



James' Place Service Evaluation YEAR FOUR REPORT

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J James' Place

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Acknowledgements

This report is the work of members of staff from the School of Psychology, Liverpool John Moores University, with the collaboration of James' Place and front-line service providers. The aim was to explore whether the James' Place therapeutic model continues to be a safe and effective form of therapy for men referred into the service at both Liverpool and London centres.

The Evaluation Team would like to thank James' Place who provided funding for the evaluation. The content of this report is the product of the Evaluation Research Team and not of James' Place.

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James' Place Evaluation: Year Four Report

Executive Summary

Introduction

The fourth James' Place service evaluation examines the effectiveness of the James' Place model on reducing suicidality in men and the relationship of entrapment with suicidality. Previous research has focused on the outcomes of the James' Place model being delivered in one location, Liverpool. For this evaluation we will compare the outcomes of men utilising the service across two sites, Liverpool and London. The methodology for this research was designed and coproduced with our stakeholder group.

Evaluation Clinical data was collected from 851 men referred to James' Place between August 2021 and July 2022. Demographic information was collected by the service data system and both the CORE-10 Clinical Outcome Measure (CORE10), and 4-item Entrapment scale (E-SF) were used pre and post intervention to measure change. The CORE10 and E-SF 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 CORE10 and E-SF as result of the James' Place model. 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 at both Liverpool and London centres. The implementation of both the validated short forms for CORE10 and E-SF as outcome measures at each therapy session has been successful across both centres. The CORE10 asks men how they have been feeling for the last week, and the E-SF 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 model has been implemented successfully in another location where the population demographic is different.

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 entrapment, and now we have evidence that the model can be implemented in another location successfully. 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 third James' Place in

Newcastle 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 and London 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 is 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.
- the service seeks to evidence that the intervention effects factors associated with suicidal crisis. We recommend the introduction of 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], 2022), 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 Statistics [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 5,642 registered suicides in 2022 in England and Wales (ONS, 2023). Suicide mortality among males in England remains consistently high. Among men, in 2022, those aged 90 years and older had the highest age-specific suicide rate at 32.1 per 100,000 followed by those aged 45-49 at 23.0 per 100,000 (ONS, 2023).

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 (Syzenel 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.

Around 18–19% of people who die by suicide do not access support from a primary care provider in the year preceding their suicide (Mallon et al., 2019; NCISH, 2014; Pearson et al., 2009), with research supporting that men endure proportionally greater mental distress before they engage in help-seeking behaviour (Biddle et al., 2004). However for those men who do contact services, the current provision may include being referred to primary care or secondary mental health care services, being admitted to hospital or referred to third sector

organisations providing crisis care in community settings (e.g. crisis cafes). This may be more prevalent in men who are assessed as not needing a psychiatric intervention or those who have not made a suicide attempt or previously self-harmed.

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 showed 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 compare the outcomes of men utilising the service across two English regions. The main aims were to:

- 1) Evaluate the effectiveness of the James' Place model on reducing suicidality in men using the service over a 1-year period; and
- 2) Compare the outcomes for entrapment and psychological distress for the men using the service at two centres located in Liverpool and London.

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 across two centres.

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 at two centres.

Participants: Quantitative data was collected from a cohort of men experiencing a suicidal crisis who had been referred to James' Place between 1st August 2021 to 31st July 2022 (n=851). 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. Men accessing the service were encouraged to fill in demographic questionnaires at the point of entering the service.

The Index of Multiple Deprivation (IMD)

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.

CORE10

The CORE10 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 CORE10, 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 a statistical package 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.

Ethical Approval: Ethical approval was granted by the Liverpool John Moores University Research Ethics Committee (Reference: 19/NSP/057) and written consent was gained from men using the service at their initial welcome assessment.

