James' Place Liverpool Evaluation

YEAR THREE REPORT

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James' Place

Contents

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James' Place Evaluation: Year 3 Report

Executive Summary

Introduction

The third James' Place service evaluation examines the effectiveness of the James' Place model on reducing suicidality in men over a three-year period and the relationship of entrapment with suicidality. Prior research has validated the construct of a suicide crisis syndrome (SCS), a specific psychological state that precedes and may precipitate suicidal behaviour. The feeling of entrapment is a central concept of the SCS as well as of several other recent models of suicide. However, its exact relationship with suicidality is not fully understood; previous research suggests that entrapment may represent key symptomatic targets for intervention in acutely suicidal individuals as internal entrapment could help to predict suicidal ideation and could predict a change in suicidal ideation over time. More research is needed on the prevalence of entrapment for people in suicidal crisis and the relationship between the two. The methodology for this research was designed and coproduced with our stakeholder group.

Evaluation Clinical data was collected from 1068 men referred to James' Place between August 2018 and July 2021. Demographic information was collected by the service data system and both the CORE-10 Clinical Outcome Measure (CORE-OM), and 4-item Entrapment scale were used pre and post intervention to measure change. The CORE-OM and Entrapment scale are client self-report questionnaires, which are administered prior to each session of therapy. The client was asked to respond to 14 questions about how they have been feeling over the last week, using a 5-point Likert scales.

Impact of James' Place

Lives Saved For the men who completed pre and post questionnaires, all experienced a significant positive change in the items measured by the CORE-OM and 4-item Entrapment scale as result of James' Place. Across the cohort, for men who received therapy, there was a statistically significant reduction in mean scores between initial assessment and end of treatment. The results showed a significant improvement in the health of the men arriving in a crisis to the service when therapy was provided both face-to-face at the centre in Liverpool and remotely online or via telephone during the pandemic. The implementation of both the validated short forms for CORE-10 and entrapment 4-item scale (ESF) as outcome measures at each therapy session has been successful. The CORE-10 asks men how they have been feeling for the last week, and the ESF asks them how they feel now.

Value of James' Place James' Place is making a life-changing difference to individuals, their families, their communities, and the wider system. James' Place provides a substantial social value contribution to a wide range of stakeholders, including family members, friends, statutory and non-statutory services (including the NHS, welfare services), employers and education establishments. The service has continued providing therapy to men remotely between March 2020 and July 2020 using an adapted James' Place model during the

pandemic. Following that period most of the men returned to receiving therapy face-to-face as this was possible due to the environment.

Recommendations This evaluation has highlighted the effectiveness of the James' Place model in saving lives and has focussed on promoting the effectiveness of the intervention specifically as a suicide prevention intervention. Our research to date provides evidence that the James' Place model reduces psychological distress, and now we know it also reduces entrapment. Future research will focus on evidence efficacy with other factors associated with suicide prevention, such as resilience and belongingness. The charity has now opened its second James' Place in London and aims to open more centres to meet need across the UK. Based on the findings of this evaluation, we would recommend that the:

- James' Place model developed in Liverpool be implemented as a model within its future centres.
- As entrapment is identified as a key risk factor for suicide, this evaluation suggests that the intervention if effective in reducing at least one risk factor for suicide, i.e. entrapment. The service should continue implementing the use of the short form clinical outcome and entrapment measures at each therapy session and research the longer-term effects on feelings of entrapment.
- Service seeks to evidence that the intervention effects factors associated with suicidal crisis. We recommend the introduction additional measures and in the first instance resilience. The service should then review the introduction of other measures for prevalent precipitating factors in future (e.g. belongingness).

1. Introduction

With over 700,000 people dying by suicide each year worldwide (World Health Organisation [WHO], 2021), suicide remains a significant, yet preventable, public health risk. Suicide among men is a major public health problem and is the leading cause of death among men under the age of 50 and for people aged 20-34 years in the UK (Office for National Statistic [ONS], 2022). Prevalence of death by suicide among men is consistently higher than women in most countries (WHO, 2019; Turecki and Brent, 2016). Recent figures show that men accounted for three quarters (4,129 deaths by suicide) of the 5,583 registered suicides in 2021 in England and Wales (ONS, 2022). Suicide mortality among males in England remains consistently high. Among men, in 2021, those aged 50 to 54 years had the highest age-specific suicide rate at 22.7 per 100,000 (456 deaths). Male rates for all age groups were higher in 2021 than in 2020, except for those aged 75 years and over where the rate remained unchanged (ONS, 2022).

There is no single reason why people take their own lives. Suicide is a complex and multi-faceted behaviour, resulting from a wide range of psychological, social, economic and cultural risk factors which interact and increase an individual's level of risk. Socioeconomic disadvantage is a key risk factor for suicidal behaviour. Men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas (ONS, 2022). The greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour (Samaritans, 2017).

Prior research has validated the construct of a suicide crisis syndrome (SCS), a specific psychological state that precedes and may precipitate suicidal behaviour. The feeling of entrapment is a central concept of the SCS as well as of several other recent models of suicide. However, its exact relationship with suicidality is not fully understood. Li and colleagues (2018) suggest that entrapment may represent key symptomatic targets for intervention in acutely suicidal individuals as internal entrapment could help to predict suicidal ideation and could predict a change in suicidal ideation over time (Holler et al, 2022). The Integrated Motivational Volitional (IMV; O'Connor et al, 2011) model also proposes that entrapment is central to the common pathway to suicide (O'Connor & Portzky, 2018). However, research is sparse about whether feelings of defeat and entrapment change over time and repeated measurement of entrapment is necessary to adequately capture the empirical relations of it for individuals (Syenzel et al, 2020). The Entrapment measures E-SF – 4 item entrapment scale short form provides comparable information about entrapment as the full scale, but its brevity increases the likelihood that the assessment will be implemented into everyday clinical practice (De Beurs et al, 2020). More research is needed on the prevalence of entrapment for people in suicidal crisis and the relationship between the two.

