James’ Place Liverpool Evaluation

YEAR TWO REPORT

August 2021

Authors: Pooja Saini, Jennifer Chopra, Claire Hanlon, Jane Boland, Ellen O’Donoghue

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 is a safe and effective form of therapy for men referred into the service.

The Evaluation Team would like to thank The James Wentworth-Stanley Memorial Fund, now James' Place, who provided funding for the evaluation. The content of this report is the product of the Evaluation Research Team and not of the James Wentworth-Stanley Memorial Fund.

We would like to thank all the James' Place staff, local Emergency Department nurses, Primary Care Practices, Student Welfare Counsellors, and our Experts-by-Experience and the men who used the service who have shared their experience/taken part in the qualitative interviews.

We would also like to thank the Applied Research Collaboration North West Coast (ARC NWC), who supported the project at its inception stage and with project oversight.

James' Place Evaluation Team:

Dr Pooja Saini (PI), Senior Lecturer, School of Psychology, Faculty of Health, Liverpool John Moores University

Jennifer Chopra (Co-I), Senior Lecturer, School of Psychology, Faculty of Health, Liverpool John Moores University

Claire Hanlon (Co-I), PhD Student, School of Psychology, Faculty of Health, Liverpool John Moores University

Jane Boland (Co-I), Clinical Lead, James' Place Charity

Ellen O'Donoghue (Co-I), CEO, James' Place Charity

James’ Place Evaluation: One-Year Report

Executive Summary

Introduction

Over 800,000 people die by suicide each year worldwide. Suicide amongst men is a major public health problem, and is the leading cause of death among men under the age of 50 and for young people aged 20-34 years in the UK. James’ Place is a charity set up to help men in suicidal crisis. It opened its first centre in Liverpool in 2018, and offers a proven intervention delivered by trained, professional therapists. It is the first of its kind in the UK. Following on from the year one evaluation, this evaluation aimed to examine the effectiveness of the James’ Place model on reducing suicidality in men over a two-year period and compare the findings pre and post the COVID19 pandemic. The methodology was designed pre COVID19 and was adapted to address the changes necessitated by the pandemic.

Evaluation Clinical data was collected from 546 men referred to James’ Place between August 2018 and July 2020. Demographic information was collected by the service data system and the CORE-34 Clinical Outcome Measure (CORE-OM) was used pre and post intervention to measure change. The CORE-OM is a client self-report questionnaire, which is administered before and after therapy. The client was asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point Likert scale ranging from ‘not at all’ to ‘most of the time’. This information was supplemented with qualitative data generated through in-depth (n=6) with therapists about the delivery of intervention pre and post the COVID19 pandemic. Interviews explored therapist experiences.

Impact of James’ Place

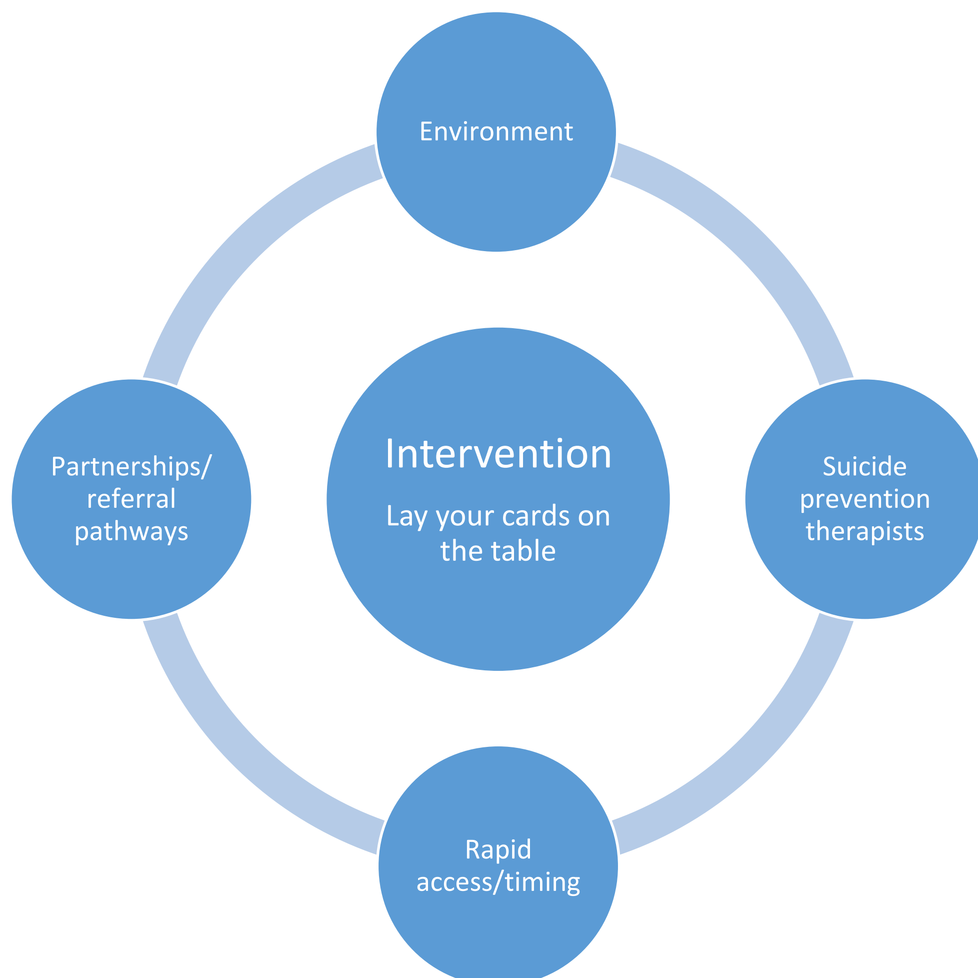
Lives Saved For the men who completed pre and post questionnaires, all experienced a significant positive change in the items measured by the CORE-OM as result of James’ Place. Across the cohort, for men who received therapy before or during the pandemic, there was a statistically significant reduction in mean scores between 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.

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 managed to continue providing therapy to men remotely using an adapted James’ Place model during the pandemic.

Recommendations This evaluation has highlighted the effectiveness of the James’ Place model in saving lives and managing to adapt during a global pandemic. The James’ Place model consists of five components: environment, suicide prevention therapists,

partnerships/referral pathways, rapid access to the service and the ‘Lay your cards on the Table’ intervention (see Figure 1). During the pandemic, all components remained the same except for the environment component which needed to be changed and adapted from face-to face therapy at the centre to remote online delivery due to government restrictions for a period of three months at the start of the first lockdown. We would recommend that James’ Place use a similar model when implementing the service in other settings if the need arises again. The charity is in the process of opening 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.

Figure 1: The James Place model (Boland and Milford-Haven, 2018)



1. Introduction

With over 800,000 people dying by suicide each year worldwide (World Health Organisation [WHO], 2020), 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], 2019). Prevalence of death by suicide among men is consistently higher than women in the majority of countries (WHO, 2019; Turecki and Brent, 2016). Recent figures show that men accounted for three quarters (4,903 deaths by suicide) of the 6,507 registered suicides in 2018 in the UK (ONS, 2019). Suicide mortality among males in England significantly increased by 14% in 2018 compared to 2017, with a 31% increase of men aged 20-24 years dying by suicide and middle-aged men (40-50 years) accounting for a third of all suicides in England in 2018 (ONS, 2019).

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, 2019). The greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour (Samaritans 2017).

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). To date there is no published research on the effectiveness of community-based brief therapeutic psychological programmes for men in suicidal crisis. Additionally, 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).