3. Findings

3.1 Men referred to the James' Place Liverpool and London services

Between 1st August 2021 and 31st July 2022, James' Place Liverpool (N=542) and London (N=309) received a total of 851 referrals from Emergency Departments, Primary Care, Universities, communities or self-referrals. Of those, 558 referrals were accepted, 445 attended for a welcome assessment and 276 went on to engage in therapy. Of those, Liverpool accepted 362 referrals, of which 159 went on to engage in therapy and London accepted 196 referrals, of which 117 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 37 years (range 18-76 years). The mean age was the same for both centres. At both centres, men attended a mean number of 6 sessions, ranging between 1-16 sessions.

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

Area	Liverpool 2018-2021	Liverpool 2021-2022	London 2021-2022	Total 2021-2022	Year 4 comparisons
Demographic	N (%) (N=1068)	N (%) (N =542)	N (%) (N=309)	N (%) (N=851)	CORE-OM Significance
<i>Ethnicity</i>					p=.45
White British	740 (69%)	225 (42%)	47 (15%)	272 (32%)	
Other ethnicity*	139 (13%)	35 (7%)	45 (15%)	80 (9%)	
Not specified	189 (18%)	282 (52%)	217 (70%)	478 (56%)	
<i>Relationship Status</i>					p=.44
Single	552 (52%)	152 (28%)	56 (18%)	208 (24%)	
Married	110 (10%)	34 (6%)	10 (3%)	44 (5%)	
In a relationship	123 (12%)	43 (8%)	15 (5%)	58 (7%)	
Divorced	12 (1%)	1 (0.2%)	2 (1%)	3 (0.4%)	
Separated	40 (4%)	10 (2%)	6 (2%)	16 (2%)	
Widowed	6 (1%)	3 (1%)	0	3 (0.4%)	
Not specified	225 (21%)	271 (50%)	220 (71%)	478 (56%)	
<i>Sexual Orientation</i>					p=.13
Heterosexual	352 (33%)	135 (25%)	47 (15%)	182 (21%)	
Homosexual	47 (4%)	11 (2%)	10 (3%)	21 (3%)	
Bisexual	10 (1%)	0	1 (0.3%)	1 (0.1%)	
Not specified	659 (62%)	396 (73%)	251 (81%)	647 (76%)	
<i>Employment Status</i>					p=.62
Employed	366 (34%)	204 (38%)	50 (16%)	254 (30%)	
Unemployed	353 (33%)	218 (40%)	30 (10%)	248 (29%)	
Students	127 (12%)	34 (6%)	9 (3%)	43 (5%)	
Retired	13 (2%)	9 (2%)	2 (1%)	11 (1%)	
Carer	7 (1%)	1 (0.2%)	0	1 (0.1%)	
Not specified	193 (18%)	76 (14%)	218 (71%)	334 (39%)	

*See Appendix B for full breakdown of ethnicities

Demographic data

Table 1 shows the demographic characteristics about the men who were referred to James' Place and shows the differences across the centres. Similar to previous years, for both centres, the majority of men were single, heterosexual and in employment. The years 1, 2 and 3 data in Liverpool show strikingly high 'single' readings compared to year 4 and year 1 in London, however there is also more missing data and this could account for the suggested decrease. The London centre shows a higher percentage of non-white British men than Liverpool but it would be very helpful to have better ethnicity data in order to know whether this is an accurate reflection of the men using the service across different regions. Similarly, for level of deprivation there are more data gaps in the London figures, thus it is unknown if there are fewer men from most deprived backgrounds attending in London.

