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The James' Place model: Application of a novel clinical, community-based intervention for the prevention of suicide among men

Title Page

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Structured abstract

Purpose: High suicide rates among men presents a global challenge for commissioners and clinicians. Innovative approaches towards suicide prevention interventions designed for men are needed. The James' Place (JP) service opened in 2018, and its model of practice is a clinical, community-based intervention for men experiencing suicidal crisis. This paper aims to describe the implementation framework within which the JP model is applied.

Design/methodology/approach: Fostering a public health case study approach, this paper provides a description of how the JP service operates, including the referral pathways, key components of this innovative model, and its impact upon the men who receive the intervention. Illustrative case studies derived from semi-structured interviews from men and therapists are reported.

Findings: The JP model is dynamic and flexible, allowing the tailoring of a suicidal crisis intervention to suit the needs and priorities of the individual and the wider local community. Clinical and practical implications, such as reduction in suicidality are discussed.

Originality: Rapidly accessible, effective community-based interventions for men experiencing suicidal crisis are required. Yet, while widely advocated in policy, there remains a dearth of evidence illustrating the real-world application and value of such services within a community-setting. The JP model is the first of its kind in the UK, and an example of an innovative clinical, community-based suicide prevention intervention offering support for men experiencing suicidal crisis.

Introduction

Suicide remains a major, global public health risk despite the antecedents of suicide being better understood. Men are particularly at risk of dying by suicide as figures consistently show significantly more men than women die by suicide (Naghavi, 2019). This trend is reflected in suicide deaths in England also, where three quarters of all suicide deaths in England in 2019 were men (4303 out of 5691 suicide deaths), compared to 1388 of women (ONS, 2020).

Poorer rates of help-seeking behaviour among men experiencing suicidal distress are frequently reported (Luoma *et a*l., 2002). One possible reason being that help-seeking behaviour contrasts with men's notion of the masculine ideal, which includes norms of stoicism and emotional control (Levant *et al*., 2011) and promotes self-reliance (Pirkis *et al*., 2017). In addition, men accessing mental health services have reported feeling disenfranchised with pathways, due to negative experiences such as unease disclosing distress or unmet needs (Seidler *et al*., 2018a). Progression from suicidal thoughts, to plans and finally enactment among men is much quicker than in females (Schrijvers *et al*., 2012) making prompt availability of therapeutic intervention imperative.

The perceived inaccessibility of conventional pathways to suicide prevention services for men suggests that current approaches lack reach among men most vulnerable to suicide. It has been suggested that tailoring suicide prevention interventions to be gendered, such as being community-based and *men-friendly*, to suit men's needs could improve accessibility and engagement among men (Seidler *et al*., 2018b; Oliffe *et al.,* 2020). However, tailoring must be balanced to avoid perpetuation of toxic masculinities and the treatment of men as a homogeneous group. Instead, the fluidity of men's masculine identities in different contexts should be recognised (Struszczyck *et al.,* 2019). Chandler (2021) asserts the importance of the "*context*" in which the "*content*" of men's suicidal distress is communicated. Arguably, the contextual environment needs to be balanced in power to enable men to feel at ease to relinquish their masculine norms (e.g., stoicism) during discourses with health professionals and to engender conversations around suicidality. There remains a lack of research and

suicide prevention services which consider the perspectives of men experiencing suicidal crisis (Struszczyck *et al*., 2019), however this is an approach endorsed by James' Place (JP), the first community-based service in the UK delivering a clinical intervention for men experiencing suicidal crisis.

Methods

Fostering a public health case study approach, this paper describes the JP service, and how it operates, including the referral pathways and clinical journey of men who engage with JP. Ethical approval was granted by the Liverpool John Moores University Research Ethics Committee (18/NSP/024 & 19/NSP/057).