James' Place exists to save the lives of men in suicidal crisis. The charity was set up by Clare Milford Haven and Nick Wentworth-Stanley in 2008 after their twenty-one-year-old son, James, died by suicide ten days after a minor operation. James had no history of mental illness or depression and had sought urgent help for anxiety and suicidal thoughts, but didn't find it.

James' Place makes the experience of finding help as easy as possible. It offers men who are experiencing a suicidal crisis a brief, intensive, therapeutic intervention in a safe environment. Men who walk through the door at James' Place will be in a space where they feel valued and respected. Figure 2 shows the 'Clinical Journey' for men referred to the service.

Figure 2: The Clinical Journey for men referred to the James' Place service

The first James' Place opened in June 2018 in Liverpool, the first of its kind in the UK, and has to date supported more than 450 men experiencing suicidal crisis, delivering over 2,000 therapy sessions using an innovative and safe therapeutic intervention. A new James' Place centre will open in London in 2021, and there are plans to open further centres in the UK over the next three years.

Globally, the COVID-19 pandemic has caused unprecedented disruption, impacting on communities, livelihoods, and economies across the world (World Health Organisation [WHO], 2020). The national and devolved governments' restrictions and guidance throughout the pandemic have been ever-changing in response to the level of the coronavirus present in the various countries and regions of the UK. The World Health Organisation declared the pandemic on the 11th March 2020 (WHO, 2020). Following this the UK government imposed its first official advice on controlling the virus by announcing the introduction of 'social distancing' on 16th March 2020, closure of hospitality on 20th March 2020, and a full nationwide lockdown on the 23rd March 2020 (Prime Minister's Office, 2020a).

In England, these restrictions included all schools being closed with education moving to home-schooling, all non-essential workplaces to close or for staff to work from home where possible. The first lockdown lasted seven weeks and then gradually eased from the 10th May, with the guidance changing from "stay at home" to "stay alert" and the "rule of six" mixing outdoors (Prime Minister's Office, 2020b). Restrictions eased for a final time on 4th July, allowing up to two households to mix indoors and the hospitality industry (i.e. hotels, pubs and restaurants) to re-open with social distancing measures in place (Prime Minister's Office,

2020c). Figures 3a-3c below show the timeline for COVID19-related government restrictions and the James' Place response at different time points for year two of the service.

Figure 3a: Pre-national lockdown timeline with face-to-face therapy

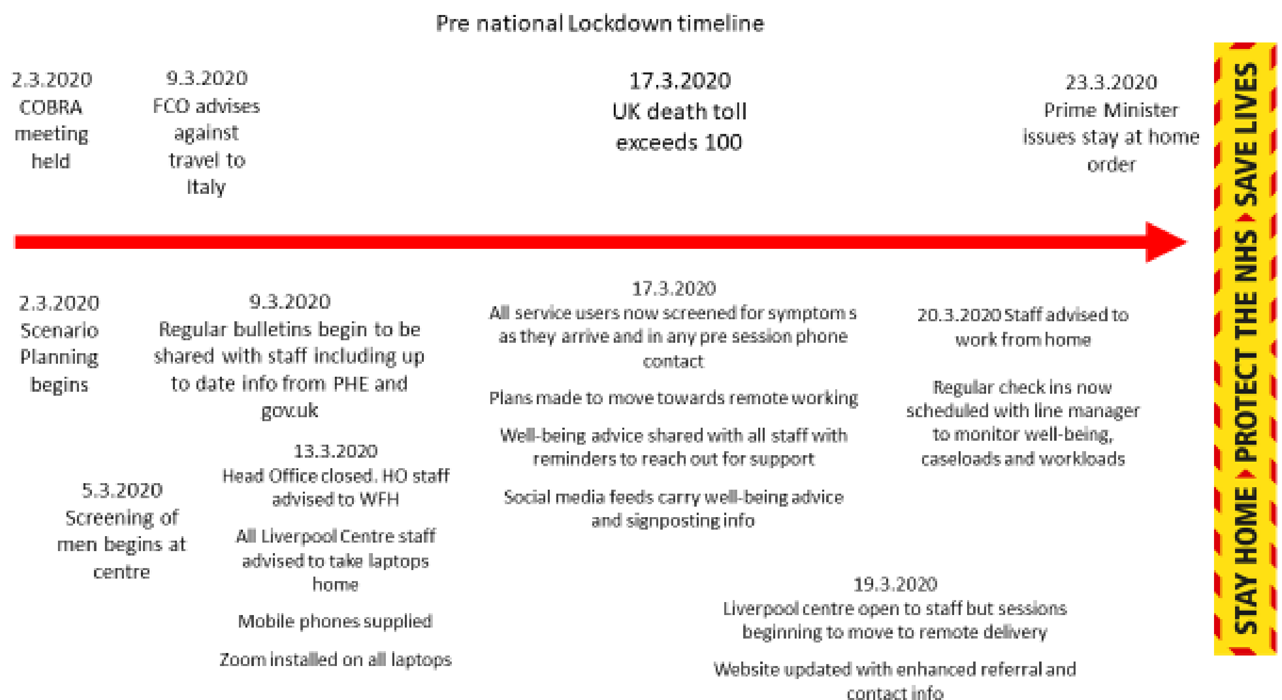


Figure 3b: National lockdown timeline to the easing of Government restrictions and remote therapy

