers' well-intentioned attempts to educate pupils about mental health-related topics in the curriculum (Alder, 2022; Barker et al., 2023). This was brought out particularly clearly by Lillie in relation to a lesson on cyber bullying and self-harm behaviour (especially cutting), which, for her, was delivered insensitively and exacerbated her mental health needs. As she explained:

> We were doing a lesson about cyber bullying, and he [teacher] went like this when he talked about self-harm [cutting hand gesture against arm]. No trigger warning or anything. He went "you have to be careful about what you say online because it can lead some people to do this" [showed cutting movement again] I was like "wooooah". He just doesn't care.

Other pupils similarly referred to instances when they did not feel they could trust teachers to take their mental health needs seriously. Commenting upon her use of a "time out pass" allowing her to leave a lesson if she was feeling overwhelmed after a period of hospitalisation following a suicide attempt, Elena said: "When I do use my pass, I still get the odd teacher just going (sighing and rolling eyes) 'Alright' and it's like 'If you want me to kill myself, just say it'". Delilah also recalled a stressful situation when one of her teachers attempted to restrain her after another pupil had found a razor blade in her bag and passed this to the teacher without her permission. Speaking in relation to a sustained period of self-harm which led her to feel angry at the way her teacher acted, she explained:

> It was the start of this school year and I was obviously struggling with my self-harm for like 9 months by then … I see them [another pupil] giving him [teacher] the razor blade. So, I'm like

> "What is going on here?" … He [teacher] was like, "You're going to have to calm down or I'll have to restrain you" … I was furious … He was trying to get my hands behind my back and stuff. I was like "Fuck that", so I left the classroom … [I was] covered in scratches all over my arms and neck … I wasn't going to have him walk me … with my hands behind my back like I was getting arrested.

For other pupils, the failure to support their complex mental health needs was brought into sharp relief when some participants, including Elena, described how this unintentionally impacted her in school:

> I was really low. I needed a helping hand, but no one gave it to me. I gave loads of signs and I tried to talk to people. I was like "Can you talk to me a second? Can you help me?" No one helped me. I got really low, and I tried overdosing. I was found in the bathroom unconscious.

Concerns about how teachers might respond also shaped what pupils originally chose to disclose, particularly in relation to suicide attempts. Delilah explained:

> They don't really know that much about the overdose that failed. The first one. The hanging one was like last, last Christmas. Like Year 8. Then the overdose was Year 9. Then the second one, the second hanging, was this December and then the overdose was this January. Because like, teachers are teachers. They're not made for that kind of stuff. If you tell them all the things that happen to you, you don't want them to treat you differently.

"It just feels like another thing we can fail at": teachers' roles and mental health

The expectation that teachers will support pupils with significant mental health need in schools also had various unintended impacts on teachers. Jack, for example, emphasised the guilt and emotional anguish he regularly experienced when seeking to support pupils who engaged in self-harm behaviours as well as those experiencing suicidal ideation and who attempted suicide in schools:

> You feel like, "Oh, did I miss something?" … You find a child in the toilet who's cut themselves and they've gone out with a toilet pass … You know, "I need to go to the toilet cause I'm on my period". You go "Yeah. OK. No problem". You find them half an hour later and the ambulance is arriving. You feel guilty because you can't do your job properly.

The guilt Jack reported was compounded by the lack of mental health support, training and professional development opportunities available to him (beyond his Mental Health Lead Intermediate Course training) and other teachers, something which he described as follows:

> Children come into my classroom with suicidal ideations, suicidal thoughts … What happened to me this year, finding a child who'd severely self-harmed in the toilets to the point of the toilet cubicle being covered in blood and a genuine suicide attempt on the school premises. I'm not qualified to deal with that. There was no conversation with my line manager to say was that distressing, you were, you know, holding paper towels over a child's arm and calling an ambulance with the other hand. I'm covered in this child's blood. And then I go and teach my lesson … There's no kind of care for teachers in that. There's no provision for our mental health at all. No specific help for any teachers.

As other studies have concluded (Best, 2006; Davies & Matley, 2020; Dowling & Doyle, 2016; Goldberg et al., 2019; Shelemy et al., 2019), failing to provide teachers with sufficient mental health training and development to adequately fulfil their claimed

professional responsibility for supporting pupils with complex mental health needs was interpreted by Jack as evidence of "another thing we can fail at". For him, the personal and professional impact of being required to support pupils' complex mental health needs regularly resulted in a sense of unfulfillment, increased workload and conflicting pressures to support pupils' academic success (particularly examination performance) whilst managing the impact their personal circumstances had on pupils' mental health and their own (Barker et al., 2023; Kidger et al., 2010; Stoll & McLeod, 2020; Wilson et al., 2023). As Jack explained:

> Teachers are frustrated because they can't do their job properly. They're unfulfilled because it's [supporting pupil mental health] another stick to beat teachers with … We already feel got at all the time … It just feels like another thing we can fail at because we're not given the tools to do it … It's almost like, what's the end result for us? The goal for schools is to get kids through exams, to improve their life by helping them escape areas of deprivation, escape domestic violence, of horrible experiences. But we're almost patching them up enough to get them through an exam.

