The Feasibility and Effectiveness of the James' Place Brief Psychological Therapeutic Model among Men Experiencing Suicide Crisis

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Abbreviation List

Age standardised mortality rate - ASMR

Collaborative Assessment Model of Suicide - CAMS

Integrated Motivational Volitional theory of suicide – IMV

Interpersonal theory of suicide - IPT

James' Place - JP

Lay your Cards on the Table – LYCT

Liverpool John Moores University - LJMU

National Institute for Health Care and Excellence – NICE

Northern Ireland Statistics and Research Agency - NISRA

Office of National Statistics – ONS

University College London - UCL

Welcome assessment - WA

World Health Organisation – WHO

Abstract

Introduction: Men are disproportionately more likely than women to die by suicide. Research has uncovered several risk factors associated with suicide among men. However, poor uptake and engagement with mental health services by men has led to calls for accessible and suicide prevention approaches sensitive to men's needs. James' Place (JP) is a community-based suicide prevention service delivering a therapeutic suicide prevention intervention called the James's Place Model (JPM) to adult men experiencing suicidal crisis. This thesis aimed to examine feasibility and effectiveness of the JPM.

Methods: A mixed-methods design was used. A systematic review of 14 papers examined the role of co-production in community-based adult suicide prevention services. Routinely collected service data of 511 men, questionnaire data collected from 28 men with follow-up (3- and 6-months) and descriptive analyses of internal audit records of 30 completed cases of men who had received the JPM comprised quantitative data. Semi-structured interviews (n=8) and case studies of JP specialised suicide prevention therapists (n=2) and case studies of men who have received the JPM (n=4) formed qualitative data.

Findings: The JPM is perceived as an accessible and acceptable community-based suicide prevention intervention for men. Key components of the JPM including rapid access, the therapeutic environment cultivated at JP and dynamic nature of lay your cards on the table normalise men's suicidal experiences and facilitates disclosure of suicidal distress, allowing therapists to tailor intervention delivery to individual needs. While the effectiveness of the JPM could not be statistically tested, men's accounts indicate it as being perceived as effective in the immediate- to short-term, with evidence of continued implementation of relapse strategies learned.

Discussion: The research adds support to research showing that men will disclose suicidal distress and points to the need for community-based, tailored suicide intervention delivery for men which can be accessed at point of crisis.

Declaration

I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Candidate Profile

I rediscovered education later in life and fell in love with Psychology thanks to an engaging Liverpool community college tutor who reignited my love of learning. In 2001, I entered higher education for the first time at Liverpool John Moores University (LJMU), going on to attain a Bachelor of Science (Honours) degree in Applied Psychology (first class), whilst working full-time and having had my first child during this time. From there, I earned a Distinction in Health Psychology master's from LJMU in 2012, and several years later, an MPhil in Psychology from the University of Manchester.

Since 2012, I have consistently worked as a Research Assistant on various projects. These include Sports England "*This Girl Can*" campaign, a study exploring the acceptability and effectiveness of physical activity monitoring devices among children and young people with Cystic Fibrosis, an evaluation of the NHS Health Checks scheme, and more recently, a study piloting suicide prevention in schools (multimodal approach to preventing suicide in schools (MAPSS).

Throughout my PhD, I have continued to develop my research skills by publishing my first named author papers (4 papers related to my PhD and 1 paper unrelated to my PhD). I have also presented my research findings at National and International conferences and was part of a research group delivering a symposium at the 31st International Association for Suicide Prevention conference in 2021 on community-based suicide prevention approaches for men experiencing suicidal crisis. I have also begun to develop funding applications to support research in several areas including safety planning by applying to internal funding opportunities at LJMU (e.g., QR PSF) and external funding opportunities (e.g., Martin Lawlor fund). As my research has progressed it has naturally gravitated towards exploring suicide within autistic people, and I hope to take this research interest further post-PhD.

Published Journal Articles

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Chapter 1: Introduction

Foreword

Suicide is defined as *"intentionally ending one's own life"* (Turecki et al., 2019) and poses a significant global public health risk to individuals, with almost 700 000 people dying by suicide worldwide each year (World Health Organisation [WHO], 2021a). This equates to one death by suicide every 40 seconds across the world (WHO, 2019). Let us pause to consider this for one moment. In the time that it has taken you to sit down, open to this page and start reading this opening paragraph, someone, somewhere will have died by suicide. Worse still, possibly more than one person. Each death by suicide is a tragic loss, which has devastating repercussions for family, friends, and significant others among the wider community. However, suicide is preventable and can be significantly reduced through effective, evidence-based intervention, something every person who has contributed to this thesis feels passionately about.

This thesis evaluates an innovative, co-produced therapeutic model delivered by qualified therapists in a therapeutic community-based centre called James' Place, which offers support to men in suicide crisis. Since the focus of this thesis is upon a service specifically created for men, this introductory literature review chapter will consider the following areas broadly and is framed within the context of suicide among men:

- The incidence of suicide, including men
- Risk factors and correlates associated with suicide among men
- Outline current theories of suicide
- Provide an overview of the James' Place Therapeutic Model

1.1. Suicide Incidence Rates

1.1.1. Suicide Incidence

Suicide rates vary country to country (Tureki and Brent, 2016), however globally around 700 000 people each year die by suicide (WHO, 2021a). In 2019, age-standardised rates of suicide were 9 per 100 000 occurring per annum worldwide, with a range of fewer than 2 suicide deaths per 100 000 to over 80 suicide deaths per 100 000 (WHO, 2021b). By comparison, in England and Wales in 2021, 5583 suicide deaths were recorded, equivalent to approximately 10.7 suicide deaths per 100 000 (ONS, 2022). This is consistent with suicide rates recorded in the year prior to the COVID-19 pandemic for England and Wales equivalent to 11.0 (5691 in total) in 2019 (ONS, 2020). Notably in 2020, a decrease of 467 suicide deaths compared to the preceding year was recorded, relating to a 10.0 deaths per 100 000 population (5224 in total) (ONS, 2021). It is suspected that a statistically significant reduction in male suicide at the beginning of the COVID-19 pandemic and delayed coroner investigations during the pandemic account for this decrease in suicide deaths.

Just as geographical differences in suicide rates are found between countries worldwide (Turecki et al., 2019), regional differences in suicide rates are found across the four countries of the UK. In 2021, a total of 237 deaths by suicide occurred in Northern Ireland, equivalent to 14.3 age-standardised suicide deaths per 100 000 persons (Northern Ireland Statistics and Research Agency (NISRA), 2021). Scotland recorded a total of 762 suicide deaths in 2022, with males accounting to 556 suicide deaths compared to 206 females (National Records of Scotland, 2022). This compared with 347 suicide deaths in Wales, relating to an age-standardised mortality rate (ASMR) of 12.7 per 100 000 population in 2021 (ONS, 2022). Lastly, the ASMR in England was 10.5 suicides per 100 000 population, with a total of 5219 deaths recorded in 2021 (ONS, 2022). Moreover, research has shown a north-south divide in suicide rates exists within England. Buchan et al., (2017) evaluated trends in suicide rates from 1965 to 2010 in England and found a consistently higher incidence of suicide in the north compared to the south. Although Buchan et al's., (2017) research showed that this trend stabilised from 2010 to 2015, ONS figures reveal that this

may have been a temporary reprieve. The Northeast of England recording the highest rate of suicide in 2021 with an AMSR of 14.1 suicide deaths per 100 000 population compared to London 6.6 per 100 000, which recorded the lowest rate of suicide in England (ONS, 2022).

These figures serve as a stark reminder of suicide incidence. However, they fail to fully capture the true extent of the anguish of those experiencing suicidal distress. It is estimated for each suicide fatality, there are 20 non-fatal suicide attempts made by individuals to end their life (WHO, 2023). Suicide is complex and multifaceted in nature, involving various psychosocial and emotional risk factors. While research has advanced understanding of the risk factors associated with suicide, suicide rates remain high and suicide prevention remains an important research and public health priority.

1.2. Suicide Prevention Policy

In recognition of the direct and wider indirect effects of suicide, suicide prevention has become a key public health priority both globally and locally within the UK. In terms of global suicide prevention strategies, WHO recently updated and extended their Comprehensive Mental Health Action Plan 2013 - 2020 (WHO, 2021c) until 2030 for example. The Comprehensive Mental Health Action Plan 2013 - 2030 contains four main objectives "*to strengthen effective leadership and governance for mental health; to provide comprehensive, integrated and responsive mental health and social care service in community-based settings; to implement strategies for promotion and prevention in mental health; to strengthen information systems, evidence and research for mental health"* (WHO, 2021c p.5). Global targets underpin each target including a reduction in suicide rates by a third in 2030 and the development of suicide prevention strategies particularly for sub-groups at increased risk within each member state country (WHO, 2021c).

Each devolved nation within the UK has a national suicide prevention strategy. For example, in 2012 "*The Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives Report*" was published which aimed to reduce suicide among the

general population and to improve support for individuals bereaved or affected by suicide in England. Six areas of improvement were initially identified in 2012, which were later developed to seven areas in 2017, including the reduction of suicide among high-risk groups, tailored approaches for mental health in specific groups, and reducing self-harm rates. Since the publication of the first report, subsequent annual reports have been published by the Department of Health and Social Care (DHSC) documenting progress of the strategy to date and outstanding developments needed. The fifth release of the briefing acknowledged the additional pressures attributable to the COVID-19 pandemic upon national suicide prevention efforts and announced £2.3 billion in additional Government funding for mental health with £57 million of this ring-fenced for suicide prevention and suicide bereavement (DHSC, 2021). Whilst COVID-19 does not appear to have increased suicide rates, the report does speculate that "*enduring effects*" of the COVID-19 legacy are likely and yet to be fully realised such as economic risk factors of suicide including unemployment and debt (DHSC, 2021 p8). However, whilst COVID-19 pandemic presented unprecedented challenges to mental health service provision and shone a light upon increasing inequalities, it is important to recognise that increased suicide rates were recorded in 2018 and 2019 (ONS, 2019; 2020). Appointment of the first minister for patient safety, suicide prevention and mental health in 2018 brought further political focus to suicide prevention attracting and encouraging conversations about suicide and mental health. However, much more work is needed to address high rates of suicide.

The DHSC recently released the suicide prevention in England: 5-year cross-sector strategy (DHSC, 2023). This strategy broadly aims to act upon three goals of; 1) reducing the rate of suicide in the next five years; 2) improving availability of support for people who self-harm; and 3) improving availability of postvention support for those bereaved by suicide (DHSC, 2023). Implementation of this strategy galvanises suicide prevention efforts from across different sectors. Sectors include academia, health (e.g., DHSC and NHS England), third sector organisations (e.g., voluntary, community and social enterprise), and national and local government departments (e.g., the ministry of defence, police). Each share the goal of addressing a series of priorities of action including the provision of accessible and

tailored targeted suicide support for at risk priority groups (e.g., middle-aged men, autistic people) and provision of effective crisis support (DHSC, 2023).

In recognition of the dual potential of suicide prevention policies to influence acute and long-term responses to suicide crisis and suicide prevention respectively, a recent critical analysis examined the construction, conceptualisation and provision offered within UK based suicide prevention policies from 2009 to 2019 (Marzetti et al., 2022). The findings revealed that suicide was constructed as *"self-inflicted", "deliberate" and "death-intentioned"* within the policies analysed (Marzetti et al., 2022 p.6). Likewise, suicide prevention strategies are aligned to this construction of suicide and consequently policy asserts that suicide is "*preventable through a combination of surveillance, crisis intervention and medicalised, mental health care*" (Marzetti et al., 2022, p.10). The authors argue that conceptualisation of suicide in this way detaches the psychosocial, emotional, societal, and political back drop in which it occurs (Marzetti et al., 2022). As a result, suicide is pathologized and depoliticised, and portrayed as an individualised issue, and neglects the intersectionality and impact of broader, diverse factors (e.g., socioeconomic, emotion) associated suicide (Marzetti et al., 2022). This shifts the focus of suicide prevention towards prioritising prevention of death over a holistic approach (Marzetti et al., 2022). Subsequently, much more work is needed to address suicide rates and to ensure provision of suicide prevention approaches which are effective, acceptable, and accessible to their targeted audience that consider the broader context in which suicidality occurs, particularly for identified high-risk groups including men.

Suicide rates consistently remain high among men commanding innovative, accessible, and acceptable approaches to suicide prevention interventions. James' Place was created for this purpose and forms the context of this thesis as an innovative, therapeutic community-based approach to suicide prevention for men experiencing suicidal crisis. Therefore, this literature review focuses upon suicide among men. However, it is acknowledged by the author that suicide afflicts people of all genders and ethnicities, irrespective of class and that it is imperative we create safe therapeutic spaces for every individual experiencing thoughts of suicide.