There were no significant differences in CORE10 scores at initial assessment or at discharge across any of the demographic groups. This is similar to previous years findings (Saini et al, 2022). This data needs to be interpreted cautiously due to the high number of 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

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

Level of deprivation	Year 1, 2 & 3 N (%) (N=1068)	Liverpool N (%) (N=542)	London N (%) (N=309)	Total N (%) (N=1919)
Most deprived (1-5)	801 (75%)	426 (79%)	176 (57%)	1403 (73%)
Least deprived (6-10)	175 (16%)	100 (19%)	53 (17%)	328 (17%)
Missing	92	16 (3%)	80 (26%)	188 (9%)

The majority of men using the service were from the most deprived areas of the cities (73%). Similar to previous reports, in year 4 the findings show no significant difference between the outcomes for the men living in the most and least deprived areas against the CORE 10 scores at initial assessment ($F(1)=.278$, $p=.60$) or following treatment ($F(1) = .280$, $p=.60$). 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. Overall, in year 4 most of the referrals came from Secondary Care

(44%), 26% from Primary Care and 23% via self-referrals. Compared to Liverpool, the London Centre received more referrals from secondary and primary care, and a smaller percentage of referrals from self-referrals or other services.

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

	Liverpool Year 1, 2 & 3 N (%) (of 1068)	Liverpool N (%) (N =542)	London N (%) (N=309)	Total N (%) (N=1919)
Secondary Care	392 (37%)	210 (39%)	164 (53%)	766 (40%)
Primary Care	288 (27%)	121 (22%)	103 (33%)	512 (27%)
Self-referral	250 (23%)	161 (30%)	32 (10%)	443 (23%)
Other	73 (7%)	47 (9%)	10 (3%)	130 (7%)
Not specified*	65 (6%)	3 (1%)	0	68 (0.4%)

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

Factors related to the current suicidal crisis

Precipitating factors were identified for 385 (87%) of the men. The factors related to the current suicidal crisis the men were collected at the time of referral into James' Place (see Appendix Table A). 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 ($p>.05$).

Overall, the most common precipitating factors men presented with were relationship breakdown (17%) or family problems (17%).

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

Clinical outcomes

Table 4 shows the severity levels for men using the service across Liverpool and London.

Table 4: CORE10 scores and severity levels

	Liverpool Year 4 M (SD)	London Year 1 M (SD)	Total M (SD)
Initial CORE 10	29.66 (5.27)	28.99 (5.77)	29.05 (5.64)
Mid CORE 10	23.78 (8.22)	24.19 (7.94)	24.19 (7.94)
Discharge CORE 10	17.16 (9.47)	18.78 (9.57)	18.79 (9.58)

There was a statistically significant reduction in mean scores between assessment and end of treatment ($t(255)=18.06, p<.001$). The mean movement on the CORE 10 was 10.09 (range: -11 to 36). Previous years used the CORE-OM and were initially collected at different time points; therefore, a direct comparison cannot be shown to the current data. Figure 1 shows the reduction in psychological distress for men using both services at the end of their treatment. However, the reduction is greater in Liverpool.