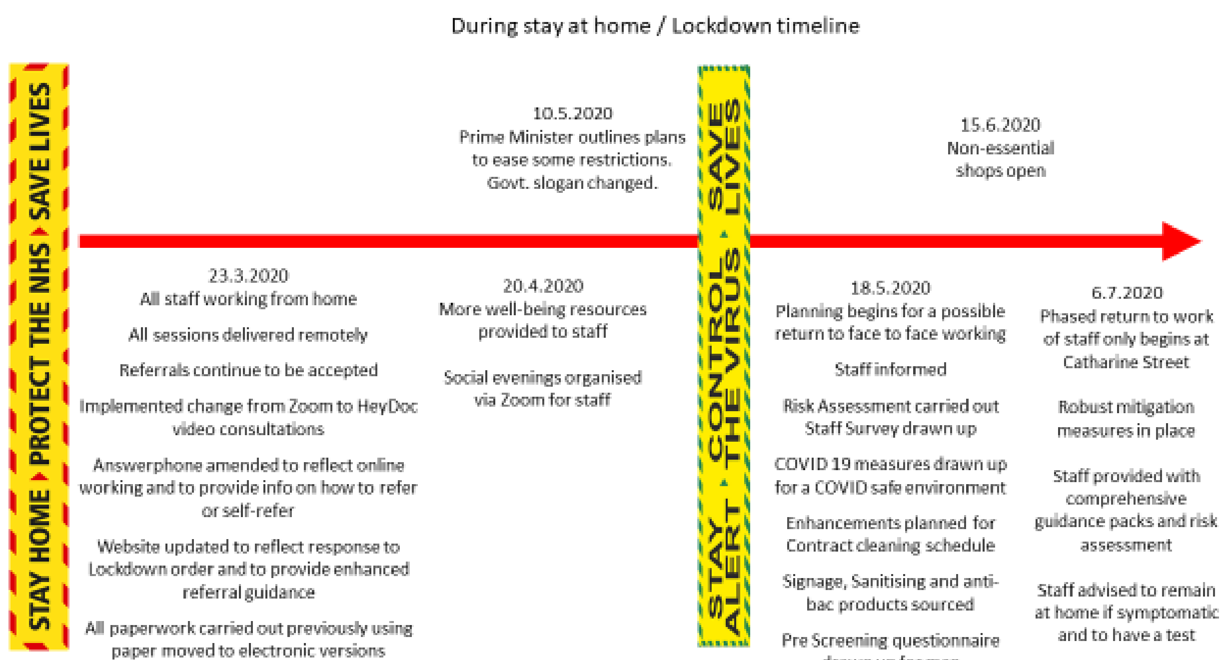
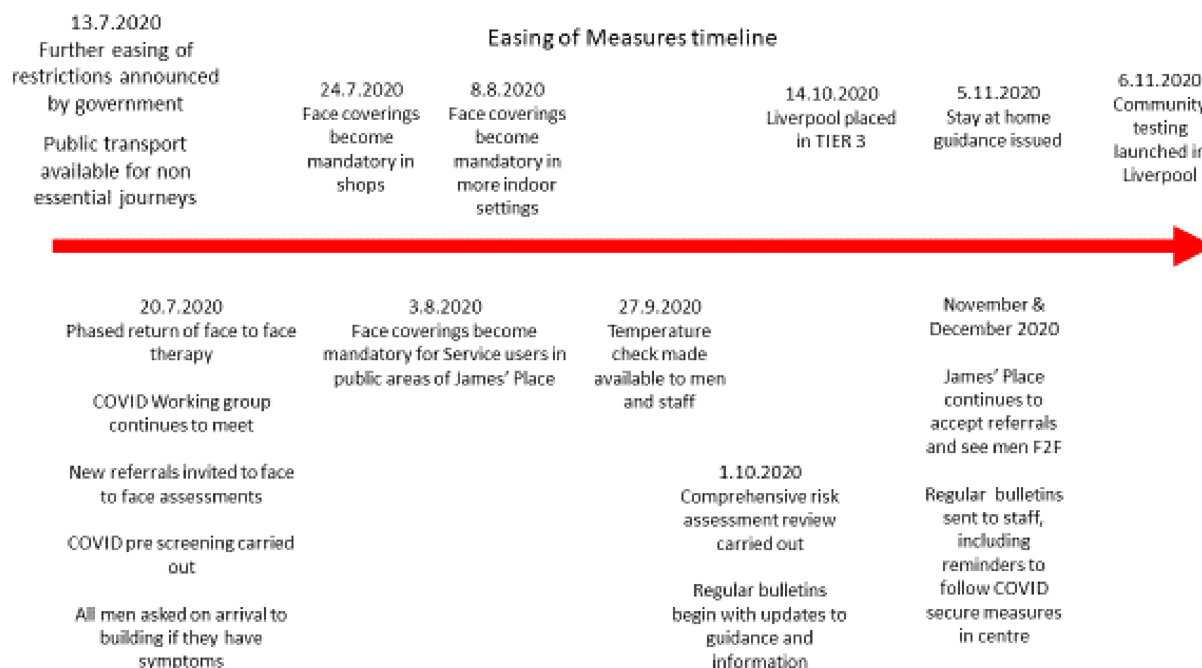


Figure 3c: Easing of the Government restrictions and return to face-to-face therapy



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. The main aims were to:

1) Evaluate the effectiveness of the James' Place model on reducing suicidality in men using the service over a 2-year period; and

2) Compare the outcomes of the men using the service pre and post the COVID19 pandemic.

3) Gain feedback from therapists about delivering the service pre and post the COVID19 pandemic to refine and improve the service, and to build and share learning on what works to address suicidal crisis.

2. Method

Design: A mixed-methods approach was used for this study. A range of quantitative and qualitative data was collected and analysed to evidence the effectiveness of the James' Place model and to assess the delivery of the intervention pre and post the COVID19 pandemic. The methodology was designed pre COVID19 and was adapted to address the changes necessitated by the pandemic.

Methods: Pre and post data was collected for the primary outcome measure. 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.

Pre and post COVID19 pandemic data was compared for men using the service before and after the March 2020 lockdown. Six interviews were used to supplement this data for the purposes of understanding the delivery of the service remotely during part of year two.

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 2020 (n=546). Referrals came from Emergency Departments, Primary Care, Universities, other community settings or self-referrals.

Qualitative data was elicited through six in-depth interviews with therapists (carried out between March and May 2021). Figures 2a-2c outline the James' Place service response to the changing situation for staff and the restrictions posed by the COVID19 pandemic. Interviews explored therapists' experiences of delivering the intervention remotely, returning to face-to-face therapy and their perspectives on the men's engagement and outcomes following the hybrid model that included remote therapy and/or face-to-face therapy.

Procedure for quantitative data collection: Demographic data was collected from the service data system on all men referred to the service. Clinical data was collected from the pre and post CORE-34 Clinical Outcome Measure (CORE-OM). The CORE-OM is a client self-report questionnaire, which is administered before and after therapy. The client was asked to respond to 34 questions about how they 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 or not the clients level of distress has changed, and by how much) (see Figure 1). 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. A range of psychological, motivational, and volitional factors that play a key role in suicidality were assessed for risk factors using the Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV; 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 in the first 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.

Procedure for qualitative data collection: Prior to the interviews or group discussions, all participants gave verbal consent. Gatekeeper consent was received from James' Place prior to data collection from the therapists. Semi-structured interview schedules were used to elicit discussions about the design, implementation and remote delivery of the James' Place model since the start of the COVID19 pandemic. Researchers experienced in qualitative methods conducted one-to-one interviews. The interviews and discussions lasted between 20 minutes to 40 minutes.

Qualitative data analysis: Thematic analysis was used to analyse the four therapist interview transcripts and was selected as an appropriate method for examining the interview data because it provides a way of getting close to the data and developing a deeper appreciation of the content (Braun & Clarke, 2006). All data transcripts were checked for errors by listening back to the audio-recording and reading the transcripts simultaneously. Pooja Saini (PS) and Claire Hanlon (CH) conducted the interviews and listened back to the audio-recorded interviews to become familiar with the whole data set. PS, CH and Jen Chopra (JC) conducted analysis of the anonymised transcripts that have been used within this report.

Patient and Public Involvement: The research question was developed through a collaboration involving the James' Place Research Steering Group who oversee all of the research taking place at the centre. The group 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. Experts-by-experience are members of the Research Steering Group. 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 and verbal consent from those staff who took part in the interviews.

3. Findings

3.1 Men referred to the James' Place service

Between 1st August 2018 and 31st July 2020, James' Place received 546 referrals from ED, Primary Care, Universities, communities or self-referrals. Of those, 417 (76%) attended for a welcome assessment and 337 (81%) 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 34 years (range 18-66 years). Men attended a mean number of sessions of 6, ranging between 1-19 sessions.

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

Demographic	**N (%) (N=546)**	**Significance against CORE-OM**
Ethnicity		p=.93
White British	368 (87%)	
Other ethnicity	54 (13%)	
Missing	124	
Relationship Status		p=.59
Single/Non-cohabiting couple	266 (73%)	
Married	45 (12%)	
In a relationship	29 (8%)	
Divorced	6 (2%)	
Separated	18 (5%)	
Widowed	1 (0.3%)	
Missing	181	
Sexual Orientation		p=.99
Heterosexual	110 (83%)	
Homosexual	18 (14%)	
Bisexual	5 (4%)	
Missing	413	
Employment Status		p=.78
Employed	167 (41%)	
Unemployed	157 (39%)	
Students	68 (17%)	
Self Employed	9 (2%)	
Retired	3 (1%)	
Carer	2 (1%)	
Missing	140	

Demographic data

Table 1 shows the demographic characteristics about the men who were referred to James' Place. Eighty-seven percent (368/422) of the men were white British and 13% (54/422) from other ethnicity groups. Relationship status showed that 73% (266/365) of the men were single, 12% (45/365) married, 2% (6/365) divorced and 5% (18/365) separated. However, we suspect that the 'single' category may include men who were divorced or separated or those who were not cohabiting. Sexual orientation of the men was 83% (110/133) heterosexual, 14% (18/133) homosexual and 4% (5/133) bisexual; however, there was missing data for 76% (413/546) of the men attending at James' Place. Forty-one percent (167/406) of men were employed, 39% (157/406) unemployed, 2% (9/406) self-employed and 17% (68/406) students.