Suitable support provision for men in suicidal crisis is needed, especially for men who communicate suicidal distress; however, service provision is lacking, particularly within community settings (Pearson et al, 2009; Saini et al, 2010, 2015, 2017, 2020; Mughal et al, 2021). Previous findings suggest that existing suicide prevention services are incompatible with the needs and preferences of men who are experiencing suicidal distress (Pearson et al.,

2009; Saini et al., 2010, 2015, 2017). This adds further to the research evidence suggesting suicide prevention interventions should be tailored to suit the specific needs of their target audience (Zalsman et al., 2016; Lynch et al., 2016). Recently published data shows the effectiveness of a community-based brief therapeutic psychological programme for men in suicidal crisis (Saini et al, 2021a; 2022, Chopra et al 2021; Hanlon et al, 2022); and reports that three in four men state feelings of entrapment at initial assessment (Saini et al, 2020; 2021b).

The purpose of this report was to evaluate the effectiveness of the James' Place model, which delivers a clinical intervention within a community setting for men in suicidal crisis and to explore the relationship between entrapment and psychological distress. The main aims were to:

1) Evaluate the effectiveness of the James' Place model on reducing suicidality in men using the service over a 3-year period; and

2) Compare the outcomes for entrapment and psychological distress for the men using the service.

2. Method

Design: A cohort study approach was used for this study. Quantitative data was collected and analysed to evidence the effectiveness of the James' Place model and to assess the entrapment and psychological distress scores.

Methods: Pre and post data was collected for the primary outcome measures. This information was used to explore the demographic information for the men being referred into and engaging with the service and whether the James' Place model was effective in reducing suicidality.

Participants: Quantitative data was collected from a cohort of men experiencing a suicidal crisis who had been referred to James' Place between 1st August 2018 to 31st July 2021 (n=1068). Referrals came from Emergency Departments, Primary Care, Universities, other community settings or self-referrals.

Procedure for quantitative data collection: Demographic data was collected from the service data system on all men referred to the service. The therapists gave the questionnaires to the men at their first session and then at their final session for years one and two and then at all sessions from year 3 onwards.

CORE-34 Clinical Outcome Measure (CORE-OM)

The CORE-OM is a client self-report questionnaire including 34 questions about how clients have been feeling over the last week, using a 5-point Likert scale ranging from 'not at all' to 'most of the time'. The 34 items cover four dimensions; subjective well-being, problems/symptoms, life functioning, and risk/harm, producing an overall score called the global distress (GD) score. Comparison of the pre and post-therapy scores offer a measure of 'outcome' (i.e., whether the client's level of psychological distress has changed, and by how much). For the CORE-34, scores are presented as a total score (0 to 140) as well as a mean score. Higher scores indicated higher levels of psychological distress, and a total score of 51 or above shows the clinically significant range. Scoring includes less than 20 - non-clinical range; 21 to 33 – low level distress; 34-50 - mild psychological distress; 51 to 67 - moderate psychological distress; 68 to 84 - moderate-to-severe psychological distress; 85 or above - severe psychological distress. In September 2020, the CORE-34 was replaced by the validated CORE-10 measure to enable the administration of the questionnaire at more time points.

CORE-10

The CORE-10 includes 10 questions about how clients have been feeling over the last week and uses a 5-point Likert scale ranging from 'not at all' to 'most of the time'. For the CORE-10, scores are presented as a total score (0 to 40) as well as a mean score (between 0 - 4). Higher scores indicated higher levels of psychological distress, and a total score of 11 or above shows the clinically significant range. Scoring includes less than 10 - non-clinical range; 11 to 14 - mild psychological distress; 15 to 19 - moderate psychological distress; 20 to 24 - moderate-to-severe psychological distress; 25 or above - severe psychological distress. Comparison of the pre and post therapy scores offer a measure of 'outcome' (i.e. whether or

not the client's level of distress has changed, and by how much). Connell et al (2007) published benchmark information and suggested a GD score equivalent to a mean of 10 or above was an appropriate clinical cut-off, demonstrating a clinically significant change, while a change of greater than or equal to five was considered reliable.

E-SF – 4 item entrapment scale

This 16-item Entrapment Scale was initially developed to assess feelings of entrapment within the context of depression (Gilbert and Allan, 1998). Respondents are asked to indicate on a 5-point scale (0= "not at all like me", 1= "a bit like me", 2= "moderately like me", 3= "quite a bit like me", 4= "extremely like me"), how much each statement applies to the respondent. The validated E-SF – 4 item entrapment scale short form provides comparable information about entrapment as the full 16-item scale (De Beurs et al, 2020). Two out of the four items are related to external entrapment, such as "I am in a situation I feel trapped in" and the other two items refer to internal entrapment (example: "I want to get away from myself"). The total score indicates higher levels of entrapment.

Psychological, Motivational, Volitional and Precipitating factors

A range of psychological, motivational, and volitional factors that play a key role in suicidality were assessed for risk factors using the IMV model of Suicidal Behaviour (O'Connor 2011). It is a therapist's objective view of the presence of the risk factors outlined in the IMV model – therapists are trained in agreeing what the risk factors mean and how they would identify them during sessions with the men. Other precipitating factors to the suicidal crisis were also recorded by the referrer into the service.