1.3. Risk Factors Associated with Suicide Risk Among Men

Research investigating suicide has uncovered several risk factors most associated with increased probability of suicide occurring due to the presence of these variables. Individuals with increased suicide risk are more likely to die by suicide than those who do not possess suicide risk factors. Just as suicide is complex and multifaceted, research examining the determinants that pose an individual at increased risk of suicide are also complex and multifaceted (Franklin et al., 2017). Several studies have explored the risk factors associated with suicide (e.g., Franklin et al., 2017; O'Connor & Nock, 2014; Turecki et al., 2019) including those among men (Richardson et al., 2021a). Different approaches to understanding risk factors correlated with increased suicide risk can be taken including at a population or individual level, or across the life course (Fazel & Runeson, 2020). Furthermore, to disentangle and elucidate the complexities of suicide risk, attempts have been made to encompass suicide risk factors into theoretical models of suicide (Franklin et al., 2017). However, no theoretical model entirely explains suicide (Franklin et al., 2017) including suicide among men (Richardson et al., 2021a). Likewise, despite the identification and implication of several risk factors associated with increased suicide risk they fail to adequately explain why an individual dies by suicide (O'Connor & Nock, 2014),

Recent systematic review findings sought to determine the nature and extent of risk factors predictive of suicide among men (Richardson et al., 2021a). Sixty-eight different risk factors were identified, and studies included within the review highlighted how these can fluctuate in prominence across the life course among men (Richardson et al., 2021a). Alcohol and drug use or dependence, relationship status (i.e., married, single, divorced, or widowed), and depression were noted by the authors as having garnered increased evidential support for predicting suicidal behaviour among men across both the prospective and retrospective studies included within the literature (Richardson et al., 2021a). Other risk factors included physical ill-health (e.g., cancer), chronic health conditions (e.g., type 2 diabetes), negative life events or trauma (e.g., death of a partner or cohabitee or recent death of a family member or friend; or adverse childhood experiences), and low IQ (Richardson et al., 2021a).

The following section provides a brief overview of some of the most prominent risk factors most associated with suicide among men as supported by the findings of recent systematic review findings (Richardson et al., 2021a). However, it is important to note this is not an exhaustive evaluation of all risk factors of suicide among men. Nor do they fully or adequately account for and explain increased suicide prevalence among men.

1.3.1. Alcohol and/or Drug Use and Suicide

Substance use is a significant, yet modifiable risk factor associated with increased risk for suicide (WHO, 2014). While different types of substance use (e.g., marijuana, cocaine, amphetamines) have been implicated in suicide deaths, a review of cohort studies found alcohol and opioid use were among the most widely reported substances attributed to 22% and 20% of suicide death cases respectively (Wilcox et al., 2004).

Both acute- and problematic use of alcohol/alcohol dependence are associated with increased suicide-related behaviour, including completed suicide and suicide attempts (Berglund & Ojehagen, 1998; Cherpitel et al., 2004; Hufford et al., 2001; Nostrom & Russow, 2016). Further, a seven-fold increased risk of suicide attempt in the 24 hours following acute use of alcohol has been reported (Bagge et al., 2013). Kõlves et al., (2006) reported alcohol abuse and alcohol dependence was found in 10% and 51% of suicide cases respectively. This compared to a rate of alcohol of abuse and dependence of 7% and 14% of controls respectively. Moreover, 68% of males compared to 29% of females met diagnostic criteria for alcohol abuse or dependence, with middle-aged men (aged 35-49 years) who died by suicide accounting for the highest risk of alcohol dependence (83.9%) compared to controls (Kõlves et al., 2006).

As with alcohol, drug use including illicit drug use and dependence has also been correlated with increased risk of suicide (Breet et al., 2018). Recent meta-analysis findings reported a pooled prevalence rate of suicide ideation and attempts of 35% and 20% respectively among patients with substance use disorder (Armoon et al., 2021). Wilcox et al., (2004) in their review of retrospective and prospective cohort studies that opiates, marijuana,

cocaine, and amphetamines were present in 20%, 10.2%, 4.6% and 3.4% of suicide deaths respectively. Of the substances examined, alcohol and opiate use were correlated with higher risk of suicide (Wilcox et al., 2004).

Various pathways have been posited to explain how alcohol and/or drugs are correlated with suicide mortality (Orpana et al., 2020). For example, drinking alcohol may be an avoidant coping strategy to alleviate psychological distress and is associated with inducing depressed mood, anxiety and impulsivity which may contribute to increased suicidal thoughts and behaviours (Gonzalez, 2019; Hufford et al., 2001). Small effect sizes for alcohol dependence and small to medium effect sizes for drug dependence and suicide among men have been reported (Richardson et al., 2021a). However, further research is required to elucidate whether alcohol and drug use acts as an antecedent, coping mechanism or facilitator for suicide behaviour (Richardson et al., 2021a). Disentangling the causal mechanisms of alcohol and drug use could inform development of targeted intervention to support individuals where alcohol and drug use is a significant risk factor.

1.3.2. Relationship Status

Systematic review findings concluded that married people are less likely to die by suicide (Ides et al., 2010). While both men and women may experience relationship difficulties and/or breakdown, being single irrespective of whether this is a result of being unmarried, separated or divorced poses an increased risk of suicide among men and women (Naess & Pin Quing, 2021). However, research evidence suggests that this relationship is complex, with some studies confirming an increased suicide risk among men, while others among women (Evans et al., 2016). For example, Kõlves et al., (2010) reported that during separation 28.3% of men versus 15.5% of females experienced suicide ideation. Kposowa (2003) found that divorced men were eight times more likely to take their own lives than women. Other research findings conflict with the assertion. Fekete et al., (2005) reported more divorced women than divorced men died by suicide. Similarly, Petrovic et al., (2009) reported 54.5% divorced men versus 50% divorced women died by suicide. However, less

widowed men than women were found to have died by suicide (22.3% widowed men versus 34.5% widowed) (Petrovic et al., 2009).

Notwithstanding the conflicting research evidence supporting a gender difference between men and women and the impact of relationship status/breakdown and suicide, the post-breakdown of relationship period appears to be a particularly sensitive period for men posing them at increased risk of suicide (Scourfield & Evans, 2015). The social and emotional support provided within a relationship such as marriage is conceptualised as a protective factor against suicide (Kposowa, 2000; Naess & Pin Quing, 2021). It is proposed that the ensuing stressors experienced post-relationship breakdown heighten suicide risk for men (Kõlves et al., 2010; Scourfield et al., 2012). For example, legal, financial, property difficulties, and child custody difficulties (Kõlves et al., 2010; Scourfield et al., 2012), shame associated with the relationship breakdown (Kõlves et al., 2010) and loss of emotional support giving rise to feelings of loneliness due to loss of social-emotional connectivity (Scourfield and Evans, 2015). Subsequently, this may hamper help-seeking and disclosure of distress as this contrasts with masculine ideals (discussed earlier) (Oliffe et al., 2022; Vickery et al., 2021).

1.3.3. Depression

Psychiatric problems are frequently reported among people who die by suicide (Cavanagh et al., 2003). Of these, depression has been identified one of the most commonly occurring mental health disorders occurring among people who die by suicide (Cavanagh et al., 2003; Chesney et al., 2014). For example, findings from a recent systematic review and meta-analysis of psychological autopsy studies examining risk factors for general population adults who died by suicide reported 71.1% of suicide cases had a mental health disorder compared to 22.2% of control cases at the time of death (Favril et al., 2022). Moreover, of the mental health disorders examined depression was found to be most strongly correlated with suicide (Favril et al., 2022).

Rates of depression is reported to be twice as high among women than men (Kessler, 2003; Oliffe et al., 2019; Salk et al., 2017). Yet, suicide rates among men are significantly higher than women. It has been suggested that differences in the expression and experiences of depressive symptomatology among men may account for this disparity (Whittle et al., 2015). Traditional diagnostic criteria and assessment methods focus upon manifestation of specific symptoms such as feelings of sadness, loss of appetite and sleep disturbances (Oliffe et al., 2019). However, it is posited depression can manifest among men in ways that counter traditional presentations due to expression of their masculine norms (Oliffe et al., 2012; 2019). For example, depression may emerge due to adherence to masculine norms of stoicism and self-reliance which may lead to poor help-seeking and engagement with maladaptive, avoidance coping strategies such as alcohol and substance use or from unemployment loss due to inability to financially support their family (Cochran & Rabinowitz, 2003; Oliffe et al., 2012). Subsequently, current diagnostic criteria for depression may not be attuned to detecting such non-conventional manifestations of depressive symptomatology (Rutz et al., 1997). To accommodate and overcome issues associated with differing patterns of depressive symptomatology among men, there has been a call within the literature for male-sensitive suicide prevention interventions (Seidler et al., 2016). It is suggested that reframing help-seeking within a contemporary, strength-based context of masculinity (Seidler et al., 2016) and the development of male-sensitive suicide prevention interventions which foster a problem- and solution-focussed approach (Whittle et al., 2015) could improve accessibility to mental health services.

1.3.4. Self-Harm and Suicide Ideation

Self-harm is an act of deliberate self-injury or self-poisoning, with or without suicidal intent and/or motivation (Hawton et al., 2003a; NICE, 2022). Varying definitions of self-harm pervade the literature (e.g., deliberate self-harm, non-suicidal self-injury) with some definitions of describing self-harm as deliberate with suicide attempt and others without suicide intent (Duarte et al., 2020; Samari et al., 2020; Soomro et al., 2015). Estimated

rates of self-harm between men and women vary. Some studies report more women than men self-harm (e.g., Bresin & Schoenleber, 2015; Lutz, 2022); others report no difference between men and women (e.g., Klonsky, 2011; Victor et al., 2018); and Clements et al., (2019) report increasing rates of self-harm among men. Nevertheless, self-harm is widely considered the strongest predictor of suicide (Carr et al., 2017; Hawton et al., 2003b). For example, Owens et al., (2002) conducted a systematic review of 90 studies to determine rates of fatal and non-fatal repetition of self-harm, finding approximately 7% of people had died by suicide after 9 years (Owens et al., 2002).

Men are particularly at risk of death following repeated self-harm. Carroll et al.'s, (2017) systematic review and meta-analysis of 177 papers found 2.7% of men compared to 1.2% of women died 1 year following a self-harm incident. Indeed, men are more likely to die by suicide on their first attempt (Jordan & McNeil, 2020). One proposed explanation for increased risk of death following self-harm is the methods used by men which are often more violent and aligned to masculine norms of impulsive risky behaviours such as burning/branding, hitting and use of a firearm (e.g., Jordan & O'Neil, 2020; Kaplan et al., 2009; Sornberger et al., 2012; Victor et al., 2018). It has been shown that adherence to masculine norms underpin self-harm methods used by men as a function of coping and communicating their emotional distress, including suicide ideation (Everall et al., 2006; Green et al., 2018; Meissner & Bantjes, 2017; Tofthagen et al., 2022). For example, male norms of emotional suppression and increased suicidal distress and risk were identified in 92% of studies included in recent systematic review and meta-synthesis findings exploring risk and recovery factors of suicide among men (Bennett et al., 2023).

It could be speculated that emotional suppression by men who are experiencing suicidal thoughts and behaviours including self-harm may thwart help-seeking efforts. However, closer examination of hospital attendance figures for self-harm and suicide ideation reveal more men than women present at hospital emergency department's (ED) for suicide ideation than self-harm (Griffin et al., 2019). Moreover, men are more likely than women to refuse hospital admission and to leave ED's without having secured a care emergency plan (Griffin et al., 2020). Negative attitudes from health care staff towards individuals who self-

harm including hostility and frustration, and lack of sufficient knowledge and ability in the management of self-harm are reported (Marzano et al., 2015; McCarthy et al., 2023; Mughal et al., 2020; Raynor et al., 2019). Collectively, these findings illustrate the complex landscape of suicide risk, self-harm and suicide ideation among men and raise questions over understanding of help-seeking behaviour among men for suicidal thoughts and behaviour.

1.4. Help-Seeking Behaviour

In seeking to understand the gender paradox of increased suicide rates among males, researchers have turned their attention towards differences in help-seeking behaviour between men and women. Men are less likely than women to seek help across all health domains, both physical and mental health (MacKenzie et al., 2006; Matheson et al., 2014). Approximately double the number of women seeking help for every one of their male counterparts for health-related issues (Möller-Leimkühler, 2002; 2003). Avoidance of help-seeking behaviour among males extends to services for mental health also, particularly those experiencing suicidal ideation (Cleary et al., 2017; Harris et al., 2015; Luoma et al., 2002; Pearson et al., 2009; Schaffer et al., 2016).

In examining primary care contacts prior to suicide, Luoma et al., (2002) found that approximately three quarters of people consulted with their primary care giver in the year preceding their suicide. This rate decreased in the month preceding their suicide, with approximately half contacting their primary care giver in the month-preceding their suicide (Luoma et al., 2002). However, when gender comparisons in help-seeking rates were conducted, the findings revealed that approximately 36% women (range 32-39%) versus 18% of men (range 16% - 20%) sought help from primary care in the month preceding their suicide (Luoma et al., 2002). Contrastingly, Stanistreet et al., (2004) reported that 56% of men contacted their GP in the 3 months preceding their suicide or undetermined death, with this rate reducing to 38% in the month prior to their suicide or undetermined death, marginally higher than that reported by Luoma et al., (2002). Yet, to further complicate the

issue of help seeking behaviour among men, research has shown that men who do engage with primary care services report greater levels of distress before embarking upon seeking support, such as reinforced self-stigmatising beliefs (Biddle et al., 2004; O'Brien et al., 2005; Sagar-Ouriaghli et al., 2019; Wide et al., 2011). While for those men who do consult with service providers and disclose their suicidal ideation, appropriate service provision may be lacking, particularly those available and accessible within the community (Pearson et al., 2009; Saini et al, 2010; 2016; 2018).