This data needs to be interpreted cautiously due to the high number of missing data. For years one and two, demographic information has been collected via referral forms; but the information shared for each of the men referred into the service can vary. To reduce the amount of missing data, therapists at the service are going to add some of the missing data within the initial assessment in order to provide more accurate demographic information for men attending the service.

The Index of Multiple Deprivation (IMD) data

The majority of men (N=284, 61%) 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 N (%) (of 469)	Year 1 N (%) (of 162)	Year 2 N (%) (of 307)
Most deprived (1-5)	374 (80%)	130 (80%)	244 (80%)
Least deprived (6-10)	95 (20%)	32 (20%)	63 (20%)

The majority of men using the service were from the most deprived areas of the city (80%) across both 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 scores at initial assessment or following treatment ($F(2, 128) = .557$, $p=.57$). 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 over years one and two. Men were referred from a variety of places. Over one third (39%) of the referrals came from Secondary Care, 24% from Primary Care and 22% via self-referrals. In the first year of the service opening, referrals were mostly received from Secondary care and then Primary Care and 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 GPs decreased from years one to two. Unknown *'not specified'* referral data reduced from 30% to 1% from year one to year two; thus reflecting improvements in data collection for how men were referred into the service.

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

	Year 1 & 2 **N (%) (of 546)**	**Year 1** **N (%) (of 212)**	**Year 2** **N (%) (of 334)**
Secondary Care	212 (39%)	74 (35%)	138 (41%)
Primary Care	130 (24%)	57 (27%)	73 (22%)
Self-referral	119 (2%)	17 (8%)	102 (30%)
Other	24 (4%)	0 (0%)	24 (7%)
Not specified*	65 (11%)	64 (30%)	1 (0%)

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

Factors related to the current suicidal crisis

Precipitating factors were identified for 337 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 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 (27%) or family problems (26%). In year two more factors were added following the other reasons men commonly discussed within their sessions during year one. These included: 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

Within the sessions, therapists recorded data on the psychological variables (see Appendix Table C). The most common psychological factors that affected men were past suicide attempt/self-harm (75%), rumination (78%), thwarted belongingness (71%), humiliation

(59%) and entrapment (56%). These psychological variables were more present in men attending in year two compared to year one.

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

Clinical outcomes

Figure 1 shows the clinical reduction in the average change for the CORE-OM total scores for 337 of the men who completed the CORE-OM at assessment and 145 of the men following treatment for both year one and two. Figures are also shown for the breakdown of year one and two. 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

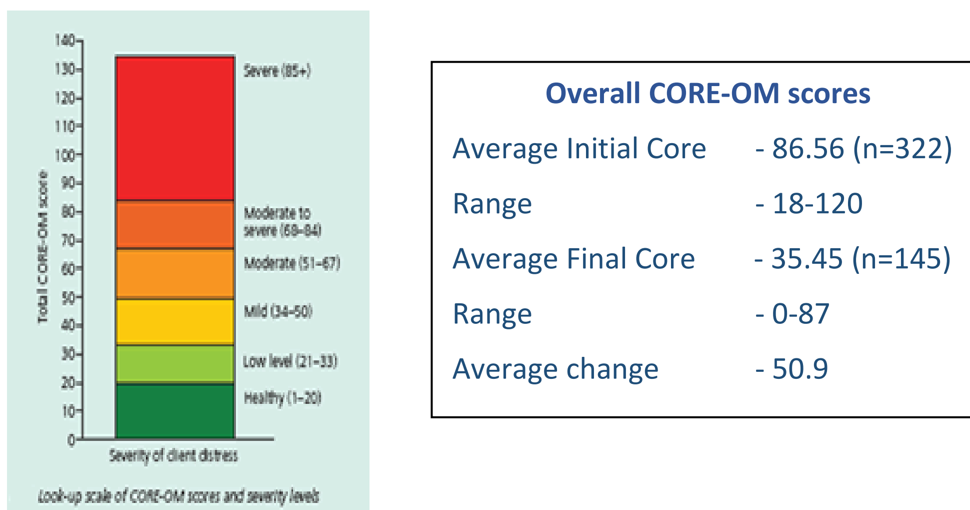


Table 4 shows the variation of how men scored on the CORE-OM at initial assessment and following treatment in total and for each year. 133 men experienced a clinically significant change in general distress scores between initial assessment and following treatment, with 5 showing a reliable change, and 7 demonstrating no clinical change. (Missing data N=192). Each year there have been up to 8 men who scored moderate to severe or severe following treatment. As the CORE-OM 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 4: CORE-OM severity category

	Overall		Year 1		Year 2	
Severity Category	**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%)

Overall CORE-OM scores

For years one and two, 337 men were assessed using the CORE-OM; however, data was available for 322 men (96%). Of those, 87% scored moderate to severe or severe for levels at distress at their initial assessment. 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. Scores were similar across both years for men attending for therapy at the service.

Table 5a: Overall CORE-OM scores

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

Pre and Post COVID19 data

179 (53%) men were referred and accepted into the service before the COVID19 pandemic (1st August 2018 – 22nd March 2020), and 158 (47%) were during the pandemic (23rd March 2020 -31st July 2020). Pre-COVID19, younger men (53%) aged 18 to 30 year olds were significantly more likely to be referred to the service, compared to during the pandemic when older men (58%) aged 31 years and above were more likely referred (Chi Square = 4.30 (1), *p*=.04). No significant differences relating to ethnicity, marital status, or sexual orientation for men accepted into the service were evident before or during the pandemic.

Table 6: Occupation of men accepted into the James' Place service

Occupation	Before pandemic N (%)	During pandemic N (%)	Chi Square
Employed	70 (39%)	57 (36%)	10.56, *p*=.01*
Unemployed	44 (25%)	47 (30%)	
Student	34 (19%)	13 (8%)	
Not specified	31 (17%)	40 (26%)	

*significant

Table 6 highlights that significantly less students were referred into the service during the pandemic, and there was also an increase in those with non-specified occupations. Table 7 shows that significantly more referrals came from secondary care services and self-referrals than other categories during the pandemic.

Table 7: Referrer details for men attending the James' Place service

Referrer	Before pandemic N (%)	During pandemic N (%)	Chi Square
Secondary Care	59 (33%)	64 (41%)	49.45, $p<.0001$*
Primary Care	43 (24%)	34 (22%)	
Self-Referral	28 (16%)	45 (29%)	
Third sector	5 (3%)	14 (9%)	
Not Specified	44 (25%)	1 (1%)	

*Highly significant

Table 8: CORE-OM severity category

Severity Category	Before pandemic		During pandemic	
	Initial assessment N=168	Following treatment N = 69	Initial assessment N = 154	Following treatment N = 76
Severe	105 (59%)	3 (2%)	93 (59%)	3 (2%)
Moderate to severe	42 (24%)	6 (3%)	47 (30%)	4 (3%)
Moderate	13 (7%)	9 (5%)	11 (7%)	9 (5%)
Mild	6 (3%)	15 (8%)	2 (1%)	18 (11%)
Low Level	1 (1%)	15 (8%)	1 (1%)	18 (11%)
Healthy	1 (1%)	21 (12%)	0 (0%)	24 (15%)

Table 8 shows the variation of how men scored on the CORE-OM at initial assessment and following treatment for men before the pandemic and during the pandemic. More men scored moderate to severe and severe during the pandemic than before (89% v 83%) but a higher proportion left with healthy to mild scores (37% v 28%). Thus suggesting that the James' Place model was just as effective, if not more, for men attending in more distress during the pandemic. Remote delivery did not seem to affect the engagement or outcomes of the therapy for men compared to when it was delivered face-to-face in the Liverpool centre.