Quantitative data analysis: The sample size was predetermined based on the number of men who used the service each year. Data was analysed using SPSS 27. To examine client outcomes repeated measures general linear models were used to compare pre and post treatment data. Magnitude of effect sizes (r) were established using the Cohen criteria for r of 0.1 = small effect, 0.3 = medium effect and 0.5 large effect. For referrals, these were coded as secondary care (mental health practitioners, crisis and urgent care, ED), primary care (GPs, nurses, support workers, improving access to psychological therapies [IAPT], occupational health, and student wellbeing services), self-referrals (individual/family member), and other (voluntary organisations and charities). The index of IMD score ranged between 1 = most deprived and 10 = least deprived. Scores of 1-5 indicate the most deprived areas and scores of 6-10 the least deprived areas.

Patient and Public Involvement: The James' Place Research Steering Group who oversee the research taking place at the centre includes commissioners, clinicians, academics, researchers, therapists, James' Place staff members and experts-by-experience. Experts-by-experience are men who have personal experience of being in a suicidal crisis or those who have been bereaved by a male suicide. Members of the group were involved in choosing the methods and agreeing plans for the dissemination of the report to ensure that the findings are shared with wider, relevant audiences within the field, particularly as some members are part of the National Suicide Prevention Alliance and NIHR Applied Research Collaboration.

3. Results

3.1 Men referred to the James' Place service

Between 1st August 2018 and 31st July 2021, James' Place received 1068 referrals from ED, Primary Care, Universities, communities, or self-referrals. Of those, 562 (53%) attended for a welcome assessment and 482 (85%) went on to engage in therapy. For those who did not attend the welcome assessment, the reason was usually no response when the men were followed-up or some said they were not feeling suicidal anymore. The mean age was 36 years (range 18-86 years). Men attended a mean number of 7 sessions, ranging between 1-19 sessions.

Demographic data

Table 1: Demographics characteristics for men referred to the James' Place service

Demographic	N (%) (N=1068)	Significance against CORE-OM
Ethnicity		Core 34 p=.93
White British	740 (69%)	Core 10 p=.50
Other ethnicity	139 (13%)	
Missing	189	
Relationship Status		Core 34 p=.59
Single	552 (52%)	Core 10 p=.06
Married	110 (10%)	
In a relationship	123 (12%)	
Divorced	12 (1%)	
Separated	40 (4%)	
Widowed	6 (1%)	
Missing	225	
Sexual Orientation		Core 34 p=.99
Heterosexual	352 (33%)	Core 10 p=.26
Homosexual	47 (4%)	
Bisexual	10 (1%)	
Missing	659	
Employment Status		Core 34 p=.78
Employed	366 (34%)	Core 10 p=.08
Unemployed	353 (33%)	
Students	127 (12%)	
Retired	13 (1%)	
Carer	7 (1%)	
Missing	193	

Table 1 shows the demographic characteristics about the men who were referred to James' Place. Sixty-nine percent of the men were white British (740/879) and 13% (139/879) from other ethnicity groups. Relationship status showed that 52% (552/843) of the men were single, 12% (123/843) were in a relationship, 10% (110/843) married, 1% (12/843) divorced and 4% (40/843) separated. Sexual orientation of the men was 33% (352/409) heterosexual, 4% (47/409) homosexual and 1% (10/409) bisexual; however, there was missing data for 62% (659/1068) of the men attending at James' Place. Thirty-four percent (366/875) of men were employed, 33% (353/875) unemployed, and 12% (127/875) students. There were no significant differences in psychological distress scores at initial assessment or at discharge across the demographic groups. This data needs to be interpreted cautiously due to the missing data. Demographic information has been collected via referral forms; but the information shared for each of the men referred into the service can vary.

The Index of Multiple Deprivation (IMD) data

Over half of the men (N=545, 51%) referred to the service were from areas classed as the most deprived (an index of IMD score of 1) (see Table 2 and Appendix Table A for more detail). The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas (Lower Super Output Areas [LSOA]). It is a combined measure of deprivation based on a total of 37 separate indicators that have been grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area. Every LSOA in England is given a score for each of the domains and a combined score for the overall index. This score is used to rank all the LSOAs in England from the most deprived to the least deprived, allowing users to identify how deprived areas are relative to others.

Table 2: Levels of deprivation for men using the James' Place service

Level of deprivation	Year 1, 2 & 3 N (%) (of 1068)	Year 1 N (%) (of 162)	Year 2 N (%) (of 307)	Year 3 N (%) (of 517)
Most deprived (1-5)	801 (75%)	130 (61%)	249 (74%)	422 (82%)
Least deprived (6-10)	175 (16%)	32 (15%)	63 (19%)	80 (16%)
Missing	92	50	27	15

Three-quarters (75%) of the men using the service were from the most deprived areas of the city across most years of service delivery. The findings show no significant difference between the outcomes for the men living in the most and least deprived areas against the CORE-OM 34 scores at initial assessment or following treatment (F (2, 132) = .730, p=.48), or against the CORE-10 scores at initial assessment or following treatment (F (2, 136) = .655, p=.52). Thus, suggesting that the James' Place model was just as effective for men across different levels of deprivation.

Referrals to the service

Table 3 shows the referrer details for men who were seen at James' Place. Men were referred from a variety of places. Over a third (37%) of the referrals came from Secondary Care, 27% from Primary Care and 23% via self-referrals. In the first year of the service opening, referrals were mostly received from secondary care followed by primary care and then self-referrals were introduced. In year two, referrals were received by other organisations including voluntary organisations and third sector organisation. Referrals from secondary care and self-referrals increased and referrals from primary care decreased from year one to year two. Unknown *'not specified'* referral data reduced from 30% to 1% from year one to year two and then to 0% in year 3; thus, reflecting improvements in data collection for how men were referred into the service. In year three, primary care referrals increased, and both secondary care and self-referrals decreased compared to year two.