The divergent, and sometimes conflicting, features within the pattern and nature of help-seeking behaviour among suicidal men highlights the challenges and complexities in creating timely and effective interventions for men during their suicidal crisis. One explanation for these contrasting findings in help-seeking behaviour relates to gendered roles undermine protective health behaviour that may pose men at increased suicide risk (Connell & Messerschmidt., 2005; Payne et al., 2008). Such "toxic practices" include risk taking behaviour, such as excessive alcohol consumption, drug use and violence (Armstrong et al., 2020; Courtenay, 2000).

1.4.1. Factors Affecting Suicide Prevention Service Access

Understanding factors which hinder and support help-seeking behaviour and access to mental health support when men are experiencing suicidal thoughts and behaviours is important, and could inform development of tailored interventions to promote engagement with suicide prevention services (Affleck et al., 2018). Barriers for men accessing services for mental health difficulties, including suicidal crisis, can be broadly categorised as attitudinal and structural/systemic (Rice et al., 2020; Seidler et al., 2020).

Attitudinal barriers associated with a lack of engagement with mental health services are underpinned by stigma towards mental health difficulties (Manescu et al., 2020). For men experiencing mental health difficulties, including suicidal distress, this manifests at the attitudinal level as a perceived sense of self-reliance and stoicism, and reluctance to express their emotional vulnerabilities (Moller-Leimkuhler, 2003; Noone & Stephens, 2008;

Struszczyk et al., 2019). For example, River (2018) found that men were deterred from seeking support from services framing their suicidal distress as mental illness. On the other hand, factors affecting access to treatment such as availability of services, constitute structural barriers to mental health access (Green et al., 2020).

Seidler et al., (2020a) found that two thirds of men endorsed the attitudinal barrier statements of “I need to solve my own problems” and “it’s hard for me to admit I need professional help”, and men who endorsed “I need to solve my own problems” were twice as likely to not want treatment (Seidler et al., 2020a). Further, the authors suggested endorsement of ‘I would not know how to find a psychotherapist (counsellor)”, particularly among men wanting to engage in treatment who had high distress scores, could thwart efforts to seek appropriate support due to a perceived accessibility of mental health service provision for men (Seidler et al., 2020a). These findings align with the supposition that dominant masculine norms of stoicism, self-reliance, reluctance to disclose mood-related symptoms, and denial of mental health difficulties are reported to hinder men from seeking mental health support (Courtenay, 2000; Emslie et al.,2006; Galdas et al., 2005; Rice et al., 2020).

While less research has examined the facilitators of access to mental health services by men for mental health problems including suicidal thoughts and behaviours, several factors have been identified which could be harnessed to promote engagement with services. These include improving mental health literacy around when, how and where to seek help for mental health, avoiding stereotypical representations of depressed men and pathologising suicidal thoughts and feelings, promoting pro-active coping approaches with intervention content which focuses upon problem-solving, and normalising mental health by positive reframing of attitudes and beliefs towards symptoms and treatment (Fogarty et al., 2015; Johnson et al., 2012; River, 2018; Sagar-Ouriaghli et al., 2019; Seidler et al., 2020b). Essentially, these facilitators centre around normalising mental health problems and the engagement with services that offer provision which is sensitive and tailored towards the needs of men (Seidler et al., 2018; 2020).

1.4.2. Interventions for Men Experiencing Suicidal Crisis

Attempts to harness the facilitators of access to mental health service provision and to address the many risk factors for men experiencing suicidal crisis have led for calls for multimodal suicide prevention approaches (O'Connor et al., 2023). Such approaches involve improving accessibility to community-based co-produced interventions that have been co-designed by those men they target support towards, strive to reduce mental health stigma and redress structural issues (e.g., addiction and debt), through person-centred, non-medically framed care (Bennett et al., 2023; River, 2018; Galdas et al., 2023; O'Connor et al., 2023). Core to these approaches is that they create a gender-sensitive environment in which men can articulate their suicidal distress and receive compassionate care from professionals who understand the male experience of suicidal crisis (Bennett et al., 2023).

An example of this type of gender-sensitive suicide prevention intervention for men includes the MATES in construction program (Doran et al., 2021). MATES is a workplace suicide prevention intervention based in Australia which aims to prevent suicide among workers in the construction industry (Doran et al., 2021). It fosters a multi-modal approach to suicide prevention and involves several components including delivery of suicide prevention by peers (e.g., safety planning, assessment of additional support that may be required), site-based activities increasing awareness of suicide, non-clinical case management connecting workers to support services, and a 24-hour support line for workers and their families (Doran et al., 2021). This targeted approach to suicide prevention among men working in construction aims to improve mental health and suicide literacy, social support and help-seeking intentions, and reduce stigma within a non-clinical environment to reduce suicidal distress and promote resilience and psychological wellbeing (Gullestrup et al., 2023). Indeed, this model of suicide prevention is effective in supporting construction workers to overcome traditional male-dominant ideals barriers and attitudes to help-seeking (Ross et al., 2019).

An example of a suicide prevention intervention delivered here in the UK is Offload (Wilcock & Smith, 2019; Wilcock et al. 2021). Embracing Rugby as a theme to engage men in a

mental health awareness programme, Offload aims to support men aged 16 years or older experiencing mental health problems (i.e., anxiety and depression), who are socially isolated, and at risk of suicide (Wilcock & Smith, 2019; Wilcock et al., 2021). Linking with local Rugby clubs, Offload involves delivery of a 10-week programme by men with lived experience of mental health difficulties including anxiety, depression and/or suicide ideation, who are affiliated with Rugby (e.g., former Rugby player or coach) (Wilcock & Smith, 2019; Wilcock et al., 2021). Weekly sessions are delivered to men over two 40 minutes sessions to replicate a game of two halves and involved a mental fitness session, followed by activities linked to the topic of that week such as a quiz, a physical activity session, a meet-and-greet opportunity with a player (Wilcock et al., 2019). Topics covered over the duration of the intervention focused on several areas including resilience and wellbeing, coping strategies, stress and mood management, goal-setting and problem solving (Wilcock & Smith, 2019; Wilcock et al., 2021). Reported intervention outcomes include improved coping for mental health difficulties, improved social support and social and emotional connectedness with others, and increased willingness to discuss mental health problems (Wilcock & Smith, 2019). Using non-stigmatising language and delivering solution-focussed strategies within a community-based, non-clinical, trusted, and familiar setting was perceived by stakeholders involved its design to promote a safe-space in which men could share and discuss their mental health difficulties (Wilcock et al., 2021).

Intervention design features such as those underpinning MATES and Offload, have been highlighted as key components for successfully promoting men's engagement in suicide prevention interventions (e.g., Galdas et al., 2023; Oliffe et al., 2020). However, a lack of understanding surrounding the drivers attributable to suicide ideation becoming translated into suicide action has significantly hampered progress in suicide prevention (Klonsky & May, 2013). In attempt to further understanding in this area, several theories of suicide have been proposed.

1.5. Theories of Suicide

While research has revealed several risk factors associated with increased suicide risk such as those highlighted above, less remains known about how these diverse factors (e.g., psychological, biological, environmental) may culminate to engender suicide ideation, to progress onto suicide-related action (e.g., plans and attempts) (Diaz-Olivian et al., 2021; O'Connor & Portzy, 2018;). To advance understanding of how and why suicide may occur, several theoretical models have been proposed including the stress-diathesis model of suicide behaviour (Mann et al., 1999); the three-step theory of suicide (Klonsky et al., 2015); the reinforcement model of suicidality (Hennings, 2020); the Integrated Motivational-Volitional model (O'Connor, 2011; O'Connor & Kirtley, 2018); the collaborative assessment and management of suicidality (CAMS) (Jobes, 2012) and the Interpersonal Personal Theory (Joiner, 2005; Van Orden et al., 2010). Each emphasise the interaction of diverse risk factors during the stages of suicide development from suicide ideation and the translation of this into suicide behaviour (Diaz-Olivian et al., 2021).

For the purpose of this literature review, the Integrated theory of suicide (O'Connor, 2011; O'Connor & Kirtley, 2018), the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) and the collaborative assessment and management of suicidality (Jobes, 2012) will be discussed as they bear most relevance to the James' Place Model (Boland & Milford-Haven, 2018) and clinical practice.

1.5.1. The Integrated Motivational-Volitional Theory of Suicide

The integrated motivational-volitional (IMV) theory of suicide is a three-factor diathesis-stress model (O'Connor, 2011; O'Connor & Kirtley, 2018). Synthesising understanding of suicide from health psychology, psychopathology, and suicide research, the IMV is comprised of three distinct phases in which suicide occurs within an ideation-to-action framework (O'Connor & Kirtley, 2018). The first of these phases is the pre-motivational phase which encompasses the biopsychological- and vulnerability-risk factors, and

negative life events attributable to the development of suicidal ideation and intent (O'Connor & Kirtley, 2018).

The motivational phase describes the emergence of suicide ideation which is underpinned by feelings of defeat and/or humiliation, and entrapment (O'Connor & Kirtley, 2018). During this second phase, the presence of feelings of defeat, and humiliation initiate the motivational phase (O'Connor & Kirtley, 2018). However, whether these develop into a sense of entrapment is dependent on whether additional factors called threats to self-moderators (e.g., rumination and problem solving) amplify or diminish the magnitude of defeat (O'Connor & Kirtley, 2018). In the final step of motivational phase, entrapment is translated into suicide ideation (O'Connor & Kirtley, 2018). This is facilitated by motivational moderators (e.g., social support, thwarted belonginess) which either exasperate or attenuate the entrapment-suicide ideation relationship (O'Connor & Kirtley, 2018). Lastly, the final phase of the IMV is the volitional phase (O'Connor & Kirtley, 2018). Here, it posited that volitional factors (e.g., access to means, impulsivity, acquired capability, exposure to suicide) must be present to facilitate the translation of suicide ideation/intent to translate into suicide behaviours (O'Connor & Kirtley, 2018).

Various components of the IMV have been empirically assessed. For example, Owen et al., (2018) examined whether defeat and entrapment underpinned suicide ideation development among people experiencing bipolar disorder and found that defeat and entrapment significantly predicted suicide ideation at 4-month follow-up. Branley-Bell et al., (2019) evaluated whether IMV volitional factors predicted the emergence of suicide attempt by comparing individuals with a history of suicide ideation, suicide attempt and controls. Individuals with suicide attempt history significantly differed from those with suicide ideation history on volitional factors, reporting greater capability for suicide, exposure to suicide and/or self-harm via family or friends, and impulsivity (Branley-Bell et al., 2019). However, comparable motivational factor scores were reported across both groups (Branley-Bell et al., 2019). Forkmann and Teismann (2017) tested the utility of entrapment of perceived burdensomeness, thwarted belonginess of predicting suicide ideation within the context of the IMV. While entrapment and perceived burdensomeness predicted suicide ideation, no

moderation effects were found for perceived burdensomeness and thwarted belonginess on the entrapment-suicide ideation relationship proposed within the IMV (Forkmann and Teismann, 2017).

1.5.2. Interpersonal Theory of Suicide

Interpersonal theory of suicide (IPT) proposes that simultaneous interaction of thwarted belongingness, perceived burdensomeness, the desire to die by suicide and the capability for suicide, results in suicide attempt or suicide (Joiner, 2005; 2009). Both thwarted belonginess and perceived burdensomeness are conceptualised as two requisite cognitive-affective states for suicide ideation to emerge (Joiner, 2005; VanOrden et al., 2010). The former refers to perceptions of absence of, and disconnection from, meaningful and reciprocal and caring interpersonal relationships (e.g., family, friends) which gives rise to feelings of not belonging (i.e., "I do not belong") (VanOrden et al., 2010; 2012). On the other hand, perceived burdensomeness relates to perceptions of burdensomeness unto significant others such as family and friends (i.e., "they would be better off without me") (Van Orden et al., 2010; 2012). Having these interpersonal needs unmet in isolation may engender transient feelings of suicide (Forkmann et al., 2020).

Although conceptualised as distinct constructs, according to IPT it is only if both thwarted belongingness and perceived burdensomeness occur together that the desire to die by suicide (e.g., I am better off dead) is produced (Forkmann et al., 2020; Van Orden et al., 2010; 2012). As the third antecedent of suicide in IPT, desire to die by suicide is conceptualised to be driven by a stable and enduring feeling of hopelessness engendered by the belief that their feelings of thwarted belongingness and perceived burdensomeness will not be improved (Van Orden et al., 2010; 2012).