Table 9a: CORE-OM scores at initial assessment before and during the pandemic

Outcome	Assessment Mean (SD) before pandemic	Assessment Mean (SD) during pandemic	F	*p*	Partial eta squared
General distress	85.31 (18.36)	87.73 (17.73)	.01	.91	.000
Subjective Wellbeing	12.22 (2.85)	12.74 (2.51)	.48	.49	.004
Problems/symptoms	33.37 (6.89)	34.97 (6.42)	.02	.90	.000
Life Functioning	27.97 (7.68)	30.16 (6.90)	.56	.45	.004
Risk/Harm	9.91 (4.88)	9.37 (4.13)	.44	.51	.003

Table 9b: CORE-OM scores following treatment before and during the pandemic

Outcome	Mean (SD) before pandemic following treatment	Mean (SD) during pandemic following treatment	F	*p*	Partial eta squared
General distress	36.35 (23.95)	34.61 (24.31)	.01	.91	.000
Subjective Wellbeing	5.23 (3.74)	5.32 (3.92)	.48	.49	.004
Problems/symptoms	16.62 (10.32)	15.29 (10.43)	.02	.90	.000
Life Functioning	12.71 (8.60)	12.47 (8.86)	.56	.45	.004
Risk/Harm	1.80 (3.00)	1.66 (2.79)	.44	.51	.003

For both men who completed an assessment before and during the pandemic, the CORE-OM showed a statistically significant reduction in mean scores between assessment and following treatment, for each outcome category (general distress, subjective wellbeing, problems/symptoms, life functioning, risk/harm), demonstrating a large effect size (see Tables 9a and 9b). The initial assessment mean indicated severe levels of distress, with this reducing to mild levels on average following treatment. There was no significant differences on general distress scores (F= (1) .01, p.91), or any of the domains before or during the pandemic.

3.3 Remote delivery of the James' Place service: Qualitative findings

Following the thematic analysis process, five inter-related themes were conceptualised as reflecting the corpus of this material. The themes illustrate the areas how the service responded to the COVID19 pandemic. The first theme related to service deliver move to remote therapy and was conceptualised as '*Preparation for remote working*'. The second theme identified was '*Experience of men using the James' Place service*' and how the men engaged with remote therapy. The third theme *'Challenges for delivering the James Place model remotely'* related to the impact of the changing delivery of the James' Place service. The fourth theme '*COVID19-related concerns*' informs on the worries staff had about returning to face-to-face delivery. The final theme '*Lessons learned during the global*

pandemic' demonstrates what did and did not work when adapting the service delivery model during a global pandemic. Each of these themes is developed below.

Findings from the interviews with therapists demonstrated how the service adapted and provided a safe and welcoming, James' Place model (from 22nd March 2020 the introduction of remote online consultations until 4th July 2021 when an adapted model was used for a phased return to face-to-face delivery) where men reported being supported, and were encouraged to talk about their problems and find solutions. The intervention they received appeared to increase their awareness to understand their own thoughts and feelings, and they were able to adopt coping strategies and this in turn had a positive impact upon their mental health and their thoughts around suicide and wanting to act on these.

Theme 1: Preparation for remote working

Although the staff suspected lockdown would occur, therapists did not initially feel prepared to implement the James' Place model remotely:

> *"Not very prepared. No, not at all, actually, when I think about it. No, I think there was the inkling that it was going to happen when it was going to happen, I don't think they were really prepared for it, especially for the length of time it went on for."* (P2)

The service provided staff with the IT equipment to enable them to work from home. One administrative staff member prepared a Microsoft Word version and PowerPoint presentation of the 'Lay your cards on the table' tool that was previously used within face-to-face sessions via individual cards. Therapists had a role in preparing the transformation of the James' Place model from face-to-face to online remote delivery; this was seen as positive as they coproduced the changes required. Most of the staff were involved in informing the men of the changes in response to COVID19, organising caseloads and booking new referrals. Therapists reported how men were receptive to the necessary changes because they were aware of the pandemic and how it was unfolding:

> *"Everyone was very much, because it was all new last year, so everyone was very much, "Yes, of course, of course," and we just, like, decided whether it was going to be phone or video, and, yes, carried on online."* (P1)

Staff reported needing to use video consultations via the service's clinical information system (CIS) for delivering the remote therapy and how they found this method simple to use. Therapists had some limited experience of working remotely before but most had not done it to this level previously. Some reported having minor network issues at the beginning, but no-one reported them to be a major problem:

> *"Basically they had been booked in and it was just click on the link and it worked and it worked really well. So internet at that point wasn't so problematic as it seems to be*

every now and again. It was really good. It just seemed to work really well from the beginning. I didn't have any technical issues. The men had already been spoken to and prepared for that because I wasn't doing welcome assessments at the time. So it just seemed to work quite smoothly from my point of view." (P2)

All of the therapists commended the administrative team for their role in preparing for remote service delivery. The Clinical Lead played an integral role, along with the administrative team, in transferring the James' Place model from face to face to remote delivery:

*"Admin did brilliant in moving everything from paper copies, kind of thing, to online." (*P3)

Whilst there was a sense that a lockdown may occur, the lack of Government notice of the lockdown and their uncertainty severely limited preparation time – giving the service approximately a week to prepare to deliver the service remotely:

"We did see that it was coming. But literally, it was like everybody was in on the Friday and then that was it. The building was shut for three months. The only person who went in was me, just to make sure it was safe. That we had cancelled the milk, turned off the heating, or just put it on low. I just went in to make sure we weren't overrun by mice." (P4)

"Yes, we all went home on Friday thinking that we could be back in the building, then the whole country shut down." (P1)

Although most aspects of the changes were positive, many staff discussed how the planning of remote delivery was impeded by unclear Government guidance:

"I think what was also challenging was that the guidance was so wishy washy. I think that, for a small organisation, we actually spent a lot of time looking at the guidance that was there. So if we had been a hairdressers, we would have known what to do and if we had been a restaurant and things like that, but, you know we would have had more guidance. So it was about interpreting the guidance in a way that felt as safe as possible. Our environment leant itself to being able to come back in a way that was safe, I think. The rooms are big and we could have the windows open. We have got the windows open and stuff like that. But it was really challenging, the whole thing." (P4)

Theme 2: Experiences of men using the James' Place service

Therapists felt the men understood the situation and the need to for the changes and that the transition was smooth from face-to-face to remote therapy:

> *"It was okay at the beginning, and nobody complained. It was a smooth transition, I think."* (P1)

Although the adjustment took a bit of time to get used to both for the men and the therapist:

> *"It was awkward, at the beginning, but we did get used to it. So, it was okay*."