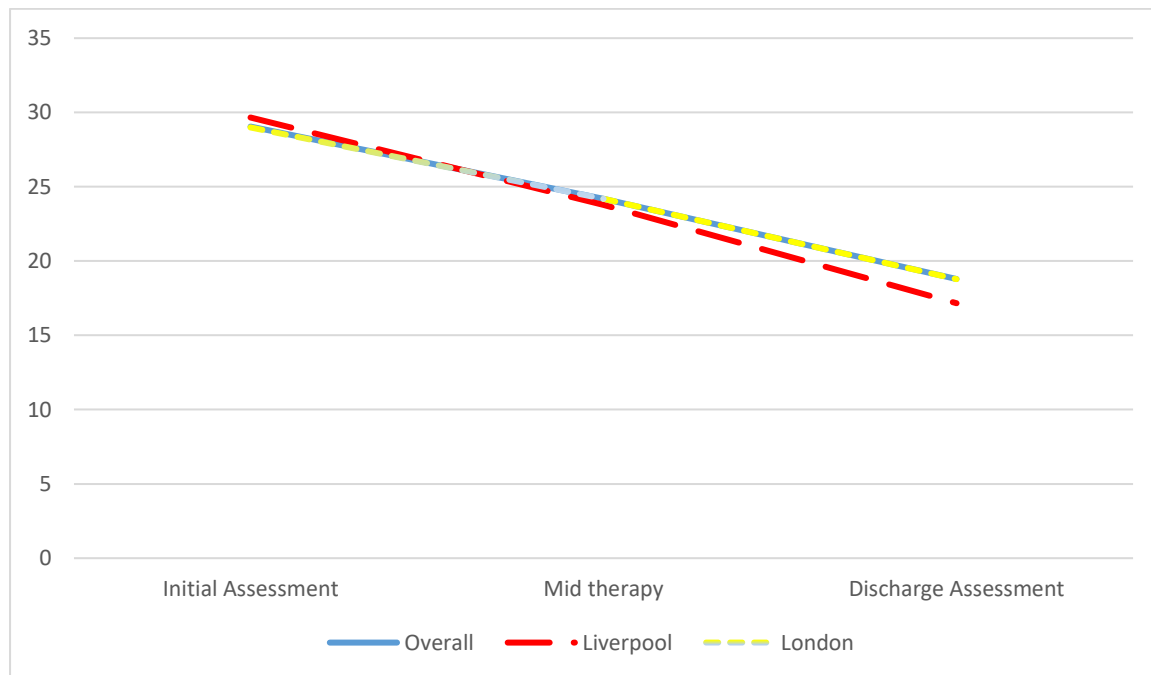


Figure 1: Mean CORE10 scores and severity levels for men using the service overall and by centre

Table 5 shows that most men enter the service with severe levels of psychological stress. It can also be seen that there are improvements over the course of therapy, with the lower levels of distress being more characteristic of distress at discharge. However, the London service does have a higher percentage of men still experiencing severe levels of distress at discharge. As the clinical outcomes measure 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 5: Severity categories at initial assessment and discharge

Severity Category	Liverpool Year 1*		Liverpool Year 2*		Liverpool Year 3		Liverpool Year 4		London Year 1	
	Initial (n=129)	Discharge (n=57)	Initial (n=193)	Discharge (n=88)	Initial (n=162)	Discharge (n=162)	Initial (n=159)	Discharge (n=159)	Initial (n=117)	Discharge (n=117)
Non-clinical/healthy	1 (1%)	17 (30%)	0 (0%)	28 (32%)	0 (0%)	34 (21%)	1 (1%)	42 (27%)	1 (1%)	12 (10%)
Mild	6 (5%)	24 (42%)	4 (2%)	42 (48%)	3 (2%)	25 (15%)	0 (0%)	22 (14%)	1 (1%)	12 (10%)
Moderate	11 (8%)	8 (14%)	13 (7%)	10 (12%)	4 (3%)	29 (18%)	5 (3%)	26 (17%)	9 (8%)	24 (21%)
Moderate-Severe	36 (28%)	6 (11%)	53 (27%)	4 (4%)	26 (16%)	17 (11%)	16 (10%)	34 (22%)	14 (12%)	19 (16%)
Severe distress	75 (58%)	2 (3%)	123 (64%)	4 (4%)	127 (78%)	34 (21%)	133 (85%)	30 (19%)	90 (77%)	36 (31%)
<i>Missing/incomplete data</i>	<i>11</i>	<i>83</i>	<i>4</i>	<i>109</i>	<i>2</i>	<i>23</i>	<i>4</i>	<i>5</i>	<i>2</i>	<i>14</i>

*CORE34 measure was used at initial assessment and final session (when the men attended)

Entrapment

There was a statistically significant reduction in mean scores between assessment and end of treatment ($t(233)=5.10, p<.001$). The mean movement on entrapment was 5.82 (range: -7 to 16).