Translation of suicide ideation into suicide action (non-lethal attempts and lethal suicide) is theorised to require capability of suicide (Van Orden 2010; 2012). Capability of suicide refers to the antagonistic effects of diminished fear of death and increased tolerance of physical pain and is theorised to activate suicide ideation to suicide behaviours (Van Orden

et al., 2010; 2012). IPT posits that desire to die by suicide alone is insufficient for suicide to occur (Van Orden et al., 2010). Rather, an individual must possess suicide intent occurring from fearlessness of death (Joiner, 2005; Orden et al., 2010). Translation of suicide intent into suicide actions associated with near-lethal and lethal suicide commands increased pain tolerance in order overcome the innate instinct to avoid painful threats to life such as those associated with suicide-related behaviours (Joiner, 2005; Van Orden et al., 2010). Subsequently, increased physical pain tolerance moderates the causal pathway between thwarted belongingness, perceived burdensomeness, and capability of suicide (Van Orden et al., 2010). Desensitisation towards pain and fear associated with suicide is posited to develop from repeated exposure to painful and fearful experiences during life which heightens an individual's pain threshold and diminishes their fear of death by suicide such that they can envisage, plan and engage in suicide actions (non-lethal and lethal suicide) (Joiner, 2005; Van Orden et al., 2010; 2012).

IPT has been widely applied in suicide research across different research domains and populations including college students (Becker et al., 2020), adolescents (Barzilay et al., 2015), autistic adults (Moseley et al., 2022), chronic pain (Wilson et al., 2013), prisoners (Mandracchia et al., 2015) and community-based populations (Christensen et al., 2013). Meta-analytic findings support the utility of the IPT in accounting for how suicide thoughts and behaviours arise (Chu et al., 2017). For example, IPT accounted for modest, significant interactional effects between thwarted belongingness and perceived burdensomeness on suicide ideation, and thwarted belongingness, perceived burdensomeness, and capability for suicide on increased past suicide attempts (Chu et al., 2017). However, the univariate and interactional effects of thwarted belongingness, perceived burdensomeness and capability for suicide were found to not exceed prediction of suicide beyond other risk factors (e.g., suicide attempt history and psychiatric conditions) (Chu et al., 2017). Subsequently, the authors conclude that further research is required to investigate the predictive utility of IPT beyond whom may die by suicide to predicting when death by suicide may occur (Chu et al., 2017).

1.5.3. Collaborative Assessment and Management of Suicidality

The collaborative assessment and management of suicidality (CAMS) was developed by Jobes in 2006 to remediate short-comings in the way suicide risk is assessed and managed suicidality within clinical settings, such as the lack of clinical assessment of suicidality and use of evidence-based interventions (Jobes, 2012). Within the CAMS approach, there is a shift away from a medicalised model of suicide that focuses upon the treatment of mental health problems (Jobes 2012). Rather, the power imbalance between a therapist and suicidal individual is redressed with emphasis placed upon a co-productive relationship between the therapist and individual experiencing suicidality to identify and problems (Jobes, 2012). Working together within a collaborative partnership the therapist and suicidal individual aim to understand, assess and treat risk factors and drivers contributing to an individual's suicidality (Jobes, 2012). Subsequently, CAMS is problem-focussed as the therapist and individual experiencing suicidality work together to address the latter's suicidal risk (Jobes, 2006; 2012).

The CAMS approach is comprised of a semi-structured therapeutic framework which the therapist uses to guide their clinical practice when working in conjunction within the suicidal individual (Jobes, 2006; 2012). The Suicide Status Form tool is a key component of the CAMS approach and is used to assess and monitor suicidal risk, outcomes, and to plan and develop treatment approaches co-productively with the suicidal individual both qualitatively and quantitatively (Jobes et al., 2012). This tool is completed collaboratively by the therapist and suicidal individual to identify direct psychological factors (e.g., hopelessness, psychological pain) and indirect factors (e.g., relationship problems, unemployment) relating to their suicidal crisis (Jobes et al., 2012). Therapeutic intervention involves the therapist and individual interpreting identified direct- and indirect suicide drivers within the context of the CAMS framework to target and reduce suicidal thoughts and behaviours (Jobes et al., 2006; 2012). The intervention is ended once three successive sessions have occurred in succession were suicidal thoughts, feelings and behaviours have been eliminated (Jobes, 2012).

Since its inception, the CAMS intervention has attracted significant attention and recent research evidence from several randomised controlled trials support its efficacy (e.g., Comtois et al., 2023; Ellis et al., 2015; Jobes et al., 2017; Pistorello et al., 2021). Ryberg et al., (2019) tested whether CAMS was more effective than treatment as usual (TAU) under randomised controlled conditions within a standard mental health setting. Seventy-eight participants in total took part in the study with 41 participants randomised to TAU group and 37 participants to the CAMS treatment group. Ryberg et al., (2019) reported less suicide ideation at six months among participants within the CAMS group compared to the TAU group. Also, greater improvement in mental health distress was reported among the CAMS group than the TAU group at 6- and 12-month follow-up. However, at 12-month follow-up, there was no longer any significant difference between the CAMS and TAU groups (Ryberg et al., 2019).

Meta-analysis findings on the other hand garner ambiguous support for CAMS. For example, Hanratty et al., (2019) reported a lack of support for the efficacy of CAMS in reducing suicidal ideation and self-harm in their systematic review. While Swift et al., (2021) meta-analysis findings comparing CAMS intervention against alternative suicide prevention interventions support the efficacy of CAMS. They reported CAMS significantly decreased suicide ideation, general distress, hopelessness and significantly increased treatment acceptability and hope (Swift et al., 2021). No significant differences between CAMS and alternative forms of intervention were found for suicide attempt, self-harm, other factors associated with suicide (e.g., self-esteem, resilience) or cost-effectiveness (Swift et al., 2021). However, the authors concede the magnitude of effect size for veterans and men participants were significantly reduced (Swift et al., 2021).

1.5.4. Summary of Suicide Models

Each of the models described have independently informed a wealth of research in understanding how suicide ideation emerges and transfers into suicide behaviour. Utility of these models is that they provide a theoretical lens through which to understand the

individual experience of suicide, and how suicidal thoughts and feelings develop into suicide intent and then transfer from ideation to behaviour. However, no single model of suicidal adequately and entirely explains why someone chooses to die by suicide. Arguably, the biological, environmental, and psychosocial risk factors associated with suicide are so vast and all-encompassing that it is implausible to surmise that a single model of suicide could adequately address each potential direct- and indirect driver of suicide, their interaction and the pathways which result in thoughts and feelings of suicide resulting in suicide behaviours. Nevertheless, a hybrid of the three suicide prevention models considered above provide a robust framework to work within when developing a suicide prevention intervention as they facilitate:

1. Suicide risk assessment that considers suicide risk manifestation beyond typical clinical presentations

2. Problem/Solution- and person-focussed approaches in the development of suicide prevention including safety planning

3. Co-production of therapy suited to the individual and their priorities in the alleviation of suicidal distress.

4. Co-production of targeted therapeutic intervention to address individual factors contributing to suicidal crisis.

Indeed, these three theory-driven models of suicide were used to inform the James' Place Model (JPM) (Boland & Milford-Haven, 2018) which was developed for use by the James' Place Service to support men experiencing suicidal crisis. The rationale for creating a community-based service for men experiencing suicidal crisis was to promote accessibility to timely and effective suicide prevention. This is in recognition of the well-documented challenges men encounter when trying to access mental health services that suit their preferences and needs including accessible community-based contexts to support disclosure of suicidal thoughts, intervention delivery which is informed through co-production and tailored and person-centred to meet each individual man's needs and (Galdas et al., 2023; Oliffe et al., 2020).

In this thesis James' Place is described as a suicide prevention service for men experiencing suicidal crisis. However, it is important to emphasise that this is merely shorthand for readability purposes. James' Place is an inclusive service and welcomes any adult experiencing suicidal crisis who identifies as male irrespective of gender assigned at birth.

1.6. James' Place

1.6.1. Brief Background

James Place is a community-based, therapeutic centre that offers therapeutic suicide prevention intervention, called the JPM, to men experiencing suicidal crisis. The service was first envisaged by Clare Milford-Haven and Nick Wentworth-Stanley following the tragic loss of their son James to suicide in 2006. At the time of his death, James was away from home studying at university and sought help for suicidal thoughts he was experiencing. Sadly, James did not receive the support he needed and died a couple of days after presenting at A&E following referral from a walk-in centre. Reflecting upon James' help-seeking experience, James' parents felt that he needed to have been seen in a non-medical environment that could offer non-judgmental support at the point of access. This passion and drive inspired the creation of the James Milford-Stanley Memorial Fund established 18 months following the death of James. In June 2018, funded by the James' Milford-Stanley memorial fund including £650 000 raised by James' brother Harry and three friends who sailed the Atlantic in 39 days, 14 hours and 4 minutes., the James' Place flagship centre opened in Liverpool. An additional James' Place centre was opened in London in July 2021, with plans to open further sites across the UK in the very near future. The next James' Place Centre will open in Newcastle in December 2023.

1.6.2. Accessing James' Place

There are several different referral routes into James' Place service available to the men, including self-referral, referrals from primary care (GP), local emergency departments (ED) and Universities situated within Liverpool. The diverse referral pathways to gain access to support from James' Place is deliberate as it maximises the accessibility and reach of the service and is in recognition that help-seeking behaviour among men is often complex and presents challenges to the men (see above). Currently, men are typically assessed by a James' Place therapist within 48 hours of their referral. The nuanced community-based, therapeutic approach offered by the JPM ensures that men can be confident that they will be able to gain rapid access to clinical support that they require to overcome their suicidal crisis, without having to navigate the difficulties associated with conventional clinical care, such as long waiting times.

To access the James' Place service, servicer-users must be male or identify as male, be aged 18 years or older, experiencing suicidal crisis, be registered with a general practitioner (GP), able to access James' Place building and able to engage in therapy. Each potential service-user undergoes a welcome assessment with a suicide prevention therapist to ensure that they meet this eligibility criteria prior to receiving the JPM. During this assessment the therapist establishes the therapeutic needs of the men and evaluates their individual level of suicidality and assesses their needs. Men who do not meet the eligibility criteria are discharged back into the care of their original referrer where applicable or referred on to either more suitable services (e.g., Improving Access to Psychological Therapy services).

1.6.3. The James' Place Model

The principles of co-production have underpinned every aspect of James' Place, from inception to creation of the centre, and this principle extends to informing the James' Place therapeutic approach. Co-production refers to a process of user-citizens and professionals working collaboratively to improve public services (Bovaird et al., 2016; Boyle & Harris,

2006). An equitable collaborative space is created in a process of co-production as power differentials between citizen-users and professionals is removed as the former are no longer defined by the needs that brought them to the service, but by the expertise (e.g., experiences) they bring to the collaborative working relationship (Bovaird et al., 2016; Needham & Carr, 2009; Slay & Stephens, 2013). Resultantly, co-production promotes sharing of knowledge between user-citizens and professionals to improve services, including improved mental health outcomes, service accessibility and person-centred care due to their user-centred design focus (Ezyadi et al., 2023; Harcourt & Crepaz-Keay, 2022; Lwembe et al., 2017; Webb et al.. 2021).

In the spirit of "*nothing about us, without us*" advocated within co-production, James' Place implemented co-production by inviting a diverse range of stakeholders (e.g., researchers, commissioners, academics, people with lived experience of suicide including men) to consult the design and delivery of the service from its inception (Saini et al., 2019). For example, James' Place invited views of men who had previously experienced suicidal crisis to gain an understanding on aspects of service design they would have found beneficial. Findings revealed men's preferences for a safe, home-like therapeutic environment decorated in neutral, natural furnishings and outdoor space to receive therapy (Saini et al., 2019). James' Place implemented the suggestions and asked men to view the building once it had been completed to gain their feedback which revealed that they wished they had, had access to a community-based service such as James' Place when they had previously experienced suicidal crisis (Saini et al., 2019).

Co-production remains central to delivery of the JPM. Therapists and men work side by side in the co-production of therapy and development of suicide prevention strategies suited to their needs and priorities. The IMV model has been integrated into the lay your cards on the table (LYCT) component of the JPM as individual cards have been added to represent psychological variables and known suicide risk factors such as perceived burdensomeness (renamed as "I am a burden") and thwarted belonginess (renamed as "I do not belong"). Therapists work with individual men to redress these two key risk factors, hopelessness, and capability for suicide through various methods. For example, men are encouraged to

involve a supporter within their therapeutic journey, such as a significant other, and to involve them in their therapy sessions. This redresses loneliness and unmet needs associated with thwarted belonginess by facilitating reciprocal care, and social support. Therapists also challenge erroneous self-perceptions related to the feeling that they would be better off dead and improve their lives of their significant others if they were dead to mitigate perceived burdensomeness, feelings of hopelessness and capability of suicide using talk therapy, problem solving and solution-focussed techniques (e.g., cognitive behavioural based techniques, referral to debt management services for financial difficulties). Targeting perceived burdensomeness, thwarted belongingness and hopelessness aims to reduce feelings of suicidal desire and capability for suicide. Administration of LYCT facilitates tailoring of the JPM by supporting men's disclosure and identification of factors underpinning their crisis and promotes discussion around solution-focussed approaches to support men's recovery and prevent future relapse. Subsequently, the JPM embeds person-centred care within safety planning and suicide prevention strategies, such as that promoted in the suicide prevention strategy in England (DHSC, 2023).