Positives for the men being offered or receiving remote therapy

One of the most reported positives was that the service could continue providing continuity of care for existing clients and also supporting men during the pandemic or lockdown. The offer of rapid access to men, which is a component of the James' Place model, was still applied when providing therapy remotely;

> *"…we were working and the main benefit is that, for the men that we were able to see them, even though remotely, despite everything that was happening, and to us, yes, we continued to work. So, yes, that is the benefit, because our intervention was never meant to be done over video. It is a very much in-person intervention."* (P1)

> *"I do generally think it worked well and most men didn't even question, like, "I would have preferred face to face." It was like, "This is what's available." And the feedback from all the men across the board, the thing that they get from us is that rapid access to somebody to talk to, however that's delivered to them. That, for me, is the key of why this works. It doesn't matter if it's telephone, video or in person really. It is a lovely building and it's a nice place to be but having that person to listen to and talk to within a couple of days or within a day when you're doing a referral that's the key thing for us I think."* (P2)

The remote delivery of the service provided increased accessibility for those men who would not typically engage with James' Place and it provided flexibility that was not otherwise available such as booking sessions around the men's working commitments or if they were ill:

> *""If you're working with a few guys who are employed, they want later appointments it just gave me a bit more flexibility to do that."* (P2)

> *"Some men probably did benefit from the fact that it was online and done from their own home. There's been one, I remember, who said that he's not sure… because of anxiety, not COVID or whatever, but just that going out was a challenge. So, he said that he's not sure if he would engage if it was in person. So for some men, I think it was*

easier to do it remotely. Some men it wasn't, some men, kind of, dropped off because they can't deal with being online or on the phone, they don't engage." (P1)

As illustrated above, remote therapy did not work for all of the men. However, some men were anxious to come out to appointments because of COVID19 and others were shielding, therefore the remote delivery avoided risking unnecessary COVID19 exposure for some men, particularly those needing to use public transport:

> *"I just think again they chose a time and all they had to do was find a space that was private at home and they could do the session. They didn't have to travel, they didn't have to worry about getting on the bus which a lot of our guys do- very few drive. So that safety aspect of keeping themselves safe and people that they were living with who were shielding safe was a positive for them."* (P2)

> *"You've got your ones who were shielding anyway, so they couldn't leave. Even if we did have that face-to-face service in the building, which I imagine we might have been able to, well, that was shielding. You know, it would be, like, "I can't help you, because you're not coming into the office." So, I suppose if anything, it made our service even more accessible to wider people. People who were shielding, people who might have mobility issues themselves and I've got one guy at the moment, and he is agoraphobic."* (P3)

Negatives for men being offered or receiving remote therapy

Technology was perceived as a barrier for some men, particularly older men who were not as used to technology or video conferencing. However, they could be accommodated through telephone delivery of the intervention. Therapists suggested that for some of the men, learning how to use technology while also engaging in therapy may have been too burdensome:

> *"…yes, just sometimes they just slowly disengage. There's not been many, you know, I couldn't give you any sort of number. There's been a few, and in my experience the ones that were maybe a little bit older and didn't want, they did phone, you know? They didn't do video, they wanted to do phone. Video is the better option out of the two, because you can see the person, but not everyone knows how to do it or has the internet, so the ones that were on the phone were usually in their 50s, and not so sure about the internet, and not so sure about therapy."* (P1)

> *"Men maybe being in therapy for the first time at the same time as learning some technology for the first time, it can be, yes, maybe too much."* (P3)

Lack of accessibility to technology was perceived as a potential barrier for men wishing to access the service. Particularly for the most vulnerable men at risk of suicide who may have been from more deprived backgrounds (e.g. low-SES):

> *"Or they don't have the tech that would allow them to do it. I suspect that there were people who were not referred to us because the technological barrier of accessing it - that is a challenge."* (P4)

Some men struggled to find suitable therapeutic space to receive the intervention at home, especially when they had families:

> *"So I think that having the safe and quiet space to have therapy was quite a challenge for some of the men. I think there is something about the ritual of therapy."* (P4)

It was expressed that the men had a preference for face-to-face delivery compared to remote delivery of the James' Place model, although they preferred remote to nothing at all. However, remote delivery made it easier for men to disengage and drop out of therapy:

> *"I think if people didn't want to attend, they just wanted to disengage, it was easier to just not show up, and you just don't turn on the computer." (P1)*

Theme 3: Challenges for delivering the James' Place model remotely

A number of challenges were encountered and consideration had to be given to not only the delivery of the model itself but informal aspects of staff management including their confidence to deliver the model remotely. It took a bit of time to adjust to changes of delivering the model online in terms of getting familiar with the technology and also working in a different environment (i.e. at home):

> *"At the beginning, what I just said, it took some getting used to, because, until now, all I have ever done was face-to-face, apart from when I have to have a conversation on the phone with a client, but that's not a session, that would be a supporting phone call, but yes, it took a bit of getting used to. Just the whole, kind of, getting around, technology, and, yes, it was just, sort of, working from a different environment."* (P1)

Although technology was easy to use, therapists reported having a different experience delivering therapy remotely compared to face-to-face, including staff creating alternative modes of delivery for the cards online:

> *"Yes, technologically it was an easy process to do. It was a different experience in terms of doing the sessions with the men because obviously we didn't have the physical cards but [colleague name] had put all those on a Word document. So straightaway we had that as well which made it easier. I could just email that to the men and they'd either*

looked at it or we were looking at it together as we worked through depending what system they were working with." (P2)

It took some time for the therapist to adapt to delivering therapy over the phone as some problems were encountered with the phone provided by the service, such as hearing the men was difficult at times and making judgements during therapy was difficult in the absence of being able to pick up on non-verbal cues:

"It is really hard to hear people on the mobile phones, especially for the first couple of men who didn't have the technology themselves, so it was telephone calls that were really faint and it was so hard to hear them. I found that particularly difficult but also the silences and the stuff, with the telephone it's just so hard to judge, am I giving this person enough of a silence? Are they waiting for me to speak? So trying to work with that silence is quite an important part of counselling. On the telephone you're a bit, like, "Are you still there?" (P2)

"…you're just like are you still there, sometimes people become quiet when they are thinking, sometimes they're waiting for me to speak, "So I'm just going to give you some time if you're ready to continue let me know." But it was just trying to get that little bit of patter in while still giving them time to think. The telephone was probably the bit I didn't feel quite prepared for. At the same time after a couple of sessions it was fine." (P1)

While the therapists preferred the face-to-face mode of delivering the model, they did feel delivering the service remotely worked well in some ways:

"Telephone or online is not my first option when working with people therapeutically. But if it's the only option that you've got, I think it worked brilliant. I did sign up to do a course, just so, like, you are trained in online and telephone counselling." (P2)

The therapist felt that the intervention was as effective online versus face to face:

"…they were mostly, well, not mostly, but yes, it worked. The ones that engaged, it worked for them, and also the ones that we, kind of, transitioned from face-to-face to online, we already had that relationship, so from that aspect it might have been easier because you don't have to build rapport, but then people who started remote when they had everything from welcome assessment to the end they had online, they didn't know anything different anyway. So, they didn't know what it's like to have a face-to-face therapy at [name of service]. So, I think it was as effective as face-to-face, yes." (P1)

Due to the nature of the work, one challenge reported by the therapists was the issue of boundaries, as it was more difficult to gain a clear definition between work and home when working from home:

> *"Especially working with the people we work with, it's not the best thing to have in your living room from 9:00 in the morning to 5:30."* (P2)
>
> *"Trying to help someone who's suicidal. It's not as if you just turn your laptop off at 5:30 and put the TV on; "Now I'm back at home." It doesn't work that way."* (P3)