Table 3: Referrer details for men attending the James' Place service

	Year 1, 2 & 3 N (%) (of 1068)	Year 1 N (%) (of 212)	Year 2 N (%) (of 334)	Year 3 N (%) (of 517)
Secondary Care	392 (37%)	74 (35%)	138 (41%)	175 (34%)
Primary Care	288 (27%)	57 (27%)	73 (22%)	166 (32%)
Self-referral	250 (23%)	17 (8%)	102 (30%)	131 (25%)
Other	73 (7%)	0 (0%)	24 (7%)	45 (8%)
Not specified*	65 (6%)	64 (30%)	1 (0%)	0 (0%)

*No details were recorded for who referred men into the service

Factors related to the current suicidal crisis

Precipitating factors were identified for 764 (72%) of the men. The factors relating to the men's current suicidal crisis was collected at the time of referral into James' Place (see Appendix Table B). There was no relationship between the precipitating factors and the levels of general distress found at initial assessment (p>.05). There were also no significant differences in general distress between those with and without each precipitating factor (p>.05). Majority of the precipitating factors men presented with were relationship breakdown (24%) or family problems (20%). In year two more precipitating factors were added that included other reasons men commonly discussed within their sessions during year one. These were: victim of past abuse or trauma, housing issues, physical health, mental health, victim of crime, bereavement by suicide, relationship problems, perpetrators of crime, caring responsibilities, concern for others health and COVID19/lockdown.

Psychological factors

Therapists recorded data on psychological factors men discussed within their sessions (see Appendix Table C). The most common psychological factors that affected men were

rumination (44%), entrapment (40%), past suicide attempt or self-harm (42%), impulsivity (35%), thwarted belongingness (37%), and humiliation (32%). However, this data must be interpreted cautiously as it is subjective to the therapists recording the information.

3.2 Impact of the James' Place service on men engaging with therapy

Clinical outcomes

CORE 34 Year 1 and 2 clinical outcomes

In year 1 and 2, all men who engaged in therapy completed the CORE-34. In year 3, 15 men completed the Core 34, and the remaining 188 men completed the CORE-10. The 15 men are too small a sample size to conduct any meaningful statistical analysis on, therefore the year 3 analysis only includes the cohort of men who completed the CORE-10 (N=162). For all subscales of the CORE-OM there was a statistically significant reduction in mean scores between assessment and end of treatment, with all outcomes demonstrating a large effect size (table 5). Results found that for risk/harm and subjective wellbeing, there was a clinically significant change, with mean scores reducing to under 10, indicating a level of distress classed as healthy. Problems/symptoms and life functioning demonstrated a reliable change with a reduction of more than five in the clinical distress scores following therapy.

Figure 1: CORE-OM scores and severity levels for men using the service

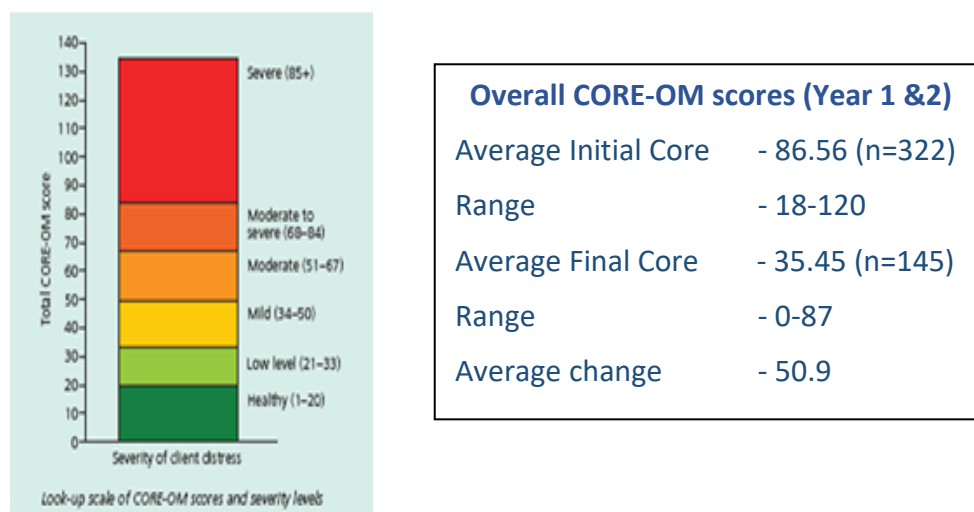| **Overall CORE-OM scores (Year 1 &2)**	
Average Initial Core	- 86.56 (n=322)
Range	- 18-120
Average Final Core	- 35.45 (n=145)
Range	- 0-87
Average change	- 50.9

Table 4 shows the variation of how men scored on the CORE-OM at initial assessment and following treatment in total and for each year. 133 men experienced a clinically significant change in psychological distress scores between initial assessment and following treatment, with 5 showing a reliable change, and 7 demonstrating no clinical change. (Missing data N=192).