Table 6: Entrapment scores overall and across two centres

	Liverpool	London	Total
	M (SD)	M (SD)	M (SD)
Initial Entrapment	13.60 (2.56)	13.18 (3.65)	13.42 (3.07)
Mid Entrapment	10.69 (4.24)	12.16 (3.19)	11.09 (4.03)
Discharge Entrapment	9.29 (14.34)	10.19 (4.51)	9.67 (11.30)
Mean Movement	7.02	3.82	5.82

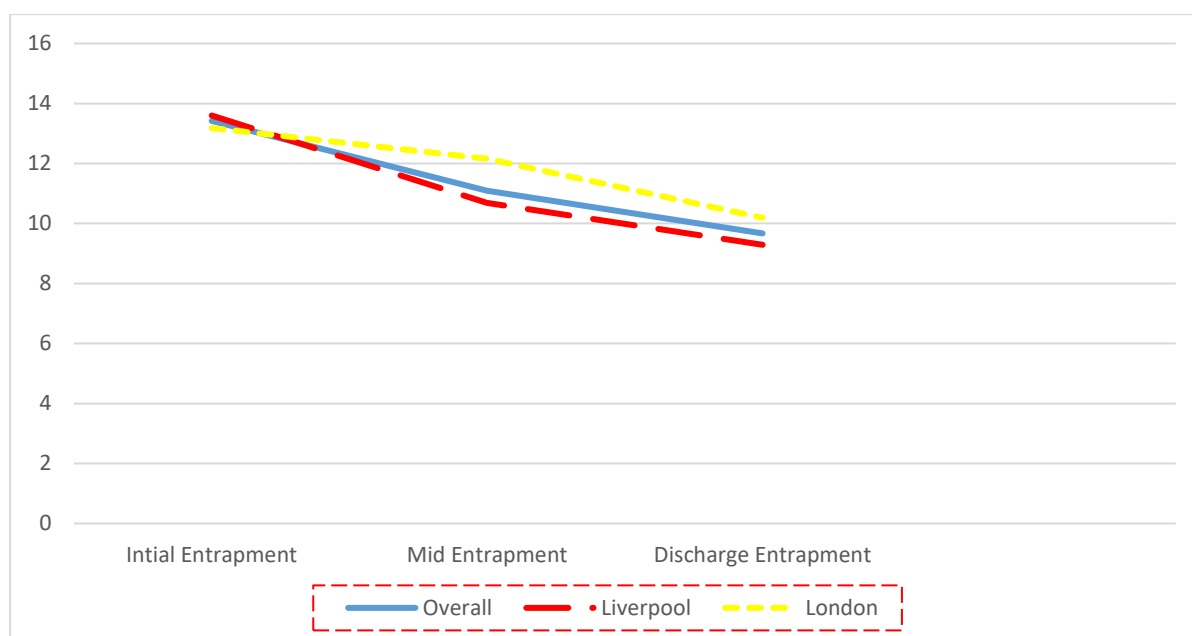


Figure 2: Mean entrapment scores overall and for each centre

Figure 2 shows the reduction in feelings of entrapment for men using both services at the end of their treatment. However, the reduction is greater in Liverpool at both the mid-point and end of treatment.

The relationship of entrapment with suicidality

Figure 3 shows a reduction in both psychological distress and feelings of entrapment for men being treated at both the London and Liverpool centres. However, it is evident that psychological distress reduced more rapidly than entrapment.