Case studies reported are derived from one-to-one semi-structured interviews which were conducted as part of on-going evaluation of the JP service. Eleven semi-structured interviews with individuals involved in the design and development of the service were conducted between December 2018 to January 2019 as part of a six-month evaluation (Saini *et al.,* 2019). Two therapist case studies are derived from these interviews. Two further case studies are derived from eight semi-structured interviews involving men who had previously completed the JP model between January and April 2020 for a one-year evaluation (Saini *et al*., 2020).

The James' Place Model.

[INSERT FIGURE 1: THE JP MODEL]

The JP model is comprised of four components shown in figure 1. Environment reflects the safe therapeutic space in which men feel confident to share their suicidal distress. JP therapists are qualified and trained to deliver the JP model (suicide prevention therapists). Men referred to JP are typically offered a welcome assessment within 48 hours and, if accepted, receive rapid access to suicide prevention support, and partnerships/referral pathways established with agencies within the local community are diverse, promoting the service's reach and accessibility.

Findings

The Environment & Setting

JP is the first community based therapeutic suicide prevention centre for men in the UK. At present there are two JP centres in the UK. The first opened in Liverpool in 2018 following successful piloting and evaluation of the JP model (Saini *et al*., 2020). Building upon this success, the second JP site opened in London in April 2020.

The importance of designing a male-orientated service suited to meet men's needs was a key priority throughout the development of the service. This was achieved by using co-production to inform the planning, design, and delivery of the JP service from inception through to implementation. While different definitions of co-production exist, JP has implemented a definition of co-production endorsed by the National Health Service (NHS) in England and NHS Improvement and Coalition for Personalised Care (formerly Coalition for Collaborative Care) (NHS, 2020). It is acknowledged that people with lived experience often have better understanding of the type of support services need to provide to support their needs, and the JP service has assimilated five values of co-production, consistent with this definition, into the

way the service works including *"a culture of openness and honesty"* and *"a commitment to shared power and decisions with citizens"* (NHS, 2020). In this way, co-production has been implemented to co-design, develop and evaluate the JP service by including feedback from a broad range of stakeholders including men and those with lived experience of suicide. Also, the JP therapist co-produces therapy with the men by considering the psychosocial drivers of their suicidal crisis which may be wide-ranging (e.g., debt management, relationship breakdown).

Multiple stakeholders from the local community, including those bereaved by suicide, those with lived experience as well as health professionals and commissioners, were involved in the co-production of JP (Saini *et al*., 2020). Men who had previously experienced suicidal crisis participated in a focus group that informed the design of the building and service delivery. Additionally, they were invited to participate in a steering group that reviewed materials, including semi-structured interview schedules and service feedback forms, used as part of on-going evaluation of the service. Discussions revealed the importance of creating a therapeutic environment that engendered a feeling of homeliness and safety, was neutrally decorated using natural furnishings, and extended to an outdoor area to allow men to receive therapy outside. Later, men were invited to view the service. They reported not only had their ideas been successfully implemented, but in reflecting upon their own experiences, they felt that the therapeutic environment would place men at ease. Also, that they would have liked to have been able to access a community-based service such as JP (Saini *et al*., 2020). The co-productive approach fostered by JP facilitated the co-creation of an environment conducive to engendering talk among men experiencing suicidal crisis and one which is attuned to their needs.

Theoretical Underpinnings of the James Place Model

Co-production has the additional benefit of relinquishing the therapist from a "*one size fits all approach*". The therapeutic alliance developed between the JP therapist and service-user aligns with the principles of co-production, as therapists use a person-centred approach to co-produce effective suicide prevention strategies and safety planning. This enables the therapists to deliver a multi-component suicide prevention intervention considering biopsychosocial factors that have contributed to the man's suicidal crisis. It allows the therapists the flexibility to engage with affiliated agencies to address environmental factors and life events that may be contributing to the crisis, and to work with the man to adapt therapeutic strategies that suit them best. For example, linking men to debt management support or benefits advisors for financial difficulties and job loss. This is particularly important as these types of issues are known to increase suicide risk in men (Richardson *et al*., 2021), and previous research has highlighted that this type of additional support is needed (Saini *et al*., 2021a).