Table 4: CORE-OM 34 severity category

Severity Category	Overall		Year 1		Year 2	
	Initial assessment (n=322)	Following treatment (n=145)	Initial assessment (n=129)	Following treatment (n=57)	Initial assessment (n=193)	Following treatment (n=88)
Severe	198 (61%)	6 (4%)	75 (58%)	2 (3%)	123 (64%)	4 (4%)
Moderate to severe	89 (28%)	10 (7%)	36 (28%)	6 (11%)	53 (27%)	4 (4%)
Moderate	24 (7%)	18 (12%)	11 (8%)	8 (14%)	13 (7%)	10 (12%)
Mild	8 (2%)	33 (23%)	5 (4%)	12 (21%)	3 (1%)	21 (24%)
Low Level	2 (1%)	33 (23%)	1 (1%)	12 (21%)	1 (1%)	21 (24%)
Healthy	1 (1%)	45 (31%)	1 (1%)	17 (30%)	0 (0%)	28 (32%)
Not completed	15/337 (4%)	192/337 (57%)	11/140 (8%)	83/140 (59%)	4/197 (2%)	109/197 (55%)

For years one and two, 337 men were assessed using the CORE-OM; however, data was available for 322 men (96%). For those who completed an assessment following treatment (n=145), the CORE-OM showed a statistically significant reduction in mean scores between assessment and end of treatment, for each outcome category (general distress, subjective wellbeing, problems/symptoms, life functioning, risk/harm), demonstrating a large effect size (Tables 5a-c). The initial assessment mean indicated severe levels of distress, with this reducing to mild levels on average following treatment. Tables 5b and 5c show the difference in CORE-OM scores between years and one two.

Table 5a: Overall CORE-OM scores for Year 1 and 2

Outcome	Mean (SD) at Assessment (n=193)	Mean (SD) following treatment (N=90)	F	p	Partial eta squared
General distress	86.56 (18.01)	35.45 (24.06)	505.02	<.0001*	.80
Subjective Wellbeing	12.48 (2.69)	5.28 (3.82)	386.37	<.0001*	.75
Problems/symptoms	34.19 (6.68)	15.94 (10.36)	344.40	<.0001*	.72
Life Functioning	29.09 (7.35)	12.47 (8.86)	417.10	<.0001*	.76
Risk/Harm	9.63 (4.50)	1.73 (2.89)	369.16	<.0001*	.74

*Highly significant

Table 5b: Year 1 CORE-OM scores

Outcome	Mean (SD) at Assessment (n=129)	Mean (SD) following treatment (n=60)	F	p	Partial eta squared
General Distress	82.91 (18.16)	36.41 (23.82)	195.06	<0.001*	.78
Subjective Wellbeing	12.00 (2.92)	5.30 (3.76)	128.86	<0.001*	.70
Problems/Symptoms	34.38 (7.27)	16.36 (10.14)	149.13	<0.001*	.73
Life Functioning	24.91 (7.01)	12.88 (8.49)	119.11	<0.001*	.68
Risk/Harm	9.38 (4.61)	1.88 (3.16)	138.16	<0.001*	.72

*Highly significant

Table 5c: Year 2 CORE-OM score

Outcome	Mean (SD) at Assessment (n=193)	Mean (SD) following treatment (n=87)	F	p	Partial eta squared
General distress	89.15 (17.56)	34.77 (24.37)	317.45	<.0001*	.80
Subjective Wellbeing	12.83 (2.47)	5.26 (3.89)	266.07	<.0001*	.78
Problems/symptoms	35.32 (6.31)	15.64 (10.57)	225.34	<.0001*	.75
Life Functioning	30.49 (6.82)	12.18 (9.17)	273.20	<.0001*	.78
Risk/Harm	9.82 (4.44)	1.62 (2.69)	231.16	<.0001*	.75

*Highly significant

The CORE-10 does not break down into subscales, so no comparison can be made on these between year 3 and the previous years.

CORE-10 Year 3 clinical outcomes

There was a statistically significant reduction in mean scores between assessment and end of treatment ($F(1,138)=195.25$, $p<.001$, partial eta squared = .59), demonstrating a large effect size (see Figure 2). In year 3, the mean initial CORE-10 score = 28.78 (5.47), the mean discharge CORE-10 = 17.42 (9.43). The mean movement on the Core 10 was 11.35 (-11 to 33), thus showing a significant clinical reduction.

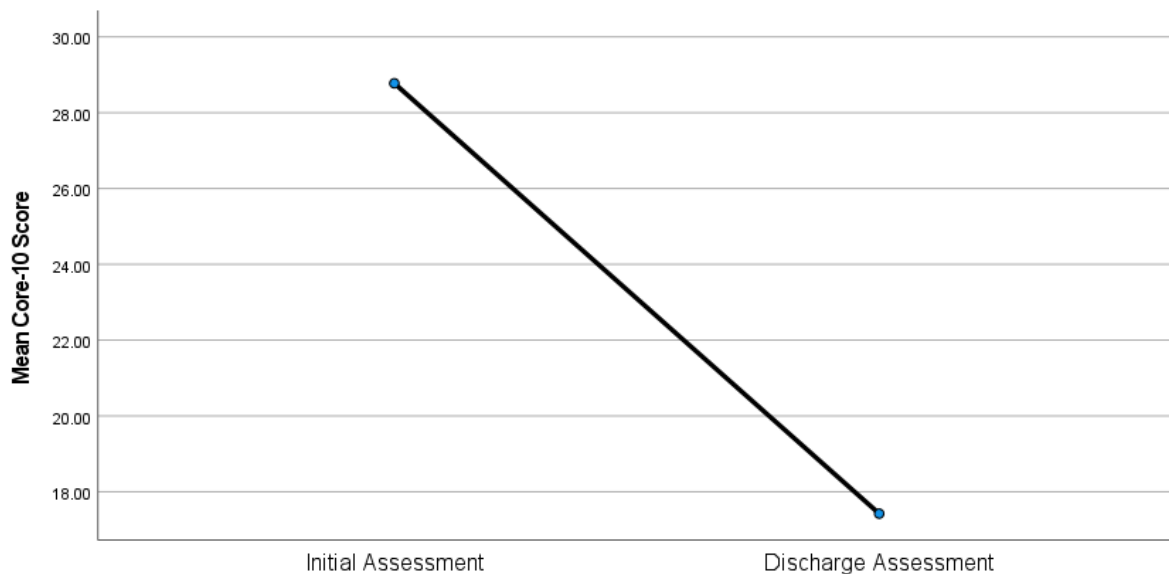**Figure 2:** Mean CORE-10 scores across therapy for Year 3