Therapists reported the challenge of dealing with crisis or emergency situations from home and how these were perceived as more difficult to manage:

> *"I think when you were dealing with a crisis situation that was harder to do remotely. So if you're trying to encourage somebody, so say somebody came into the building and I wanted them to go to hospital. We got a little bit more ability to do that and to negotiate with them because they're adults. It is negotiating, isn't it, about autonomy and safety and stuff. That felt a little bit harder to do over the phone, particularly, where you're like, "I've got to contact your supporter and stuff," and that feeling disjointed and not in as much as- when I've done that here before I might be, "I'll call your supporter while you're here so you can hear what I'm saying," and we're all on the same page about what we're saying is the next step. "I'm advising you to go to A&E. I told your supporter, they're going to meet you there." It was harder to do those kind of parts of it. So the emergency crisis parts, if you like."* (P2)

Therapists spoke about how the move to remote working meant a loss of the informal or incidental support which occurs organically in a shared working space. However the therapists' adapted and described receiving peer support using WhatsApp which was perceived as just as effective as face-to-face support:

> "*We set up a WhatsApp group; the therapists and [colleague name]. And then if we had any issues, or just needed a bit of extra support, we'd just go on the WhatsApp group, and it was fully supported by the colleagues."* (P3)

A negative aspect of the changing environment was that remote delivery of the James' Place model resulted in additional work needed to manage the service, including staff wellbeing, health and safety and interpreting the COVID19-guidance:

> *"Yes, so daily catch up meetings, weekly catch up meetings. Things that, like I said, would just happen quite naturally in a building, that we would all get in and say, "What is everybody up to today? How is everybody doing? What are we up to?" That has become a meeting. A daily, a weekly, "How are you going?" I didn't have a weekly catch up. We had monthly caseload catch ups. So yes, lots of meeting and then lots of*

meetings about COVID. We put together quite a big risk assessment. At one point, when we were at decision making points and we were waiting for government changes and things, we were having almost daily catch ups about it then. So yes, it is a lot more work. A lot more thinking. We put together a roadmap to get everybody back into the building." P4

Theme 4: COVID-19-related concerns

When anticipating a return to the service, a concern reported by therapists was more about transmitting COVID19 to vulnerable family members:

> *"…I wasn't bothered at all, for me. I was worried about, let's say, I'm still, if my mum gets it, it probably won't be great, but for myself, no."* (P2)

The therapists' did not feel particularly at risk when working at James' Place as the service had clear guidelines and policies in place for ensuring a safe working environment. They reported feeling that the risk was everywhere, such as when travelling into work or shopping:

> *"Erm, the risk was everywhere, so it didn't matter. Be it work, supermarket, the school, a bus ride in…"* (P1)

> *"It wasn't unique to coming into the office."* (P3)

Theme 5: Lessons learned during the global pandemic

The service have reflected on some of the lessons learned during the lockdown period and the through the adaptations they made to the service when required. Some staff reported that the offer of remote delivery improved accessibility of the service (i.e. remote and face-to-face). This could allow men to access the service who may not be able to do so if it is only delivered face-to-face, particularly offering flexibility and late appointments for men who are working and want to fit the sessions around their work commitments:

> *"I felt it worked really well from the get go. I was a little bit, I suppose I'm a little bit, kind of- when [colleague name] says, "We're not going to do a hybrid thing going forward," I think there are some guys that would benefit from that. I personally don't feel we should exclude it completely. I think, yes, it should be the exception in the future going forward but I don't think we should say you've got to come in and if you can't come in, you're not suitable.* (P2)

Another area of learning was to introduce a simple guidance for men to follow during the remote delivery of the service, that included frequently asked questions and what they could expect and what the therapists expected from them during sessions. For example,

finding a quiet space to have their therapy, being dressed appropriately, etc. This was a lesson learnt during first lockdown which was implemented during the second lockdown;

> *"I think the only thing was like I said before when we said about needing to do the contracting [expectations for men and therapists during session] and just saying that's something that we've introduced, that was a lesson learned at the time from the first one to the second one."* (P3)

While equipment was mainly perceived as suitable and effective, there were some issues that would need to be addressed going forward or if remote delivery was required again in the future, such as equipment issues (e.g. better phones) and preservation of peer supervision time:

> *"Absolutely. You know, furnish your staff with decent handsets. That kind of thing. Protect the therapists' peer supervision time. Because sometimes it was taken out of the calendar. And during the lockdown, I think if anything, it was even more needed, because we didn't have that catch up over coffee in the waiting room."* (P3)

In future, if a similar situation was to be encountered, the therapists perceived it would be helpful to have established work-life boundaries to create clear definitions or boundaries:

> *"…I don't know, deal with boundaries better. It's possible, I just don't know how to. I don't know if it's possible, because there's that factor of children and all that, but I would like to maybe have more defined boundaries between work and home, and to insist not to do either in the time when the other one is meant to be happening, yes, but otherwise I think it's not much that, me and generally, that could have been done differently." P1*

The lockdown forced the service to consider alternative modes of delivering the service. While this may not be the preferred way to deliver the service, the therapists feel prepared and confident to deliver the James' Place model remotely should the need arise again in the future, However the consensus was that the model is best suited to be delivered face-to-face as this is an integral part of the James' Place model's implementation framework;

> *"But I think if this kind of thing happened again, you know, we would be very much prepared… For online, remote therapeutic intervention to go ahead. I think as time went on, it becomes second nature."* (P1)

Some hard lessons were learned after the first lockdown, specifically involving and consulting staff on the return to face-to-face delivery of the James' Place model:

> "*So it did seem that the nature of our intervention is a crisis intervention, so it felt like where there were barriers to men being able to access our intervention online and over*

the phone, that we should be able to offer them a face-to-face alternative. But then, that was quite challenging, in terms of people feeling comfortable about coming back to the building...The second time around we did a more formal consultation exercise, which certainly, I think, really helped the team to feel focussed on returning. " (P4)

Staff wellbeing was perceived as a priority to ensure the service was delivered effectively; this was reported by all staff interviewed:

> *"Because our wellbeing is just as important as our clients."* (P3)

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 and CORE-OM data) show the reduction in general distress that the intervention provides. Upon further exploration with the therapists at James' Place, it was suggested 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 were seen to help the men make safer decisions in the future and did not seem to be affected by therapy needing to be adapted and provided remotely.

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. 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

From the interviews with therapists and CORE-OM scores, it was clear that there are a number of short-term positive outcomes that were experienced by the men. The findings of this report indicate that the two years delivery of the brief psychological James' Place model has been effective in significantly reducing suicidality in men. The results from the CORE-OM 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. Outcomes identified through the interviews with therapists clearly demonstrate

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 a period of time following treatment at the service.