The JP model was developed in 2018 by Jane Boland and Clare Milford-Haven. It is a theory-driven model that conceptually synthesises three prominent theories of suicide; the Interpersonal Theory of Suicide (Joiner, 2009), the Collaborative Assessment and Management of Suicidality (CAMS) (Jobes, 2012), and the Integrated Motivational-Volitional Theory of Suicide (IMV) (O'Connor, 2011; O'Connor and Kirtley, 2018). Each of these models emphasise co-production of effective suicide prevention strategies and safety planning. In this way, the dynamic and flexible approach of the JP model resembles a crisis resolution model. For example, a JP therapist conducts a detailed welcome assessment (WA) during which they evaluate risk factors highlighted in these theoretical models associated with the man's suicidal crisis. Factors such as *thwarted belongingness* and *perceived burdensomeness* which underpin the interpersonal theory of suicidality (Joiner, 2009) and motivational factors such as *defeat* and *humiliation*, and *entrapment* fundamental in the IMV model of suicide (O'Connor, 2011; O'Connor and Kirtley, 2018), are assessed; while a flexible assessment and therapeutic approach that is person-centred and problem-focussed reflects

the CAMS framework (Jobes, 2012). In this sense, the JP model integrates these three models of suicide, creating a theory-driven yet male-focused prevention approach.

The JP Therapeutic Journey

[INSERT FIGURE 2: THE CLINICAL JOURNEY OF MEN REFERRED TO THE JP SERVICE]

Figure 2 illustrates the trajectory of men through the service. For brevity, individuals accessing JP are referred to as men in this paper. However, JP is inclusive of all individuals who identify as male of all ages, sexualities, disabilities, ethnicities, and race. JP offers support to men who are aged 18 years and over, are registered with a GP (or willing to share information with a GP), who can access the building accommodation and who are able to engage in talk therapy. Referral partnerships developed by the service allow referral from various organisations within primary and secondary care, from the third sector, and from self-referrals.

Men referred to the JP service receive a WA conducted by an JP therapist within 48 hours irrespective of referral pathway used. During the WA the therapist assesses the men based on the inclusion criteria above and considers the referral information to make a structured clinical judgement relating to their suicide risk. This includes assessing the motivational factors of suicide (e.g., access to means, previous suicide attempts) and protective factors (e.g., family, information about the men's supporters). Additionally, the therapist works with the men to qualify their thinking around suicide to further evaluate their risk (e.g., fearlessness of death, whether they have planned or rehearsed a suicide attempt). WA's are often conducted by the therapist the men will see for therapy. However, complex cases may be stepped up to a senior duty therapist. Referrers are informed of the reason if men are not accepted to JP. Often, this is due to the men not being in a suicidal crisis. Men who receive a WA who are subsequently not accepted by JP receive a simple safety plan during this session.

The JP model consists of a total of nine therapy sessions structured into three lots of three sessions. Risk factors of suicide, such as those identified during the WA are used to inform the delivery of the sessions and re-evaluated subjectively and objectively by the therapist throughout the intervention (e.g., using the Clinical Outcome Measure (CORE-OM; Core System Group, 1998). For example, risk factors are managed during the initial sessions to develop safety planning with the men, and re-evaluation of risk factors towards the end of the intervention allows the therapist to reflect with the men how much their suicidality risk has reduced.

An additional key facet of the model is the "Lay your Cards on the Table" (see Plate 1) of which there are four stacks; *what's happening now, how did I get here, keeping the problem going* and *how I can get through this*. Resembling the look of a stack of playing cards, each card within the different sets describes either an emotion (e.g., sad, hopelessness) physical sensation (e.g., butterflies, dizziness), situation (e.g., someone is bullying me) or life event (e.g., breakdown of a significant relationship). Each stack of cards has been designed to prompt discussion around specific issues and correspond to specific stages of the JP model as described below.