Table 6 shows the variation of how men scored on the CORE-10 at initial assessment and following treatment in total and for each year. In years 1 and 2 there have been up to 8 men who scored moderate to severe or severe following treatment; this increased to 51 in Year 3. Currently, the reasons for the increase are unknown and this will be monitored in future years. As the CORE-OM and CORE-10 is used to inform and understand the men's distress levels at different time-points, where men score high following treatment, the decision to end therapy is made in collaboration with them and is not solely dependent on the outcome scores. When men are still scoring highly, they will be signposted to an appropriate resource and in some cases referred on for further mental health support through primary or secondary care services.

Table 6: Year 3 CORE-10 severity category

Severity of psychological distress	Initial Assessment N=162 (%)	Discharge Assessment N=162 (%)
Non-clinical/healthy	0	34 (21%)
Mild	3 (2%)	25 (15%)
Moderate	4 (3%)	29 (18%)
Moderate to severe	26 (16%)	17 (11%)
Severe	127 (78%)	34 (21%)
Missing	2	23

E-SF Entrapment score Year 3 clinical outcomes

**Figure 3:** Mean Entrapment Scores across therapy for year 3
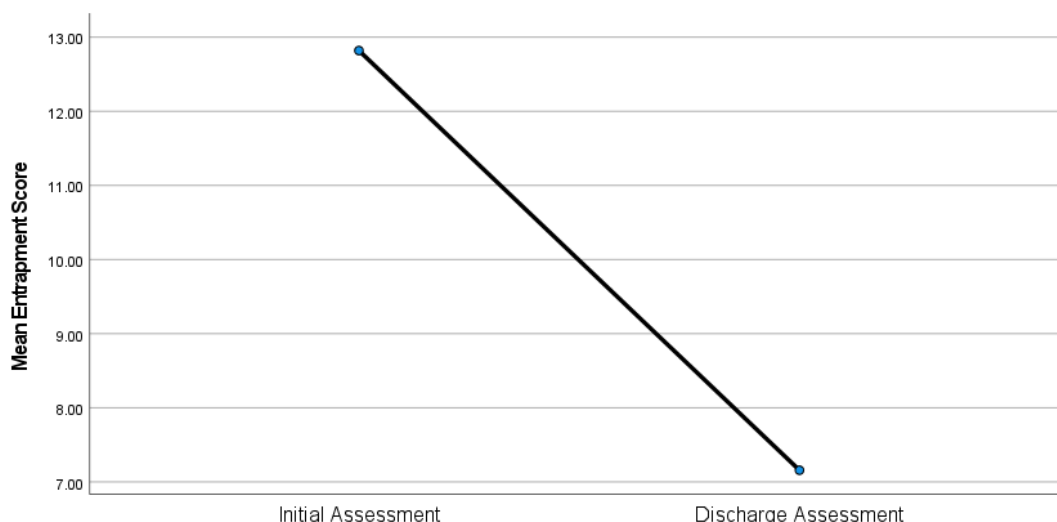
In year 3, with the introduction of the CORE-10, data was also collated for entrapment. For entrapment, there was a statistically significant reduction in mean scores between assessment and end of treatment $(F_{(1,138)}=196.39, p<.001$, partial eta squared = .59),

demonstrating a large effect size. The mean initial entrapment score = 12.82 (3.46) and the mean discharge entrapment score = 7.16 (4.94). The mean movement on the entrapment measure was 5.66 (-3 to 17).

3.3 Relationship between entrapment and psychological distress

Figure 4: Mean core 10 and Entrapment scores across therapy
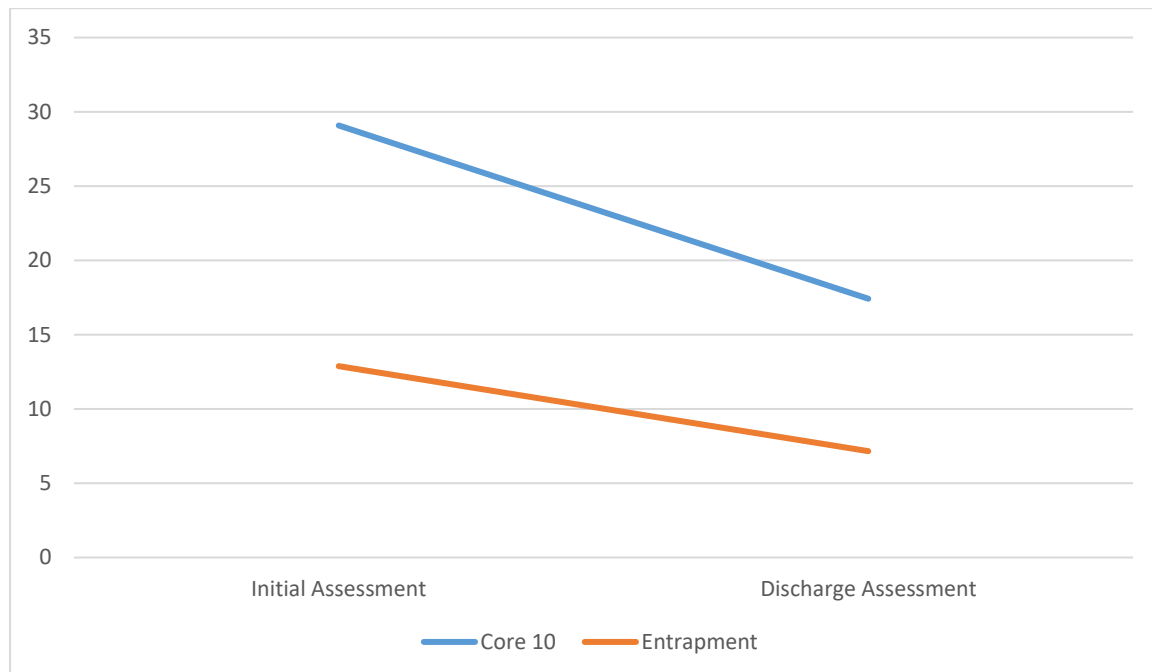
Both psychological distress and entrapment scores reduced significantly from initial assessment to end of treatment for men using the service. Figure 4 highlights that psychological distress reduced more steeply than entrapment when reviewing pre and post data at two time points.