Principally, the JPM is a talk therapy that integrates various person-centric therapeutic approaches, which aims to reduce suicidality and develop resilience and coping strategies. Strong emphasis is placed upon therapists working co-productively with each individual man to reduce their suicidal distress and to co-produce therapeutic approaches most suited to them which is consistent with both IPT of suicide and the CAMS models. Currently, men are offered a welcome assessment and nine therapy sessions delivered face-to-face. While these sessions are adapted to suit the needs and preferences of the men, sessions are typically structured in three phases, each comprised of three sessions each. The first three sessions typically occur within the first week following the man's welcome assessment, the following three sessions over the following 10 days and there is no specified timeframe for the final three sessions as these are scheduled in accordance with men's needs as shown in figure 1. Focus of the initial three sessions revolves around developing the therapeutic relationship with the man and managing suicidal risk to encourage engagement in the

therapy and to allow the therapist to identify the most appropriate time to deliver the intervention, and to safeguard the wellbeing and welfare of the man. A person-centred approach is adopted in the following three sessions and therapists may instigate a brief psychological intervention to redress negative beliefs and thinking if necessary, such as behavioural activation and sleep hygiene. Relapse prevention and detailed safety planning, while reflecting upon their experience and progress made during their therapeutic journey, comprise the core of the final three sessions. This allows men to recognise potential future suicidal crisis triggers and what strategies to implement to prevent relapse. These sessions may include reflecting upon the LYCT intervention (discussed below), alerting the men to potential early warning signs of relapse and/or discussing personalised strategies they have found effective and may deploy in the future to ward of relapse. The James' Place Model clinical journey is illustrated in figure 1 below.

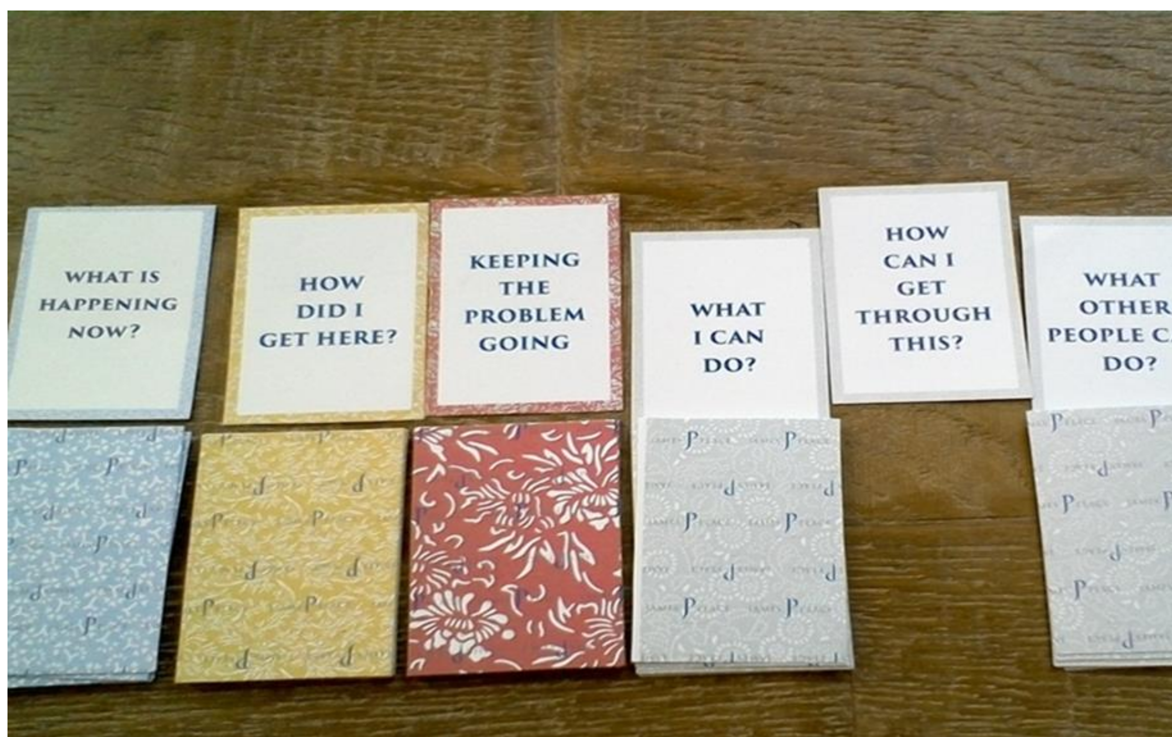
Figure 1: The James' Place Clinical Journey

Figure 1 Source: Saini et al., 2021b

The LYCT comprises a key therapeutic component of the JPM (Figure 2). LYCT is an innovative approach that that aesthetically resemble a pack of playing cards. Each card within the pack is inscribed with a word that describes an emotional state or feeling related to suicidal distress, such as "*I feel trapped*" and "*Guilt*". In addition, blank cards are available which the men can use to write down any words, emotional states, or feelings that they are

experiencing and that are specifically relevant to their own suicidal crisis experience. Typically, the LYCT component of the intervention is administered at three-time points; namely the initial session, a session during the intermediate phase and a session within the final three session. This tool has been found to be useful in promoting discussion between the therapist and man of thoughts and beliefs they may be experiencing. While efficacy of the LYCT have not been empirically tested, qualitative feedback and testimonies from both therapists and men who have utilised the LYCT support their utility for allowing men to articulate their suicidal distress (Hanlon et al., 2023; Saini et al., 2020). The rationale for the inclusion of LYCT as a component of the JPM is in recognition that some men find it difficult to engage in emotional discourse within a therapeutic setting (Moller-Leimkuhler, 2003; Rivers, 2018).

Photograph 1: Lay Your Cards on the Table



In addition to LYCT, the JPM (Boland & Milford-Haven, 2018) delivers a solution-driven intervention which integrates three theoretical models of suicide; namely 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 & Kirtley, 2018) (discussed above). Thematic to

each of these models is an emphasis upon working collaboratively with the suicidal individual to support them in identifying psychosocial factors that have contributed to their current suicidal crisis. Specifically, reducing suicidal distress, and resilience and coping strategy development underpins the JPM, and therapists offer diverse therapeutic approaches and interventions to achieve this goal, which is consistent with the CAM's model (discussed above). In this way, the James' Place therapeutic model reflects features of a crisis resolution model (Department of Health (DOH)~~,~~ 2012). However, a novel aspect of the James' Place therapeutic approach is that men, without serious mental health problems (e.g., severe depression, bipolar disorder, psychotic illness) as the underpinning causality of their suicidal crisis, are engaged during, throughout and until the end of their suicidal crisis. Co-production between the therapist and individual man to identify problems and to develop bespoke solution-focussed strategies, and tailored safety plans relative to each individual man's suicidal crisis is consistent with the CAM's model also. Additionally, in relation to the CAM's model, therapists are trained in suicide prevention and are clinically equipped to assess and identify psychological and indirect drivers of suicide.

Similarly, the IMV model of suicide has been integrated into the JPM as therapists assess pre-motivational, motivational, and volitional factors. These factors are explored during the clinical assessment, talk therapy and via the LYCT component of the JPM. Therapists work with men to assess biopsychosocial and vulnerability risk factors, pertinent self-moderators (e.g., rumination) and motivational moderators (e.g., social support), as well as volitional factors (e.g., past exposure to suicide) which may be underpinning elevated feelings of defeat and/or humiliation, and entrapment. For example, this collaborative working approach between the therapist and man may involve delivery of LYCT which have informed individual card variables and/or assessment of precipitating and psychological factors through a clinical assessment conducting by the therapists. Therapists will actively encourage men to remove medication from the home and work with men in the development of a safety plan and active coping strategies to further mitigate volitional factors such as access to means and impulsivity. Furthermore, the service assesses entrapment scores as an outcome in recognition of the key role it plays in suicide.

Please see Chapter 4 for further description of the JPM and the role co-production has had in the design, development, and implementation of the JPM.

1.7. Conclusion

Evidence supports the effectiveness of psychosocial interventions in reducing suicidal thoughts and behaviours (Zortea et al., 2020). Interventions that have been shown to be particularly promising in reducing immediate and future suicidal risk are those interventions that combine three key factors of clinical assessment, tailored crisis response and safety planning, and follow-up contact (Zortea et al., 2020). However, little remains known about the factors that contribute and sustain recovery from suicidal thoughts and behaviours (Zortea et al., 2020).

1.8. Thesis Structure

Research is emerging that shows community-based, therapeutic suicide prevention interventions for men are preferred over services accessible through pathways (e.g., General practice, hospital). Yet to date, there is little evidence examining the acceptability, feasibility and impact of support provided by suicide prevention interventions delivered within community-settings for men experiencing suicidal crisis. Therefore, a mixed methods approach will be used to achieve the aims of this thesis. This allows exploration of the role of co-production, and how this shapes delivery and implementation of a community-based suicide prevention intervention; the perceived acceptability and engagement with the James' Place model from the perspective of qualified therapists trained to deliver the James' Place model; and to understand the therapeutic impact upon suicidal risk the JPM has upon men experiencing suicidal crisis. In doing so, the research findings will provide an evidence-based framework that can inform the development and the future scaling up of the James' Place service.

Therefore, this thesis will seek to:

1. Evaluate the role of co-production in community-based suicide prevention approaches.
2. Describe the JPM.
3. Identify risk factors predictive of suicidal distress among men receiving the JPM.
4. Evaluate the perceived short- and long-term effectiveness of the JPM.
5. Explore the perceived acceptability and fidelity of delivery of the JPM from the perspective of James' Place therapists.

This PhD is constructed in a manner such that individual studies have been prepared for publication in peer-reviewed journals. This format is appropriate since the thesis author has focussed upon submitting papers for consideration for publication once each study had been completed. This was considered an important goal by the author and supervisors to maximise outputs and for the wider dissemination of the evidence produced throughout the duration of this PhD. To date, four papers have been published: *"Evaluating the role and effectiveness of co-produced community-based mental health interventions that aim to reduce suicide among adults: A systematic review",* has been published in Health Expectations: An International Journal of Public Participation in Health Care and Health Policy (chapter 3); "*James' Place Model: Application of a novel clinical, community-based intervention for the prevention of suicide among men*", has been published in the Journal of Public Mental Health (chapter 4); P*sychological risk factors predictive of suicidal distress in men receiving a community-based brief psychological intervention"* examines the utility of the LYCT component of the JPM in predicting psychological distress and has been published in Suicide and Life-threatening Behaviour and Health (Chapter 5); and lastly, "*A mixed methods evaluation of the acceptability and fidelity of the James' Place Model for men experiencing suicidal crisis"* has been published in Health Psychology and Behavioural Medicine (chapter 7). Lastly, *"A mixed methods longitudinal case study exploring the effectiveness of a community-based, brief psychological intervention among men experiencing suicidal crisis"* examines and the short- and long-term effects of the JPM, and

the acceptability of conducting research with men who have experienced suicidal crisis and has been submitted and is under review at PloS One Mental Health (chapter 6).

Eight chapters are provided in this PhD thesis. Chapter 1 describes suicide incidence, with a particular focus upon men, suicide prevention and James' Place to contextual the studies within this PhD. A methodology chapter in Chapter 2 discusses the methodological approaches used within this study and why these approaches were chosen. A systematic review of the literature comprises Chapter 3, which evaluates the role of co-production in community-based suicide prevention interventions. A public health case study of the JPM, structured in a way which follows the guidance of the publishing journal, further describes key components of the JPM and its impact upon men accessing the service in Chapter 4. The predictive utility of the LYCT in predicting suicide related outcomes is examined in chapter 5. Chapter 6 reports a mixed methods longitudinal case study which explores the perceived short- and long-term efficacy of the JPM. The final study explores the perceived acceptability and fidelity of the JPM by therapists trained to deliver the model using a mixed methods approach in Chapter 7. Lastly, this thesis culminates in a discussion chapter (Chapter 8) which summarises key findings, strengths, and limitations of the body of research produced, and implications and recommendations for future research and practice in relation to community-based suicide prevention interventions for men.

Chapter 2: Methodology

This chapter outlines the research design and methodological decisions made for each study comprising this PhD. Epistemological and ontological positions that inform generation of knowledge are described, providing a backdrop of the philosophical debates surrounding methodological approaches taken in research. Consideration is given to patient and public involvement (PPI) in the inception, design, and development of the James' Place service and how this focus on co-production was used in the development of research materials for studies comprising this PhD. Also, the unavoidable impact the COVID-19 pandemic has had upon the planned studies of this PhD is outlined. The methods of data collection and analysis, and the reasons underpinning the decision to use the methodological approach relating to each individual study are discussed. Reflective thoughts interjected throughout this chapter frame the decisions made. Lastly, ethical considerations are examined.