[INSERT PLATE 1: THE "LAY YOUR CARDS ON THE TABLE" INTERVENTION]

The first three sessions of therapy occur over the course of a week and encompass risk management, safety planning, and ensuring the man is engaged in talk therapy. During this time, the *what's happening now* cards are administered to help the men visualise how they feel and to prompt discussion with the therapist. Sessions four to six involve the therapist delivering brief psychological interventions tailored to the individual's needs. During these three sessions the *how did I get here* cards are introduced to help men recognise contributory factors to their suicidal crisis. The focus of the final three sessions (session seven to nine) is upon relapse prevention and safety planning. The therapist guides the men to reflect upon their progress and the tools developed during therapy to self-monitor their wellbeing. The *how can I get through this* cards, containing cards relating to two themes of *what can I do* and *what*

other people can do, may be used to facilitate recognition of the coping strategies, and the support mechanisms men have developed to aid identification of a lapse in their wellbeing and to prevent relapse.

Outcomes associated with the JP Model

Evaluation systems have been embedded into the JP service from its inception to enable empirical testing of the JP model. Therapists conduct a clinical assessment of the psychological, motivation and volitional factors contributing to the men's suicidality during the WA and within therapy. The clinical outcome measure (CORE-OM) and Entrapment Scale Short-Form (E-SF) (De Beurs *et al*., 2020) are currently used to provide a clinical assessment of suicidality. CORE-OM data has been collated since the service began. E-SF data were not collated by the service during the period year 1-2. However, as part of on-going service development this measure was introduced in the third year of the service to augment assessment of men's outcomes. Between 2018 and 2020 the CORE-OM 34 was initially used but was replaced by the CORE-OM 10 and administered more frequently during the third year also. The CORE-10 is as effective as the CORE-OM 34 but reduces the burden upon the men completing the questionnaire. The CORE-OM 10 consists of ten questions from which an overall score of global distress is calculated. The E-SF consists of two subscales measuring internal and external entrapment. Entrapment is a significant indicator of suicidal behaviour conceptualised as the result of an individual's attempt to flee distressing thoughts or feelings (internal entrapment) and an intolerable situation (external entrapment). CORE-OM 10 and E-SF are evaluated during every session the men attend, to monitor changes in distress throughout the therapeutic journey.

While it is not possible to report outcome data for JP London, due to the infancy of the service, process evaluations of JP Liverpool (Saini *et al*., 2020; 2021b) have consistently supported the efficacy of the JP model for men who engage in therapy. Since being operational, mean

attendance at JP Liverpool between 1st August 2018 to 31st July 2020 was 4 sessions (range 1-19 sessions). Adherence to therapy is defined as attendance at WA and at least one therapy session (Chopra *et al.,* 2021). Findings revealed a mean CORE-OM score of 86.56 (range = 18 - 120) recorded upon entering the service (Saini *et al*., 2021b) indicating severe levels of distress (O'Connell *et al*., 2007). The CORE-OM scores upon discharge yielded a mean reduction of 50.9 in global distress, accruing a mean CORE-OM exit score of 35.45 (range = 0 – 87) (Saini *et al*., 2021b). This indicates mild levels of distress (O'Connell *et al*., 2007). E-SF data were not collated by the service during this period. Results showed this reduction in scores was significant, with a large effect size (Saini *et al* 2021b). Psychological factors commonly reported by the men were past suicide attempt/self-harm (75%), rumination (78%), thwarted belongingness (71%), humiliation (59%) and entrapment (56%). These findings support the JP model in being effective in achieving a significant reduction in suicidality. More detailed outcomes for the JP service have been published elsewhere (Saini *et al*., 2020; 2021a; 2021b; Chopra *et al*., 2021). The case studies provided complement the outcome data demonstrating the reach of the service to engage, and its acceptability in meeting the needs of men experiencing suicidal crisis.