4. Discussion

James' Place model

The quantitative service data show the range of organisations who refer men into James' Place. Quantitative data (factors relating to the suicidal crisis, clinical outcome measures and entrapment) show the reduction in psychological distress and feelings of entrapment that the intervention provides. Upon further exploration with the data collated by therapists at James' Place on psychological and precipitating factors at the time of suicidal crisis, the findings suggest that through the provision of support, men accessing the service were able to begin to understand their thoughts and feelings (through increased awareness and the formation of knowledge) around what had led them to the point of crisis, help them to identify warning signs that their mental health may be worsening, and change the way in which they approached and dealt with (through coping strategies) the distress they were feeling. These actions, including safety planning, were seen to help the men make safer decisions in the future. During the COVID-19 pandemic period, the men did not seem to be affected by therapy needing to be adapted and provided remotely or face-to-face (Saini et al 2022).

Motivational factors and actions

The CORE-OM data, demonstrates how the service improves overall levels of mental wellbeing. These factors were all considered to ultimately reduce overall suicidality through reductions in thoughts around suicide, plans and intention to act on suicidal thoughts, and risk-taking behaviour. The E-SF data also showed a reduction in feeling of entrapment. These outcomes were seen to lead to an increase in recovery capital and in enabling the men to seek support for other health and wellbeing issues. With the introduction of a new CIS system the service now aims to collect data at multiple time points in order to provide insight into how the intervention supports and effects change. For example, in suicidality or feelings of entrapment.

Key outcomes

The findings of this report indicate that the three years delivery of the brief psychological James' Place model has been effective in significantly reducing suicidality in men. The results from the CORE-OM and E-SF show a significant improvement in the health of the men arriving in a crisis to the service when therapy was provided both face-to-face at the centre in Liverpool and remotely online or via telephone. The findings indicate that James' Place is making a life-changing difference to individuals, their families, their communities, and the wider system.

Long-term scores need to be collected to see whether this affect continues once men end their treatment at the service. A PhD student who has been fully funded by Liverpool John Moores University to conduct a 3-year study on: *'The Feasibility and Efficacy of the James' Place Brief Psychological Therapeutic Model among Men in Suicide Crisis'* (started in October 2019); is currently collecting data at three follow-up time points (at the time of crisis, and 6 and 12 months following the men's initial assessment). These findings will help the service to

understand whether the effects of the therapy are sustainable over time following treatment at the service.

One strength of this report is that most previous research includes demographic data for people who died by suicide; however, this service has collected data on men at the time of crisis and therefore this information has been used to establish what support men may need from the local support networks in the area. The service has identified referral pathways both in and out of the service as a core component of the James' Place model. A good example is debt, which affected 18% of the men attending the service; James' Place have invited the local Citizens Advice Bureau to come to the centre and receive referrals for men attending the service; this is working well as part of the local social prescribing model.

Another strength is how the James' Place service has established itself within the crisis care pathway of the region. For example, the local Clinical Commissioning Group (CCG) has recognised the service has an essential role within suicide prevention in the city and has funded the service to run an outreach campaign to get men into mental health services more widely.

A further strength is how James' Place has implemented the use of the ESF into routine clinical practice and shown further evidence that entrapment may precede and precipitate suicidal behaviour. Both entrapment and psychological distress reduced following delivery of the James' Place model and now we are seeking to better understand this and evidence that the intervention is effective in treating people in a suicidal crisis.

The findings in this report should also be interpreted in the context of some methodological limitations as the results may not be representative of the rest of the UK (only collected in one area where the service is situated) although many of the issues we identified are likely to apply across other areas. Another limitation to consider is the reduction of missing data for men who attend the service. Currently, this data is collected from information completed by referrers on the referral form. The service may therefore look at collating this information within the initial assessment completed at James' Place. It is important to note, however, that there have been some marked improvements in the reduction of missing data over the three years.

5. Recommendations

This evaluation has highlighted the effectiveness of the James' Place model in saving lives and has focussed on promoting the effectiveness of the intervention specifically as a suicide prevention intervention. Our research to date provides evidence that the James' Place model reduces psychological distress, and now we know it also reduces entrapment. Future research will focus on evidence efficacy with other factors associated with suicide prevention, such as resilience and belongingness. The charity has now opened its second James' Place in London and aims to open more centres to meet need across the UK. Based on the findings of this evaluation, we would recommend the following.