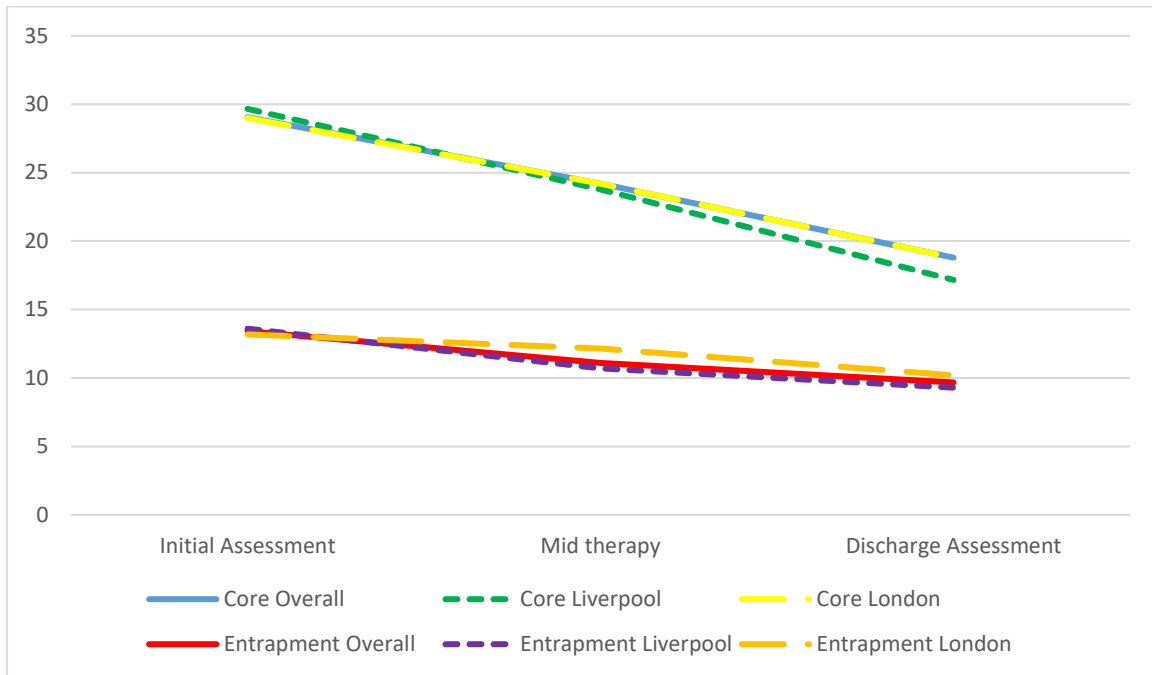


Figure 2: Mean CORE10 and entrapment scores overall and for each centre

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 across two centres. Although there was a significant reduction at both centres in psychological distress, the Liverpool centre reported a greater reduction compared to London. 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. However, there were differences in the precipitating factors reported; relationship problems, family problems, bereavement, work and drug and alcohol misuse were reported more in Liverpool compared to London due to this data not being available.

Motivational factors and actions

The CORE10 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.

Key outcomes

The findings of this report indicate that the delivery of the brief psychological James' Place model has been effective in significantly reducing suicidality in men when delivered across two centres. The results from the CORE10 and E-SF show a significant improvement in the health of the men arriving in a crisis to the service when therapy was provided across two centres. We can see some differences in levels of reduction across both centres and this will be reviewed in future research. The difference could be due to the Liverpool centre being open for longer than London. Overall, 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); has collected data at three follow-up time points (at the time of crisis, and 6 and 12

months following the men's initial assessment). The findings from this study inform the service to further understand whether the effects of the therapy are sustainable over time following treatment at the service. However, larger studies are needed that link with health services data for longitudinal research to be conducted.

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, for example as part of the local social prescribing model.

A further strength is how James' Place has implemented the use of the E-SF 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 two areas where the services are situated) although many of the issues we identified are likely to apply across other areas. Another limitation to consider is the 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.

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 entrapment in one region, and now we know it also reduces both in another region. 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 third James' Place in Newcastle and aims to open more centres in Birmingham and other cities to meet need across the UK. Based on the findings of this evaluation, we would recommend the below.

Recommendations for James' Place service delivery

- James' Place model that has been delivered in Liverpool and London 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 is 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.
- Future research should monitor the outcomes across centres to ensure consistency in delivery and capture demographic differences that may effect outcome data.

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 across two regions. Despite the challenges of implementing a new service in a new location, James' Place has continued to offer an excellent service to more men in suicidal crisis. We would recommend that James' Place use the 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), 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 and 3) the outcomes for men utilising the service at different James' Place centres.