Discussion

The purpose of this paper was to discuss the JP service, the first community-based service in the UK delivering a clinical intervention for men experiencing suicidal crisis. The outcomes reported show the efficacy of the JP model in significantly reducing suicidality among men who engage in therapy at JP (Saini *et al*., 2020; Chopra *et al.*, 2021; Saini *et al*., 2021a; 2021b).

The inclusion of theory-driven models of suicidality and co-production are integral and distinguishing features of the JP model. Risk factors associated with male suicide are complex and diverse, and subject to temporal and context-related fluctuations (O'Connor and Kirtley,

2018; Richardson *et al*., 2021) highlighting the need for holistic approaches in suicide prevention interventions. The theory-driven nature of the JP model facilitates identification of the mechanisms underpinning the men's suicidality enabling therapist to work alongside the men to adapt and tailor the JP model, creating a targeted intervention.

Arguably, poor help-seeking among men is reflective of poor understanding of what men want from a therapeutic setting. Women are more likely than men to seek professional support for mental health (Holzinger *et al.,* 2012). That is not to say that men do not wish to seek help when experiencing suicidal crisis. For example, the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) report into suicide by middle-aged men reported only 9% of men who died by suicide were not in contact with services (e.g., primary care, mental health services) prior to their suicide (NCISH, 2021). However, only 5% of men in this study were engaged with talking therapies (NCISH, 2021) despite these therapies being found to be equally efficacious for women and men (NHS Digital, 2019*).* This juxtaposition highlights the need for suicide prevention services that suit men's needs and priorities. That said, it is important to resist treating men within their experience of suicidality as a homogenous group. JP has achieved this by incorporating co-production into service development and implementation. This has provided important insights into how men experience suicidal crisis, what it is they want from suicide prevention services, and how best to adapt the service accordingly. During the first few months of opening, JP identified that men aged 55 years or older were less likely to access the service, to which they responded by conducting outreach work with primary care, to increase engagement among this cohort. Recent research revealed that there is no significant difference in engagement or efficacy of the JP model among older versus younger men (aged 18- to 30-years) (Saini *et al*.,2021a). These findings suggest the JP model adds transparency to the therapeutic alliance, affording both therapists and men the agency to work together, to co-produce effective suicide prevention strategies and to explore the potentially wide-ranging psycho-social *context* (e.g., unemployment, addiction), as well as the *content* of the suicidal crisis for the individual man. This is highlighted in Figure 1 and in

the case studies below which show the important inter-relationship between an environment that feels safe to men to discuss their suicidal distress, rapid access to qualified suicide prevention therapists and partnership / referral pathways (e.g., debt management), as factors which contribute to the mechanism of the JP model.

This approach is supported by findings reporting that men endorse an active role in therapy which is person-centred, structured, action-orientated and solution focussed (Siedler *et al*., 2018a). In this way the JP model represents a shift away from a *one-size-fits all* approach towards a nuanced, tailored approach which is known to better suit men's help-seeking behaviour.

An evidence base of peer-reviewed research findings is emerging that supports the acceptability and efficacy of the JP model for men experiencing suicidal crisis. Next steps in this endeavour will focus upon establishing whether the significant clinical outcomes reported are sustained longer term. Additionally, there are ambitious plans to extend the JP service across the UK over the next three years. Understanding the demographic and clinical characteristics of men who do, and do not engage with the JP service will facilitate creation, and strengthening of, targeted and existing referral pathways into JP care respectively, and may improve engagement among the men most at risk of suicide.