Recommendations for James' Place service delivery

- James' Place model developed in Liverpool be implemented as a model within its future centres.
- As entrapment is identified as a key risk factor for suicide, this evaluation suggests that the intervention if effective in reducing at least one risk factor for suicide, i.e. entrapment. The service should continue implementing the use of the short form clinical outcome and entrapment measures at each therapy session and research the longer-term effects on feelings of entrapment.

Recommendations for monitoring and evaluation

- Continue implementing the use of the short form clinical outcome and entrapment measures at each therapy session.
- Service seeks to evidence that the intervention effects factors associated with suicidal crisis. We recommend the introduction additional measures and in the first instance resilience. The service should then review the introduction of other measures for prevalent precipitating factors in future (e.g. belongingness).
- Ensure that demographic data is consistently collected for all the men referred into and using the service.
- Ensure that demographic data and psychological factors are collected as fully as possible to ensure that there is maximum data available to provide an accurate a reflection as possible about the men using the service. This should include details of the date when clinical outcome measures were completed (at both initial assessment and following treatment) to enable the identification of the duration over which the change has taken place, and whether this has had a significant effect.

Conclusion

This evaluation has highlighted the effectiveness of the James' Place model in saving lives over a three period, that included the COVID-19 pandemic. Despite the challenges due to the pandemic and national lockdown, James' Place has continued to offer an excellent service to men in suicidal crisis. We would recommend that James' Place use the Liverpool model as the basis for implementing the service in other settings. Future research at the services needs to assess 1) which other psychological risk factors that precipitate suicide the intervention helps to reduce (e.g. rumination, resilience, belongingness) and 2) the long-term effects of the model to understand whether the effects of the therapy are sustainable over a period of time following treatment from the service.

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7. APPENDICES

Appendix Table A

Postcode Area	IMD measure of deprivation	Year 1, 2 & 3 N (%) (of 1068)	Year 1 N (%) (of 162)	Year 2 N (%) (of 307)	Year 3 N (%) (of 517)
L8	1	81 (8%)	11 (7%)	27 (9%)	43 (9%)
L3	1	50 (5%)	17 (11%)	12 (4%)	21 (4%)
L4	1	66 (6%)	11 (7%)	18 (6%)	37 (7%)
L7	1	44 (4%)	10 (6%)	17 (6%)	17 (3%)
L6	1	40 (4%)	11 (7%)	15 (5%)	14 (3%)
L15	1	44 (4%)	10 (6%)	14 (5%)	20 (4%)
L13	1	43 (4%)	6 (4%)	17 (6%)	20 (4%)
L9	1	35 (3%)	7 (4%)	11 (4%)	17 (3%)
L11	1	33 (3%)	6 (4%)	10 (3%)	17 (3%)
L20	1	40 (4%)	3 (2%)	12 (4%)	25 (5%)
L5	1	24 (2%)	5 (3%)	9 (3%)	10 (2%)
L12	2	18 (2%)	0	11 (4%)	7 (1%)
L17	5	34 (3%)	3 (2%)	10 (3%)	21 (4%)
L14	5	25 (2%)	6 (4%)	10 (3%)	9 (2%)
L19	5	28 (3%)	2 (1%)	12 (4%)	14 (3%)
L1	6	42 (4%)	9 (6%)	14 (5%)	19 (4%)
L25	7	23 (2%)	2 (1%)	12 (4%)	9 (2%)
L18	8	23 (2%)	7 (4%)	12 (4%)	4 (1%)

All other postcode areas reported had N<10

Note: Scores of 1-5 indicate the most deprived areas and scores of 6-10 the least deprived areas.

Appendix Table B

Precipitating factor	N (%) (N=1068)
Relationship breakdown	258 (24%)
Family problems	213 (20%)
Work	172 (16%)
Bereavement	175 (17%)
Debt	156 (15%)
Victim of past abuse or trauma	128 (12%)
Physical Health	83 (8%)
Covid-19/lockdown	77 (8%)
Mental Health	77 (7%)
University	69 (7%)
Alcohol misuse	79 (7%)
Housing issues	68 (6%)
Relationship problems	54 (5%)
Drug misuse	48 (5%)
Bereaved by suicide	57 (5%)
Legal problems	44 (4%)
Sexuality	28 (3%)
Perpetrator of crime	35 (3%)
Victim of crime	23 (2%)
Bullying	20 (2%)
Gambling	14 (1%)
Being a carer	11 (1%)
Asylum issues	9 (1%)
Concerns over health of others	14 (1%)
Other	4 (0.4%)

Appendix Table C: Overall psychological variables reported by men

Psychological variable	Reported at initial assessment	Reported at discharge
Rumination	214 (44%)	110 (23%)
Entrapment	193 (40%)	58 (12%)
Past suicide attempt/self harm	202 (42%)	
Impulsivity	167 (35%)	
Thwarted belonginess	179 (37%)	89 (19%)
Burdensomeness	141 (29%)	2 (0.4%)
Social support	177 (37%)	
Defeat	139 (29%)	8 (2%)
Memory biases	129 (27%)	56 (12%)
Absence of positive future thinking	136 (28%)	34 (7%)
Humiliation	152 (32%)	30 (6%)
Imagery of death or suicide	111 (23%)	45 (9%)
Social problem solving	102 (21%)	39 (8%)
Exposure to suicidality	106 (22%)	
Coping	89 (19%)	121 (25%)
Not engaging in new goals	83 (17%)	27 (6%)
Resilience	79 (16%)	72 (15%)
Suicide plan	63 (13%)	13 (3%)
Fearlessness of death	53 (11%)	
Unrealistic goals	42 (9%)	2 (0.4)
Attitudes	42 (9%)	
Pain sensitivity/tolerance	40 (8%)	
Social norms	11 (2%)	