In this regard, Jack's comments echoed those of teachers in other studies which have emphasised how teachers' attempts to support pupils' mental health, and prevent suicide, can only be adequately understood when contextualised in the realities of their everyday practice (Barker et al., 2023; Rainer & Abdinasir, 2023; Rothi et al., 2008; Soneson et al., 2020; Stoll & McLeod, 2020). Particularly important is the simultaneous political and policy emphasis which has been placed upon pupils' academic attainment and achievement performance and school league table position (West & Shirley, 2023; Wilson et al., 2023). That concerns about academic performance have been identified in other studies as contributing to girls' own perceived poor mental health (Stentiford et al., 2023) also raises questions about how the current twin policy emphases on mental health promotion and suicide prevention on the one hand, and academic performance on the other, can be most effectively managed in schools. It also emphasises clearly the importance of understanding mental health and suicide prevention as an inherently relational feature of school practice, since attempts to support pupil mental health cannot be disentangled from those focused on teachers because they are each impacted by the other (Arthur & Bradley, 2023; Barker et al., 2023; Kidger et al., 2010; Stentiford et al., 2023; Stoll & McLeod, 2020; Wilson et al., 2023).

Conclusion

It is reasonable to assume that, ideally, government policy and guidance (DfE, 2023; DoHSC, 2023; DoHSC/DfE, 2017) which seeks to promote mental health and prevent suicide in schools has a positive impact not only on pupils, but also their teachers, wider school staff and other relevant professionals. It might also be suggested that the degree to which government can achieve its formally stated policy goals as intended in these areas will also depend upon the degree to which such policies, and those charged with enacting them (i.e. school staff and other professionals), are appropriately resourced and supported to do so. Ensuring that policy is also based on an adequate understanding of the complex causes of poor mental health and suicide, and that the practice which emanates from it is underpinned by evidence-based approaches which account for the complex mental health

needs of pupils in school settings, is another reasonable expectation of government policy.

The findings of this study, however, suggest that for pupils with complex mental health problems, the policy expectation that schools will promote mental health and help prevent suicide appears to have resulted in a series of unintended and contradictory outcomes, which, it seems reasonable to suggest, are neither intended nor welcomed by government, or indeed by schools, pupils and their families (Elias, 2012). The lived experiences of pupils and their teachers reported here revealed how the constraints on schools to support the needs of pupils with complex mental health problems has almost inevitably been met by many significant, unintended, outcomes (Garmy et al., 2015; Silverio et al., 2022). For pupils, the important structural inequalities which characterised their backgrounds and mental health needs (Ashworth et al., 2023; Hartas, 2024; Institute of Health Equity/Barnardo's, 2024; Kirkbride et al., 2024; Pickett & Wilkinson, 2024) led them to perceive schools as important settings where they needed to feel safe, are taken seriously, and respected and cared for by teachers and other school staff. This is a view which is consistent with that articulated in the government's *Suicide Prevention Strategy for England: 2023 to 2028* (DoHSC, 2023), but which for the pupils in our study at least, did not always match their lived reality of schooling. Instead, pupils did not always experience school as the safe, calm and supportive learning environment they needed to benefit their complex mental health problems. They appeared to need mental health specialist care and support which could not adequately be provided in schools.

Teachers were also shown to be significantly constrained in their attempts to support pupils' mental health, including by their mental health training and professional development, lack of experience of supporting pupils with complex mental health needs, contradictory government policy priorities, and the everyday realities of teaching pupils with diverse learning needs and backgrounds (Best, 2006; Davies & Matley, 2020; Dowling & Doyle, 2016; Goldberg et al., 2019; Shelemy et al., 2019). These challenges also appeared to do little to address current concerns about teacher retention, workload and mental health (Barker et al., 2023; Kidger et al., 2010; Stentiford et al., 2023), and raise important questions about the suitability of schools as vehicles of government policy intended to benefit pupils requiring complex specialist mental health and suicide prevention support. Indeed, as we have shown here, together with exploring intended policy outcomes, research on the impact of new statutory guidance related to school-based suicide prevention work (DfE, 2025) as part of wider mental health provision should involve identifying the many and varied unintended outcomes which no one has chosen, and no one has designed, but which have until now been generally neglected features of research (Elias, 2012). Although schools are regarded as having a role to play in suicide prevention as part of mental health promotion (DfE, 2025), in this study, pupils' complex mental health needs appeared to require more specialist support than that which could reasonably be expected to be provided in schools. Building on existing expectations (e.g. DfE, 2021; DoHSC, 2023; HM Government, 2021; Ofsted, 2023), new statutory guidance (DfE, 2025) which further engages schools in England in suicide prevention work might be an important starting point, but questions will likely remain about whether, how and by whom suicide prevention work should be provided in schools, and how this will be delivered with minimal risk in an already congested curriculum and challenging school context characterised by many other competing priorities.

Finally, it is important to note that the experiences participants reported here clearly cannot be said to be representative of other pupils and teachers in similar situations. The qualitative approach adopted has nevertheless emphasised the importance of better foregrounding the voices and lives of pupils with complex mental health needs, and those who support them, in education and mental health research (Garmy et al., 2015; Silverio et al., 2022). This is an important pre-requisite if future research is to provide a more nuanced, and more adequate, insight into how teachers and schools endeavour to meet pupils' complex mental health needs through school-based programmes in response to government policy. However, in and of themselves such programmes do not necessarily address the underlying social determinants and structural inequalities which are associated with mental health problems and suicide (Ashworth et al., 2023; Institute of Health Equity/Barnardo's, 2024; Kirkbride et al., 2024; Pickett & Wilkinson, 2024; Smith et al., 2024; Townsend et al., 2022). These require simultaneous action across health, social care and economic systems if the mental health needs of pupils and teachers are to be more effectively addressed, including as part of a broader focus on suicide prevention. While schools cannot remedy these structural conditions, school-based programmes may be strengthened by closer alignment with wider systems of support – for example through clearer referral pathways, stronger partnerships with CAMHS and community services, and protected time and training (e.g. trauma-informed) for staff to respond safely and consistently (Barker et al., 2023).

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