Case study 1 - Michael

Michael had been "*struggling*" following the death of his mother some years ago. Upon accessing the JP service he felt the environment placed him at "*ease*", a contrast to his experience of traditional support services. "*They [the NHS counselling sessions] just didn't do anything for me at all. They felt very clinical and just like you're a number*." Michael struggled to accept his need for support. Nevertheless, the therapist quickly developed a rapport with Michael and encouraged him to work through the therapeutic journey. The "lay your cards on the table" helped Michael to identify additional life events contributing to his crisis. "*There were certain cards that just other things have happened in my life, different circumstances that had happened that would be big things to normal people, but seemed less significant than my mum*". Upon discharge, Michael felt he had developed self-monitoring skills to recognise when his wellbeing may be deteriorating and the strategies to maintain his wellbeing. "*I just felt like everything was on top of me and I really just couldn't feel… like, if I drew a picture, I would have just been sat in the corner with a rock on top, just weighted down by things. Now, I feel so light, and a different person....*"

Case study 2 - Liam

Liam was experiencing suicidal thoughts associated with financial difficulties. Initially, he sought help from the crisis team, however made a self-referral to JP, feeling a CBT course he had engaged with just "*scratched the surface*". The infancy of the JP service was an initial concern, but the homely environment and friendly staff engendered Liam with the confidence to engage in therapy as it felt "*just like going to see a friend*". The "lay your cards on the table" allowed Liam to express his negative thoughts and feelings, something he had never done before. "*I knew I needed help, but I'm not, I'm not the sort of person that can express, even to my wife and that, the feelings that I have*". Supported by his therapist, Liam learnt strategies for off-loading negative thoughts and feelings outside the therapeutic setting. "*It wasn't until my therapist said, 'You write stuff down, and then even though you're thinking it, it's getting it out of your head, rather than just keeping it in your head, and just building and building and then building…it just gets that thought and misery out of your head*". The end of therapy felt daunting, but Liam recognised that "*it had come to an end*" and felt attending JP had encouraged him to speak to his wife about his suicidal thoughts and had saved his life. "*I might not be talking to you now. So that's the sort of impact that it's had, and I have to say that I had to put something into it. I had to do it. Because if I didn't, it was a waste of time doing it, going there*."

Case study 3 - Therapist 1

Therapist 1 is clinical lead for the JP service, and was involved in setting up the service and developing the JP model. Involvement of local stakeholders and agencies from the community, including men with lived experience of suicide (e.g., previous suicide attempts), is recognised by therapist 1 as important for establishing transparent collaborative working when creating a service-user led suicide prevention service for men. For example, they highlight the importance of gaining views of men with lived experience by inviting them to be part of a steering group to gain feedback on aspects of service deign, including the building design and evaluation materials the service may use (e.g., feedback forms). "*We recognised that to be truly authentic and to be truly service-user led, we need the input of people who access services. So a steering group was set up and a questionnaire and a discussion occurred, where we had access to men who access service. They [men] gave their views on what they think a building should look like*". Feedback from focus groups and questionnaires of men with lived experience provided valuable insights into what men want in suicide prevention service location and design. This informed the need for an outdoor area. "*When they had told us that when they were at their point of crisis, they felt very claustrophobic. One of them described it, I remember it distinctly, they described it as feeling like they had an elephant sitting on their chest, but actually the only outdoor space that was available to them, at that point, in A&E was to leave the hospital grounds and to actually access fresh air and space, which then gave them a further risk*". The co-productively designed nature of the JP service is seen by therapist 1 as an essential component of the JP therapeutic journey. "*That real listening to the people that would potentially be using the service and the building, was absolutely key and a fundamental part of the design and how the building was going to look and how it was going to feel and how it was going to function, and the therapeutic approach*".