2.1. Mixed Methods Research

The overarching aim of this thesis is to evaluate the feasibility and effectiveness of the James' Place brief psychological therapeutic model among men experiencing suicidal crisis. This research aim has been developed upon the basis of growing research evidence supporting the implementation of community-based, therapeutic suicide prevention approaches for men experiencing suicidal crisis. A convergent parallel mixed methods design was used broadly in this thesis allowing for the collection of both quantitative and qualitative data to occur at the same (Cresswell & Plano Clark, 2011). Accordingly, priority to both types of data (quantitative and qualitative data) are equal, and quantitative and qualitative data are analysed independently (Cresswell & Plano Clark, 2011). Within the present thesis, the quantitative and qualitative results were analysed independently within the context of the specific study, and then merged and interpretated collectively. In this sense, both forms of data are complementary (Greene et al., 1989) in providing an understanding of the effectiveness and feasibility of James' Place service.

2.1.1. Mixed Methods for Suicide Research

Paradigm debates since the 1970's have placed quantitative and qualitative methodological approaches in opposition (Tashakkori & Teddlie, 2003). This discordance stems from differences in ontological, and relatedly, epistemological positions. Ontology is defined as "*the study of being*" (Crotty, 1998 p.10). This philosophical assumption is underpinned by our beliefs about the structure and nature of reality (Kivunja & Kuyini, 2017; Scotland 2012; Slevitch, 2011), the classification and properties of different entities that exist and how these interact (Guba & Lincoln, 1989). On the other hand, epistemology is defined as "*a way of understanding and explaining how I know what I know"* (Crotty, 1998, p.3). It refers to the nature and scope of knowledge, and how it can be communicated (Kivunja & Kuyini, 2017; Scotland, 2012; Slevitch, 2011). Each paradigm is underpinned by specific assumptions relating to the ontological and epistemological stance of that paradigm (Scotland, 2012). These differing views of reality (i.e., "*what is*") and knowledge creation (i.e., *"what it means*

to know") determine methodology and methods associated with each paradigm (Scotland, 2012 p.9). As a result, methodologies (i.e., strategy and methods) taken by researchers when gathering and interpreting data are dictated by their philosophical position and its inherently associated ontological and epistemological principles (Kivunja & Kuyini, 2017; Slevitch, 2011).

Two paradigms that have dominated the paradigm debate relate to quantitative and qualitative approaches. Quantitative approaches have been philosophically positioned as the gold standard research approach and are derived from a positivist paradigm (Scotland, 2012). Positivism assumes an ontological and epistemological position of realism and objectivism respectively (Sale et al., 2002; Scotland, 2012). According to realism, entities exist independently and out of the human consciousness (Crotty, 1998; Johnson & Onwuegbuzie, 2004). Objectivism posits one true objective reality exists and that the researcher and entities under investigation are independent of each other (Guba & Lincoln, 1994; Sale et al., 2002). This perspective means that quantitative research methodology is concerned with hypothesis testing and uncovering cause-effect relationships that are predictive and generalisable (Guba & Lincoln, 1994; Sale et al., 2002; Scotland, 2012). Steps are taken to ensure the methods used when measuring and analysing results maintain objectivity that is free of value and biases to preserve the validity of the research results (Slevitch, 2011). Methods used ensure confounders are controlled and involve objective measurement using closed questionnaires, randomisation, and blinding, as well as statistical analyses (e.g., inferential statics and descriptive analyses) and large sample size (Guba & Lincoln, 1994; Sale et al., 2002; Scotland, 2012).

On the other hand, qualitative research is underpinned by a constructivist (also called interpretivist) paradigm which is ontologically and epistemologically informed by relativism and subjectivism respectively (Scotland, 2012). Relativism posits that multiple realities exist since they are subjectively informed and individually created; thus, varying from one person to the next (Sale et al., 2002; Scotland, 2012). Consequently, existence of one single true objective reality is impossible as it cannot be separated from the influence of how the researcher composes their reality (Maarouf, 2019; Scotland, 2012). This means to research

findings are inextricably linked to an individual's social world including aspects such as their culture, values, and the social context (Bishop, 2015; Crotty, 1998). Research findings are developed and understood through interaction between the researcher, what it is being researched and the subjective interpretations of both the researcher and participants of how an individual views and experiences the world (Bishop, 2015; Guba & Lincoln, 1994; Scotland, 2012). Methodologies of qualitative research seek to elicit the subjective meanings, understanding and perspectives of participants (Scotland, 2012). However, it is acknowledged that interpretations of the research findings are not unbiased or value free (Scotland, 2012; Slevitch, 2011). This is because they are influenced and described from the position of the researchers' values as they strive to construe meaning from participants interpretations which have been informed by their own values too (Scotland, 2012; Slevitch, 2011).

Both quantitative and qualitative approaches each have their merits and disadvantages. Quantitative methods can facilitate hypotheses testing, determination relationships (e.g., cause-effect), and efficient data collection from larger samples of participants to generate objective, outcome data more generalisable to the wider populations (Steckler et al., 1992; Queirós et al., 2017). Also, standardised data collection methods add reliability and validity to objective data collected (Verhoef & Casebeer, 1997). However, the deductive nature of quantitative methods of data collection reduces phenomenon to numerical values which requires researchers to be proficient in conducting and interpreting the results of statistical analyses to decipher meaning and neglects subjective and emotional characteristics of phenomena (Queirós et al., 2017; Verhoef & Casebeer, 1997).

In contrast, qualitative methods allow for data collection enriched with subjective views of participants (Steckler et al., 1992). Smaller, purposeful samples are preferred to facilitate the collection of participant data enriched by their experiences and perspective and methods include open-ended interviews, focus groups and observations (Johnson & Onwuegbuzie, 2004; Scotland, 2012). The notion of generalisability is also dismissed in favour of transferability of research findings (Slevitch, 2011) which is the degree a reader can determine whether the findings and outcomes can be applied in other contexts as

specified within the research (Korstjens & Moser, 2018). However, the subjective nature of qualitative research risks introducing researcher bias into data collection methods (e.g., interviews) and analyses which is a more time-consuming process, and findings are not generalisable to the wider population (Queirós et al., 2017).

In recognition of the relative advantages and disadvantages of quantitative and qualitative approaches, mixed methods research (MMR) emerged which integrates both quantitative and qualitative approaches. MMR strives to monopolise upon the relative strengths of both quantitative and qualitative approaches, while mitigating the weaknesses of each (Dattilio et al., 2010; Johnson & Onwuegbuzie, 2004). For example, MMR facilitates collection of qualitative and quantitative data that is enriched with both subjective perspectives of multiple realities and objective, standardised and generalisable insights respectively (Regnault et al., 2018).

Fostering an MMR approach, the present thesis aimed to exploit the benefits of both quantitative and qualitative research methods research. This was done quantitatively by distributing a survey among men who received the James' Place Model (JPM) and following them up for a period of 12-months from baseline (i.e., initial assessment) a view to gain a large volume data reflective of the effectiveness of the JPM in reducing psychological distress and sustaining changes over time. Also, retrospective assessment of service data is a common approach used in healthcare, including mental health. Often referred to as a chart/medical review, these studies can be either descriptive or analytical in nature (Talari & Goyal, 2020; Vasser & Holzmann, 2013). Utilising retrospective data in research offers the advantages of being cost-effective, allows for the study of rare events such as suicide and generation of future prospective studies (Hess, 2004; Talari & Goyal, 2020}. However, as this method relies on the data management skills of third parties outside of the researchers control, the quality of data collated using this approach can be limited by missing data, researcher difficulties in understanding and interpreting the data recording system used by an organisation (e.g., due to jargon or acronyms unknown to the researcher) due to inadequate training in data extraction and coding (Hess, 2004; Vassar

& Holzmann, 2013). In relation to the present thesis, this quantitative approach facilitates data

Arguably, additional benefits specifically relating to this thesis include that collection of retrospective data allowed for the thesis studies to proceed at a time during covid and when due to Government restrictions the researcher was not permitted to attend the service. Conversely, semi-structured interviews exploited the benefit of qualitative methods in gaining subjective views pertaining to the experiences of men receiving the JPM and their perceptions of the acceptability and effectiveness of the model as well as those of JPM therapists in relation to the accessibility and acceptability of the JPM.

It has been argued that MMR undermines the respective philosophical assumptions of each method, such that quantitative methods assume one single reality whereas qualitative methods propose multiple realities are possible. However, proponents propose MMR is an approach of *what works* involving integration of both methods to better address the research question and objectives is favoured (Bishop, 2015; Johnson & Onwuegbuzie, 2004; Regnault et al., 2018). In this sense, MMR reflects a pragmatist philosophical framework (Regnault et al., 2018) whereby the research question determines the methods used as opposed to the reverse (i.e., prioritisation of the research method) (Bishop, 2015). Subsequently, research activities are orientated towards answering the research question(s) (Johnson & Onwuegubuzie, 2004) rather than producing knowledge that either confirms or refutes reality (Bishop, 2015).

Suicide based research is proliferated by quantitative methods (Kral et al., 2012). However, even the best predictive models used in quantitative research leave "residual variance" (i.e., variance unexplained by their models) and limiting suicide research to quantitative approaches has meant subjective experiences of suicide are lacking (Krai et al., 2012). In addition, prioritising quantitative research methods in suicide research has arguably contributed to several research gaps within the field of suicide research. These include uncertainty concerning the generalisability, effectiveness and scalability of suicide

prevention interventions remain due to insufficiently powered studies due to small sample sizes in randomised controlled trials (O'Connor & Portzy, 2018).

De Leo (2002) argues that the multi-faceted nature and rare occurrence of suicide means that assessing the effectiveness of suicide prevention interventions poses a particular challenge when trying to detect their effectiveness. Preponderance with suicide outcomes such as risk and symptoms that has dominated research within the field has exasperated this problem and is inherently insular given the complexity of suicide, as it neglects understanding of *how* and *what* makes suicide prevention interventions work (Kral et al., 2012). This limitation of suicide research could be redressed by complementing quantitative methods with qualitative methods to gain a subjective understanding of suicidality and could also further advance the field of suicide research theoretically and methodologically (Kral et al., 2012). Fostering an MMR approach will enable researchers to utilise methods that facilitate comprehensive investigation of the complexities of suicide such that qualitative methods will provide valuable subjective insights (e.g., influence of culture, emotions) and quantitative will add generalisability of research findings (Kral et al., 2012).

2.2. Rationale for a Mixed Methods Approach

A pragmatist approach, whereby one method is neither preferred nor used in favour of another, has been fostered for this PhD thesis. Accordingly, a mixed method design has been used in the present thesis which has been guided by the research questions and aims of the individual studies to ascertain relevant outcomes specifically related to these (Bishop, 2015; Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2010).

The rationale for using MMR in this thesis aligns primarily with the assertion that this approach provides the flexibility to investigate a research question from different perspectives (Regnault et al., 2018). Specifically in the context of suicide-related research, using qualitative and quantitative methods in combination delivers more in-depth insights from both a subjective and objective perspective (Kral et al., 2012). Subsequently, the use of MMR caters for the complexities of suicide as phenomenon, allowing the researcher to

glean invaluable insights into men's experience of suicidal crisis and the James' Place Model (JPM) from both a service-user and James' Place therapist perspective. In this sense, the MMR approach taken in this thesis seeks philosophical and practical *"complementarity"* (Sale et al., 2002 p.8).

Secondly, taking a pragmatist approach in using MMR in this thesis has afforded me the flexibility as a researcher to respond and adapt to accommodate unplanned and unprecedented events such as small sample sizes and the COVID-19 pandemic while ensuring the programme of research is completed within the time constraints of the PhD. For example, as previously discussed, suicide-related research is often compromised due to small samples (Kral et al., 2012). James' Place is a relatively new suicide prevention service specifically designated to men and those identifying as males who are experiencing suicidal crisis. Research has shown that significantly more females (83.3%) than males participate in health research (Maher et al., 2014). I was therefore aware that ascertaining an adequate sample for the quantitative elements of this PhD would be difficult. It was pre-arranged that I would embed myself at James' Place and approach men individually to invite them to complete a questionnaire for the quantitative element of this PhD; and invite them to take part in an interview in a future study. While acknowledging I am not a participant in the research, it was hoped that my being present and a familiar face within the service would initiate conversations with the men and enhance recruitment.

The qualitative and quantitative studies comprising this thesis follow a complementarity MMR rationale in that the different methods were used to examine different elements of the same phenomenon (Greene et al., 1989); namely the role of the JPM in men experiencing suicidal crisis and the following research questions:

1. What is the role of co-production within community-based interventions that aim to prevent suicide?

2. What are the perceived facilitators and barriers to widely implementing the JPM as a community-based suicide reduction crisis intervention?

3. Is the JPM effective in reducing suicide ideation among men experiencing crisis and long-term post-crisis?

The methods used are further elaborated upon in the integration of findings section below and in the methods section of each individual study described later in this section.

Reflective Note

I welcome the opportunity to use MMR in this PhD for several reasons. I was keen to gain a comprehensive understanding of the factors influencing the effectiveness and acceptability of the James' Place service / model from both the therapist and service-user perspectives. Guided by the objectives of this thesis MMR has allowed for a breadth and depth in understanding of the James' Place model to be gained.

Also, MMR offered a learning opportunity choosing a single methodological approach would not have afforded. For example, I have not had the opportunity to run a standard multiple regression either during my studies or working as a research assistant; the latter of which have predominantly featured qualitative methods. I enjoy the dynamic and interactive nature of MMR and the ability as a researcher to interchange research activities in striving to seek answers to research questions.