Remote delivery of the James’ Place model

The themes illustrated the areas of how the service responded to the COVID19 pandemic, adapted their current model by changing the environment component and delivering an online remote therapy alternative when face-to-face therapy was not an option. The first theme highlighted how efficiently the service managed to plan a full adaptation of the delivery of the James’ Place model for a remote service. All staff reported being involved and coproducing the management of the men currently engaged with the service and new referrals coming to the service. Therapists relayed their appreciation for the administrative staff and valued the therapy tools that were provided as an online alternative. Although the service reacted well to the planning, they reported how the government guidelines were at times difficult to navigate and understand for organisations like them i.e. third sector organisations. The second theme showed that overall the therapists felt that men adapted well and seemed to have a positive experience of engaging with the James’ Place service remotely. Online delivery of the model enabled staff to continue therapy with men already engaged with the service and in some cases provided more flexibility for men who otherwise may not have attended the service (e.g. men who were working, shielding, or agoraphobic). However, delivering online therapy was more challenging and less accessible to men who were older and had less experience of using technology and for men who did not have access to technology (e.g. more deprived). The third theme discussed the challenges staff faced when delivering the James’ Place model remotely. Technology was one aspect that staff needed to ensure was suitable for delivering therapy over the phone in particular. Another challenge was delivering the therapy within their home environment and having less separation from their working day. The fourth theme highlighted the COVID19-related concerns staff had generally in the wider population and for returning to work. Staff were confident about the safety measures at work but were more concerned about increasing risks for their family members who were shielding, being at increased risk when providing therapy to men who may not be following the guidelines as stringently, or being at increased when travelling into work via public transport. Some staff reported not being involved in the conversations about returning to work following the first lockdown but this was improved for the second lockdown where all staff were consulted prior to returning to the building. The final theme indicates the learning the service gained during the adaptation of the service

delivery over the first pandemic and demonstrates what did and did not work when adapting the therapeutic model during a global pandemic.

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 of this project is that interviews were conducted with therapists who have been delivering the intervention pre and post the COVID19 pandemic. As the data collected for this project is current, some of the findings should reflect up-to-date changes in clinical practice due to the global pandemic and social distancing rules. However, the findings in this report should 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. One 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 between years one and two.

5. Recommendations

We can conclude from the year two findings that James' Place services should use a similar approach and the James' Place model when setting up in other cities across England. This report has highlighted further areas of learning that would improve the recording of data for James' Place. The recommendations would be as follows:

Recommendations for James' Place service delivery

- Return to face-to-face delivery of the service as this is the best option for both therapists and men using the service.
- Review which components of the overall model can be adapted (as environment was during the pandemic) if the need arises, such as a global pandemic.
- Continue to provide a working environment that promotes staff wellbeing.

- Continue to ensure that men are aware of the service through different marketing strategies.

Recommendations for monitoring and evaluation

- 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 before and during the COVID19 pandemic and how the environment component of the service was adapted. Despite the challenges that have arisen 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 needs to assess the long-term effects of the model in order 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

Table A: Postcode areas for men referred into the service

Postcode area	IMD measure of deprivation	Year 1 & 2 N (%) (of 469)	Year 1 N (%) (of 162)	Year 2 N (%) (of 307)
L8	1	38 (5%)	11 (7%)	27 (9%)
L3	1	29 (6%)	17 (11%)	12 (4%)
L4	1	29 (6%)	11 (7%)	18 (6%)
L7	1	27 (6%)	10 (6%)	17 (6%)
L6	1	26 (6%)	11 (7%)	15 (5%)
L15	1	24 (5%)	10 (6%)	14 (5%)
L13	1	23 (5%)	6 (4%)	17 (6%)
L9	1	18 (4%)	7 (4%)	11 (4%)
L11	1	16 (3%)	6 (4%)	10 (3%)
L20	1	15 (3%)	3 (2%)	12 (4%)
L5	1	14 (3%)	5 (3%)	9 (3%)
L12	2	11 (2%)	0	11 (4%)
L17	5	13 (3%)	3 (2%)	10 (3%)
L14	5	16 (3%)	6 (4%)	10 (3%)
L19	5	14 (3%)	2 (1%)	12 (4%)
L1	6	23 (5%)	9 (6%)	14 (5%)
L25	7	14 (3%)	2 (1%)	12 (4%)
L18	8	19 (4%)	7 (4%)	12 (4%)

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.

Table B: Factors related to the current suicidal crisis

Precipitating factor (N)	Overall N (%) (of 337)	Year 1 N (%) (of 140)	Year 2 N (%) (of 197)
Relationship breakdown	83/310 (27%)	46/113 (41%)	37/197 (19%)
Family problems	79/310 (26%)	47/113 (42%)	32/197 (16%)
Debt	56/309 (18%)	32/112 (29%)	24/197 (12%)
Work	55/309 (18%)	35/112 (31%)	20/197 (10%)
Bereavement	55/309 (18%)	22/112 (20%)	33/197 (17%)
Victim of past abuse/trauma*	36/198 (18%)		36/197 (18%)
Mental Health*	22/197 (11%)		22/197 (11%)
Physical health*	19/197 (10%)		19/197 (10%)
Housing issues*	12/197 (6%)		12/197 (6%)
University	26/310 (8%)	16/113 (14%)	10/197 (5%)
Alcohol Misuse	22/310 (7%)	21/113 (19%)	1/197 (0.5%)
Relationship problems*	13/197 (7%)		13/197 (7%)
Drug Misuse	19/311 (6%)	17/114 (15%)	2/197 (1%)
Legal problems	15/309 (5%)	12/112 (11%)	3/197 (2%)
Bereavement by suicide*	10/197 (5%)		10/197 (5%)
Victim of crime*	7/197 (4%)		7/197 (4%)
COVID19/lockdown*	8/197 (4%)		8/197 (4%)
Perp of crime*	8/197 (4%)		8/197 (4%)
Sexuality	8/310 (3%)	6/113 (5%)	2/197 (1%)
Bullying	8/309 (3%)	4/112 (4%)	4/197 (2%)
Gambling	8/310 (3%)	8/112 (7%)	0
Caring responsibilities*	3/197 (2%)		3/197 (2%)
Concern for others health*	2/197 (1%)		2/197 (1%)

*new categories added in year 2

Table C: Number of psychological variables reported by men at initial assessment

Psychological variable	Overall	Year 1	Year 2
Past suicide attempt/self-harm	234/313 (75%)	82/127 (65%)	152/186 (82%)
Rumination	233/300 (78%)	73/123 (59%)	160/177 (90%)
Thwarted Belongingness	212/300 (71%)	72/123 (59%)	140/177 (79%)
Humiliation	178/300 (59%)	60/123 (49%)	118/177 (67%)
Entrapment	162/300 (54%)	47/123 (38%)	115/177 (65%)
Absence of positive future thinking	153/295 (52%)	44/118 (37%)	109/177 (62%)
Social support	148/295 (50%)	78/118(66%)	70/177 (40%)
Impulsivity	141/295 (48%)	60/118 (51%)	81/177 (46%)
Burdensomeness	144/300 (48%)	42/123 (34%)	102/177 (58%)
Memory biases	133/300 (44%)	29/123 (24%)	104/177 (59%)
Defeat	129/300 (43%)	35/123 (29%)	94/177 (53%)
Not engaged in new goals	126/294 (43%)	30/117 (26%)	96/177 (54%)
Exposure to suicide	102/294 (35%)	37/117 (32%)	65/177 (37%)
Imagery of death & suicide	103/295 (35%)	33/118 (28%)	70/177 (40%)
Social problem solving	74/300 (25%)	25/123 (20%)	49/177 (28%)
Coping	65/299 (22%)	32/122 (26%)	33/177 (19%)
Resilience	58/295 (20%)	32/118 (27%)	26/177 (15%)
Attitudes	47/295 (16%)	12/118 (10%)	35/177 (20%)
Fearlessness of death	48/295 (16%)	20/118 (17%)	28/177 (16%)
Unrealistic goals	41/295 (14%)	9/118 (8%)	32/177 (18%)
Pain sensitivity	35/294 (12%)	16/117 (14%)	19/177 (11%)
Suicide plan	32/295 (11%)	15/11 (13%)	17/177 (10%)
Social norms	21/295 (7%)	6/118 (5%)	15/177 (9%)