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6. APPENDICES

Appendix Table A

Precipitating factor	Liverpool N (%) (N =542)	London N (%) (N=309)	Total N (%) (N=851)
Relationship breakdown	138 (26%)	10 (3%)	148 (17%)
Family problems	123 (23%)	17 (6%)	140 (17%)
Work	100 (19%)	10 (3%)	110 (13%)
Bereavement	98 (18%)	14 (5%)	112 (13%)
Debt	73 (14%)	4 (1%)	77 (9%)
Victim of past abuse or trauma	27 (5%)	10 (3%)	37 (4%)
Physical Health	19 (4%)	5 (2%)	24 (3%)
Covid-19	6 (1%)	4 (1%)	10 (1%)
Mental Health	11 (2%)	4 (1%)	15 (2%)
University	18 (3%)	1 (0.3%)	19 (2%)
Alcohol or drug misuse	122 (23%)	2 (1%)	124 (15%)
Housing issues	7 (1%)	1 (0.3%)	8 (1%)
Relationship problems	12 (2%)	3 (1%)	15 (2%)
Bereaved by suicide	11 (2%)	6 (2%)	17 (2%)
Legal problems	34 (6%)	1 (0.3%)	35 (4%)
Sexuality	17 (3%)	3 (1%)	20 (2%)
Perpetrator of crime	7 (1%)	3 (1%)	10 (1%)
Other	20 (4%)	5 (2%)	25 (3%)
Not Specified	213 (39)	253 (82)	466 (55)

Appendix B

Area	Liverpool 2018- 2022	London 2021-2022	Total 2018-2022
Demographic	N (%) (N=1537)	N (%) (N=309)	N (%) (N=1846)
<i>Ethnicity</i>			
White British	931 (61)	88 (23)	1019 (53)
Mixed British	50 (4)	14 (4)	64 (4)
Irish	21 (1.4)	4 (1)	25 (1)
Black British	4 (0.3)	15 (4)	19 (1)
Eastern European	7 (1)	5 (1)	12 (1)
White European	14 (1)	3 (1)	17 (1)
Caribbean	2 (0.2)	3 (1)	5 (0.3)
Sri Lankan	1 (0.1)	0 (0)	1 (0.1)
Chinese	7 (1)	0 (0)	7 (0.4)
Indian	11 (1)	4 (1)	15 (1)
Black African	5 (0.3)	6 (2)	11 (1)
Other Asian	2 (0.2)	1 (0.3)	3 (0.2)
Yemeni	1 (0.1)	0 (0)	1 (0.1)
Kurdish	2 (0.1)	1 (0.3)	3 (0.2)
Egyptian	2 (0.1)	0 (0)	2 (0.1)
Russian	1 (0.1)	0 (0)	1 (0.1)
Brazilian	2 (0.1)	2 (1)	4 (0.2)
Iraqi	3 (0.2)	0 (0)	3 (0.2)
Iranian	4 (0.3)	4 (1)	8 (0.4)
Syrian	1 (0.1)	0 (0)	1 (0.1)
Afghani	1 (0.1)	2 (1)	3 (0.2)
Somali	1 (0.1)	0 (0)	1 (0.1)
Other Middle Eastern	2 (0.1)	2 (1)	4 (0.2)
Vietnamese	0 (0)	1 (0.3)	1 (0.1)
South African	0 (0)	3 (1)	3 (0.2)
Libyan	0 (0)	1 (0.3)	1 (0.1)
Latino	0 (0)	1 (0.3)	1 (0.1)
West Indian	0 (0)	1 (0.3)	1 (0.1)
New Zealander	0 (0)	1 (0.3)	1 (0.1)
Japanese	0 (0)	1 (0.3)	1 (0.1)
South Korean	0 (0)	1 (0.3)	1 (0.1)
Black American	0 (0)	1 (0.3)	1 (0.1)
Not specified	394 (26)	207 (54)	601 (33)