2.3. Research Context: James' Place

Data collected from James' Place informs this PhD thesis. The James' Place centre is the first community-based suicide prevention service for people who identify as male who are experiencing suicidal crisis in the UK. At James' Place rapid access (typically within 48 hours of referral) to a brief psychological intervention is delivered to men experiencing suicidal crisis by qualified therapists trained to deliver the JPM. The JPM is theoretically informed by the Interpersonal theory of suicide (Joiner et al., 2009), The collaborative assessment and management of suicidality (Jobes, 2012), and the Integrated motivational-volitional theory of suicide (O'Connor, 2011; O'Connor & Kirtley, 2018). Specialised suicide prevention therapists work collaboratively with men to co-produce safety planning and

effective suicide prevention strategies within the remit of the JPM, which is typically delivered within nine hourly sessions following referral and a welcome assessment.

Further details of the JPM are described in a published peer-reviewed public health case study which comprises chapter four of this thesis. It is noteworthy that James' Place is an inclusive service of people who identify as male. The James' Place service and, author and supervisors of this PhD thesis, recognise that multiple genders exist beyond a dichotomous configuration. Therefore, reference to men and/or male(s) in this thesis is used in the interest of brevity and ease of reading and is not intended to be reductive or ignorant of different gender identities.

Reflective note

Reviewer comments prior to publication of the public health case study in chapter 4 alerted me that referring to people accessing the James' Place service as simply men suggested a homogenous concept of men which ignored issues relating to sexuality, race and ethnicity, and ability/disability. I was surprised to read this as I know this not to be true of the service.

In fact, James' Place inclusion criteria is limited to a few specific inclusion criteria (i.e., adults who identify as male, who are over the age of 18 years, registered with a GP, able to access the accommodation and willing to engage in therapy) to ensure they capture as many people identifying as male as possible. However, once I reflected upon the comments, I recognised the reviewer had indeed raised an important and valid concern that needed clarifying. I discussed the comment within supervision and raised it within the James' Place steering group. The service has tried to collate demographic information (e.g., gender, sexuality, disability, ethnicity. and race) however this was frequently omitted or incomplete from the referral form by the referring party (e.g., GP practice, A&E) or the men do not wish to disclose this information. James' Place is committed to improving this and regularly does outreach work with referrers to improve referral pathways and processes. Subsequently, since the publication of this study James' Place have appointed an outreach officer and have a new online referral form to communicate the inclusive nature of the James' Place service. Similarly, I have taken steps to clarify this within the studies of this thesis.

2.3.1. Participant Sampling and Recruitment

The James' Place service is at the heart of this PhD and played an essential role in facilitating access to participants for this study. Participants within the quantitative studies of this thesis were men who were accepted by the James' Place service for therapy. James' Place accept men experiencing suicidal crisis into the service on the following inclusion criteria:

- Adult (aged 18 years or older. Note, there is no upper limit to age)
- Identify as male
- Experiencing or recently experienced suicidal crisis
- Willing to share information with a GP.

The principal aim of this thesis was to investigate the immediate- and long-term effectiveness of the JPM among men experiencing suicide crisis and, in the period, post-suicide crisis. A mixed-methods qualitative case study approach was used to explore the immediate and long-term effectiveness of the JPM, and its acceptability. As a third-party gatekeeper, James' Place provided all men accessing the service with the participant information sheet detailing the aims and purpose of this study to all men. Study 4 inclusion criteria were aligned with James' Place inclusion criteria outlined above to not add any additional burden to James' Place therapists.

To safeguard the wellbeing and safety of the men, James' Place therapists initially invited men to participate in this study. Participants were approached by a James' Place therapist at the end of a pre-scheduled therapy session which at that time would have been held either face-to-face or online. The decision on when to approach a participant lied with the James' Place therapist as they are best qualified to understand the most appropriate time to ask men whether they wished to be involved within the study. Although no record was kept monitoring when therapists invited the men to participate, it was anticipated that participants would be invited between session 2 and 4 as it is between these sessions that the largest reduction in distress is experienced. If a man expressed an interest to participate, the James' Place therapist then provided the researcher with the individual's James' Place identifier and contact details for the researcher to directly contact the participant about taking part. Once a participant agreed to take part, they were provided with the researchers contact details to contact them about taking part. Men who declined to take part were not asked again to participate. Twenty-eight men completed baseline measures for study 4, with follow-up numbers of thirteen and three at 3- and 6-month follow-

up. No questionnaires were completed at 12-month follow-up. A sample size calculation was not conducted in advance of commencing this study as this study was conceptualised as explorative for understanding the effectiveness of the JPM in the short- and long-term. It was anticipated that approximately 100-150 men may engage in therapy at James' Place based on the number of men accessing the service in the previous years. A sample size of N=100 to 150 participants was considered adequate to facilitate the use of parametric measures and accommodate robustness, allowing the use of advanced statistical analyses of data. Also, this sample size balanced statistical needs versus practical issues. However, poor uptake and adherence blighted recruitment for the quantitative arm of this study. Individual semi-structured interviews with two men who completed baseline and follow-up questionnaires comprised the qualitative arm of this study.

A quantitative study of this thesis focussed upon the LYCT component of the JPM (study 3). The aim of this study was to explore the characteristics of men who use the LYCT component of the JPM during their therapeutic journey. Sub-group profiles of men's psychological risk factors of suicide were developed and assessed to see if they were predictive of the men's trajectory through the James' Place therapeutic journey. Secondary card data collected by James' Place for 511 men who were accepted into the James' Place service were used for this study. In addition, the service gained ethical approval from the men who have been included for this information to be used as part of research and evaluation. Of these 511 men, 298 utilised at least one set of the LYCT on at least one occasion throughout the duration of therapy at James' Place. Therefore, this study did not involve active recruitment of participants.

Study 5 is a mixed methods study (combines different methods and generalisable data of surveys and individual cases) aimed to understand the fidelity of delivery of the James' Place model men experiencing suicidal crisis, adherence of the James' Place model in practice and its acceptability by recipients as perceived by the therapists at James' Place. The quantitative element of this study was comprised of an audit of internal records of thirty cases of men who had received and completed the James' Place intervention which were randomly selected from a potential 101 cases completed between 1st December 2020 to

30th November 2021. Audited cases were assessed for adherence to content of the JPM during delivery and the number of sessions delivered. The thirty cases were randomly selected by administrative staff from James' Place, and the audit took place in December 2021 and was conducted by three members of James' Place staff (JP centre manager, clinical lead, and member of administrative staff) and the researcher of this thesis. The qualitative element of study 5 assessed therapists' perceived acceptability and views of fidelity to delivery of the JPM. This involved semi-structured interviews with a total of eight therapists (5 female) trained to deliver the JPM from James' Place Liverpool (n = 4) and James' Place London (n = 4). The researcher conducted the semi-structured interviews with the therapists between November 2021 and March 2022.

2.3.2. Patient and Public Involvement (PPI)

James' Place was established in recognition that the needs of men experiencing suicidal crisis were not being adequately met by existing community-based mental health services. In aiming to readdress this gap in service provision, James' Place sought the views and perspectives of multiple key stakeholders from several agencies to co-produce the design and delivery of the James' Place service, setting up a steering group to guide service development. During the service design, stakeholders within the steering group included researchers and academics, and health professionals with expertise in the field of suicide prevention, and people with lived experience of suicide including men who had experienced suicidal crisis and received treatment from conventional mental health services. Implementation of co-production in this way facilitated knowledge exchange between experts in the design and development of James' Place which ensured men's priorities were met. For example, men with lived experience of suicide consulted on the building location and interior design along with other stakeholders. Upon completion of the building renovation, men were invited back to view the building and reported they had wished they had, had the opportunity to access a centre such as James' Place when they had experienced suicidal crisis (Saini et al., 2019).

Both as James' Place is a central to this PhD, and in keeping with the ethos of co-production fostered in the way the service was set-up and operates, it was imperative to develop a collaborative working relationship with James' Place staff (therapists, administrative staff, clinical lead, centre managers and CEO) and steering group members. Therefore, additional activities were undertaken to develop close working relationships with key stakeholders from James' Place, which facilitated invaluable insights into the values and principles underpinning the service throughout the duration of this PhD. These are outlined below.

2.3.3. Collaborative Working with James' Place Staff

The head of James' Place Liverpool and clinical lead for the service delivered a training session on the JPM to the researcher at the start of this PhD programme. This session provided detailed information on the inception, design and development of the James' Place service, theoretical underpinnings of the JPM and described planned delivery of the JPM for men experiencing suicidal crisis. In addition, the researcher forged strong working relationships with James' Place administrative staff and therapists by regularly working within communal staff areas at James' Place Liverpool.

On-going service evaluation and outcomes have been embedded within the James' Place operational procedures since it first began and continues today. Staff therefore understand research principles and procedures including ethical considerations (including informed consent) and data collection. The views and perspectives of James' Place staff (administrative staff, therapists, and clinical lead) were sought in the development of research materials (e.g., participant information sheets, questionnaire design). Staff were receptive to the proposed programme of study involved in this PhD and welcomed the opportunity to review research proposals and materials accordingly.

2.3.4. James' Place Steering Group

The researcher also joined the James' Place steering group. The James' Place steering group is comprised of key stakeholders including principal James' Place staff (CEO, clinical lead, centre managers), an academic (reader in suicide and self-harm prevention) responsible for leading research initiatives including yearly James' Place evaluation reports, a professor of general practice and individuals with lived experience of suicide. Established during the initial stages of creation of the service, the purpose of the James' Place steering group has evolved as the service has grown and expanded. However, it principally has oversight of operational matters relating to James' Place including dissemination of research outputs (e.g., yearly evaluation reports) and outreach activities. For the duration of this PhD the researcher assumed responsibilities for disseminating research activities and outputs pertaining to James' Place, arranging quarterly meetings with members, setting the agenda, and taking meeting minutes. Access to the steering group greatly enhanced the researchers PhD experience by facilitating access to local stakeholders who shared their invaluable knowledge and expertise of delivering community suicide prevention. Also, this provided a forum to share the researchers study proposals and findings and to consult on future research ideas.

2.3.5. James' Place Research Group

In response to the James' Place centre London opening, it became evident there was demand for a research specific group to be created to facilitate collaboration and knowledge exchange between academics and clinical staff. This would allow for the strategic and locally informed development of research proposals and funding bids to gather an evidence-base to support the effectiveness of the JPM. This is a critical objective for James' Place service as a third sector organisation to secure future funding for its life saving operation. Currently, the research group is comprised of academic researchers with expertise in the field of suicide prevention from Liverpool John Moores University (LJMU) and from

University College London (UCL). The latter of which are presently running a cohort study involving men who do and do not attend James' Place London.

The researcher became a member of this group from its creation in 2021, with responsibilities for setting meeting agendas, minute taking, and dissemination of James' Place related research outputs. While the remit of this group is currently under review as additional James' Place centres are imminently due to open and new research collaborations are developed with local academics and research institutes, the researcher will remain an active member of this team after their programme of PhD study is complete.

2.3.6. Peer Support Groups

Prior to the COVID-19 pandemic, it was planned that the researcher would work with James' Place staff to facilitate peer support groups for men who had completed the JPM for suicidal crisis. It was envisaged these sessions would run each week, of an evening, to maximise potential attendance of men who had recently completed their therapeutic journey at James' Place. The primary purpose of this initiative was to facilitate the opportunity for men to receive peer support during this transitional period of their recovery from other men with shared experiences. Unfortunately, COVID-19 halted the further development of this programme and prevented the researcher's involvement in this initiative.

2.4. Impact of the COVID-19 Pandemic

The global COVID-19 pandemic inevitably impacted this PhD in both quantifiable and immeasurable ways. It was announced that COVID-19 had reached pandemic status by the World Health Organisation (WHO) on 11th March 2020. As the pandemic unfolded over the next two years or so, the UK Government's advice changed in response to fluctuating levels of COVID-19 virus on a national and regional basis. On 23rd March 2020 a national lockdown was declared (Prime Minister's Office, 2020a) leading to the closure of all but essential services, including all educational settings, retail, and hospitality. In May 2020

restrictions were eased allowing the mixing of up to six people outdoors (Prime Minister's Office 2020b). Finally, in July 2020 the mixing of up to two households indoors was permitted (Prime Minister's Office, 2020c). However, LJMU remained closed and all teaching and related pedagogical activities were conducted online. This was because high rates of COVID-19 virus circulating around the Liverpool city region area led to local lockdowns, and restrictions on the mixing of households and travel. It was not until September 2021 that LJMU returned to a hybrid teaching approach with some face-to-face teaching activities permitted so long as additional safety measures (e.g., face masks, regular lateral flow testing) were adhered to.