Case study 4 - Therapist 2

Therapist 2 is a counsellor and although experienced in delivering brief psychological interventions, they received training in the JP model. Despite some reservations about the "lay your cards on the table" intervention having not delivered this type of intervention previously, therapist 2 found the cards advantageous for eliciting thoughts and feelings among the men, particularly for those reticent to engage or struggling during earlier sessions. The cards were seen as a "*powerful*" therapeutic tool that allows the man to be involved as much as the therapist in discovering the drivers of their crisis and the impact this is having upon them. "*When he first came here, he was really struggling to open up. He felt really awkward about being here, he felt uncomfortable, and he said he wanted to leave. By the second session we got the cards out and he said, "Wow, I can't believe I've been carrying this." I think for him, he felt very ashamed to talk about his issues. Then all of a sudden doing this made him really see what was going on".*

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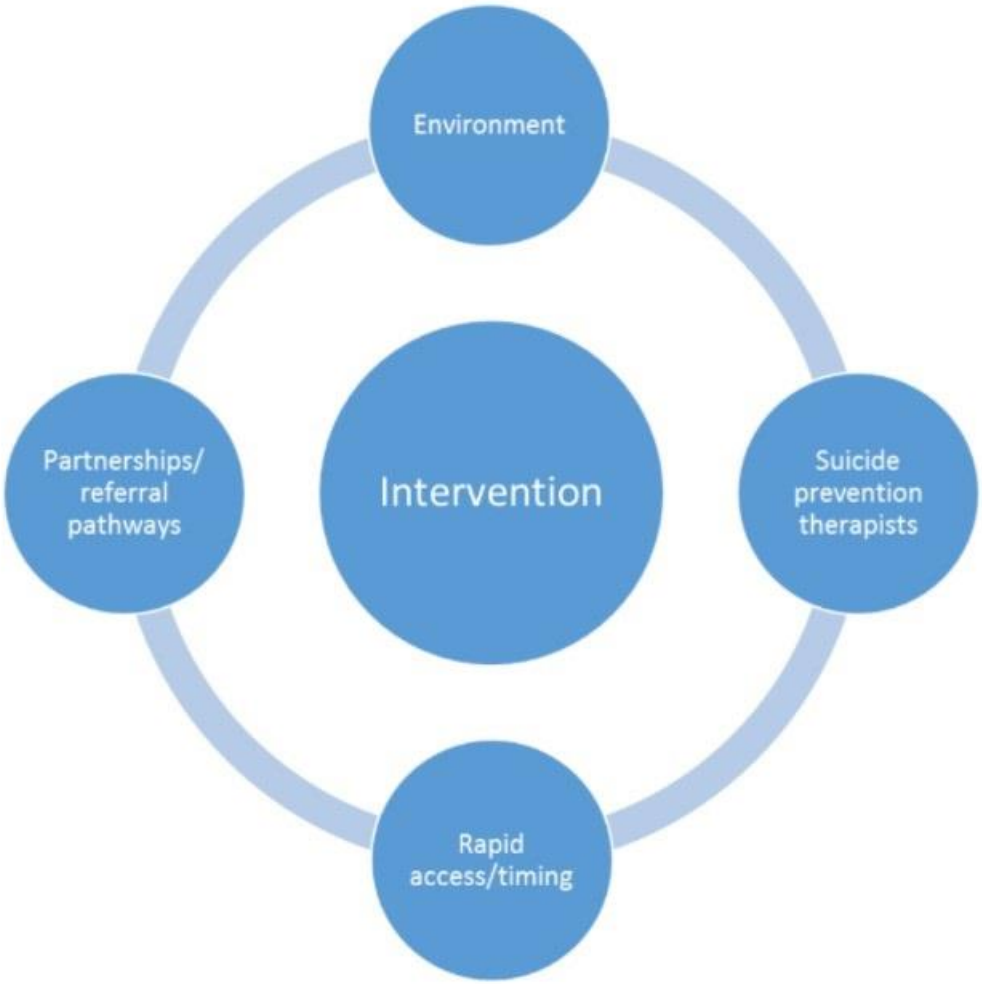
Environment
Partnerships/ referral pathways
Intervention
Suicide prevention therapists
Rapid access/timing

The JP Model

The clinical journey of men referred to the JP service

The Lay your Cards on the Table intervention