James' Place was also significantly affected by COVID-19 restrictions. As a life-saving service, James' Place staff were adamant to continue to support men experiencing suicidal crisis throughout the pandemic and made the decision to transfer from an entirely face-to-face service to delivery of the service remotely (online and telephone). Remarkably, staff at James' Place worked tirelessly in transferring the service to remote delivery over a few days and James' Place continued to offer men rapid access to suicidal support throughout the 2020 lockdowns (please see Saini et al., 2022 for more details). During this time James' Place needed to focus upon delivery of the James' Place service, and the wellbeing of men accessing the service and James' Place therapists delivering the service. Therefore, they respectively requested space to do this. Nevertheless, contact was maintained with James' Place by the researcher via quarterly steering group meetings and later in 2021 through monthly online research meetings involving the clinical lead and other staff from James' Place. Despite the unprecedented challenges James' Place staff faced, their commitment and support of this PhD never waned, and I know the planned research studies were never far from their minds.

Reflective Note

The pandemic inevitably brought with it many ups and downs. At the start of the pandemic my daughter had just turned three and required some extra support in her development. My eldest son was 10 years old at the time. On a practical note, I was no longer able to receive childcare support from my parents as they were shielding. On an emotional level, the changes in daily routine and lack of social connectedness significantly affected my children's wellbeing and required additional "mummy" attention. I often reflect on this time, particularly at the start of pandemic in 2020. It was a time of such uncertainty and disruption. As a parent and a daughter too, my priority was maintaining the wellbeing of my children, and supporting my parents and my mother-in-law who was also shielding. Admittedly, my focus was drawn away from my PhD as I had little headspace to think, even less so to do, research. However, my supervisory team were incredibly understanding and supportive during this time despite sharing similar homelife demands and worries too. Individually and collectively, they met with me on zoom and listened to my concerns and frustrations with patience and understanding, gently encouraging me to "do what you can" in the early days. Later, setting small yet achievable targets to bring momentum to my PhD work. Of note, I am extremely grateful for the weekly check ins from my director of studies David and from my second supervisor Pooja. Also, for our weekly catch ups over zoom with the wider research group which Pooja set up and led. This meant that I never felt "it was all too much", and despite working alone at home on my PhD, I never felt lonely or isolated.

On a more personal note, as a mum of two children, closure of schools presented the undesirable challenge of home schooling; a challenge faced by millions of parents nationwide including researchers within the supervisory team of this PhD. In practical terms, having young children at home presented additional ethical considerations when interviews were conducted online. For example, finding a suitable area within the family home, free from the noise and potential interruptions of children to ensure confidentiality of the participant was maintained. Also, having children at home significantly limited the availability of time to plan and conduct research-related activities. LJMU gave a blanket

additional 3 months of PhD funding to all PhD students to account for the impact of COVID-19. A further 3 months PhD funding was available on a case-by-case basis for students who experienced exceptional circumstances which I was awarded; extending the duration of my PhD from three years to three and a half years. Subsequently, COVID-19 instigated a sequence of unavoidable circumstances, restricted access to James' Place and hindered my ability to translate research plans into action which are outlined below.

Early on during my PhD it had been pre-planned that I would work in close partnership with James' Place and embed myself within the James' Place Liverpool service prior to commencing the planned programme of studies. Doing this served two purposes; firstly, it overcame the impracticalities and challenges that often emerge when working collaboratively with external partners (e.g., arranging convenient times to meet to discuss research related developments). Secondly, it facilitated accessibility to potential participants, enabling the researcher to develop a rapport face-to-face with both the men accessing James' Place and the James' Place therapists and support staff, when conducting research activities such as administering questionnaires and conducting interviews.

Being physically positioned at James' Place Liverpool was key to recruitment and participant engagement. Liverpool is ranked the fourth most deprived area in England and has the second highest proportion of neighbourhoods among the most deprived in England (Indices of multiple index [IMD], 2019). People with lower socioeconomic status are an under-served population, and less likely to engage in research for various reasons including mistrust of research and people in authority, and a perceived lack of personal benefit to taking part (Bonevski et al., 2014; Ellward-Gray et al., 2015; Savard and Kilpatrick, 2022). Similarly, gatekeepers including health professionals and clinicians may inadvertently hinder the recruitment process. For example, clinicians may purposely only invite people to take part in research because they feel they are more likely to agree to participate, while others lack the ability to take part (Bonevski et al., 2014; Kalpakidou et al., 2019). Alternatively, clinicians may be overstretched by their clinical responsibilities and not perceive research as an important priority (Kalpakidou et al., 2019).

These barriers can be averted through transparency within the research design and process, and by building trust with stakeholders early in the research process (Ellard-Gray et al., 2015). Being visible as a researcher and developing a rapport with the men and James' Place therapists was perceived as an important facilitator of recruitment for the proposed programme of studies in this PhD. Being present at the centre would have allowed myself as a researcher to engage in regular communication with both the men accessing the service and the therapists; thus, developing mutual trust in a transparent manner within the research setting prior to the research being conducted (Ellard-Gray et al., 2015; Salvard & Kilpatrick, 2022). While from a research planning and design perspective, this would have allowed me to gain invaluable insight to any nuanced pitfalls that may not have been identified otherwise. Accordingly, the research design and recruitment strategies could have been adapted to best suit the men and therapists to improve recruitment and improve the meaningfulness and generalisability of results (Salvard & Kilpatrick, 2022).

Being unable to be physically present at James' Place due to the impact of COVID-19 on me both personally (i.e., being home with children) and professionally (i.e., restrictions imposed limiting non-essential contact and travel) has arguably directly affected planned studies of this PhD. For example, building a collaborative relationship prior to commencing the research could have been particularly invaluable for a planned study investigating the short- and long-term evaluation of the efficacy of the JPM with a planned follow-up of 12-months for participants (study 4 of this thesis). This study did go ahead as planned, however low uptake by men at baseline and lack of follow-up engagement is clear. This is consistent with previous research reporting higher rates of dropout rates among men in questionnaire-based studies (Ross et al., 2003., Ryan et al., 2019). Also, opportunities for research training and dissemination were limited to online access only for a significant period of this PhD. While useful in terms of accessibility, they do limit the opportunity to network and share experiences with other PhD students.

Reflective note

I feel that researchers should allow more time for recruitment whenever feasible as it often takes longer than anticipated. When writing about the difficulties in recruiting participants from underserved populations, such as from deprived areas as Liverpool is, the literature around mistrust of people in positions of authority/power stuck a chord with me. I have worked as a research assistant since 2012 and have recruited participants from across Liverpool for different studies and experienced similar difficulties when recruiting. The people of Liverpool have historically been let down by people in positions of power (e.g., Government policy of economic demise in 1980's, the Hillsborough tragedy, the significant over-budget and delayed opening of the new Royal Liverpool Hospital, and local council scandals). I feel this has created an understandable legacy of mistrust among a lot of people anecdotally as evidenced by the discussions I have had with people within my local community and from my own research experience recruiting. However, I have often found that this can be overcome by being open and honest with people when recruiting people. The people of Liverpool have big hearts and, in my experience, will often help if people take the time to explain what research involves in a transparent and honest way.

2.5. Thesis Outline: Design of Studies and Data Analyses

2.5.1. Triangulation

Triangulation in research refers to integrating data from different sources to examine and confirm phenomena (Flick et al., 2017; Heale & Forbes, 2013). Synthesis of data can occur across two or more researchers, data sources, and methods. For example, data collected using the same methodology (e.g., qualitative data) or from different methodological approaches (qualitative and quantitative data) (Williamson, 2005). The purpose of triangulation is to confirm validity and reliability of data of inferences drawn from the data (Heale & Forbes, 2013; Williams & Morrow, 2009). However, Flick (2017) in criticising this

perspective of triangulation, proposes triangulation as an opportunity to gain *"extra knowledge"* about phenomena under investigation (Flick, 2017 p.53).

The present thesis adopted an extended conceptualisation of triangulation as posited by Flick (2017). Two researchers (the primary author and PS) reviewed codes and themes of qualitative data. The remainder of the supervisory team acted as external auditors of the codes/themes derived (Hill et al., 2005). Critical distance gained by having an external auditor not involved in the development of codes/themes adds to the trustworthiness to the qualitative data as their views and perspectives are uninfluenced by the primary researchers' discussions of data (Hill et al., 2005). Triangulation of methodological and theoretical perspectives were guided by having a supervisory team with expertise in both qualitative or quantitative methodologies who reviewed the methods used in each study to ensure a comprehensive understanding was obtained (Flick, 2017). Fostering this systematic triangulation of qualitative and quantitative methods unveils a detailed understanding of how James' Place therapists and men interact with, and perceive the feasibility and effectiveness of, the JPM.

2.5.2. Independence of Thesis Studies

There are some notable similarities across the studies of this thesis and previous research work related to the James' Place service. Namely, the primary population of focus (men experiencing suicidal crisis and James' Place therapists) and methodological approaches used (mixed methods). However, it is important to highlight how studies within this thesis stand independent of, but complementary to, previously published James' Place research studies and evaluation reports.

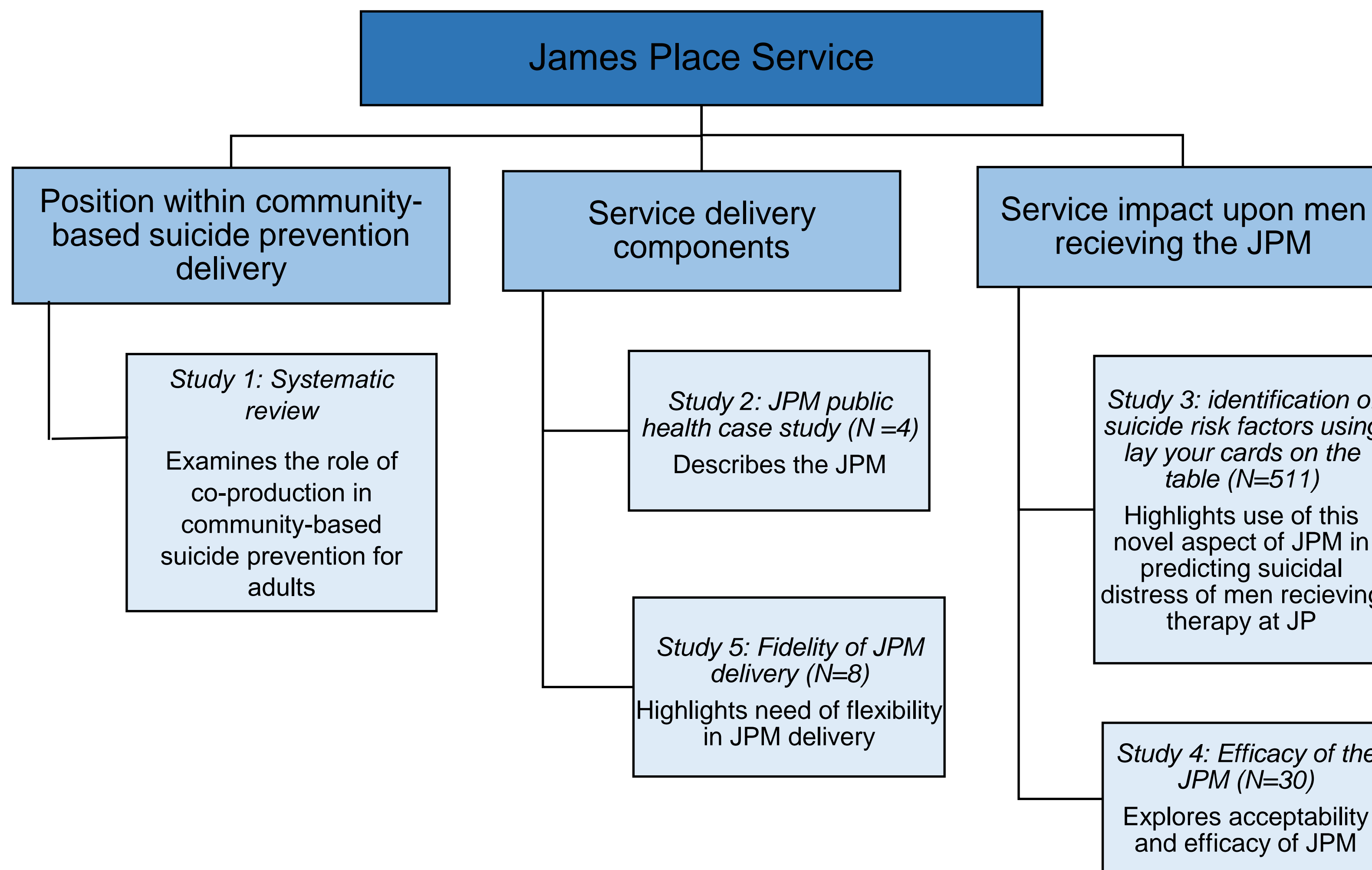
Several factors differentiate the studies of this thesis from previous James' Place research work. The duration of this post-graduate doctoral program has been four years, while evaluation work is embedded as an on-going process within the operational procedures of James' Place. A single researcher has produced the studies of this thesis versus a team of research and academic staff for previous evaluative and research studies. The aim of

this PhD strives to understand the role of co-production within community-based suicide prevention interventions; the perceived accessibility and acceptability of the JPM from the perspective of James' Place therapists; and the effectiveness of the JPM in reducing suicide in the short- and long-term. By comparison, the remit of James' Place evaluation report themes and published studies have varied. For example, the focus of evaluation studies have reflected current, topical affairs relating to the service such as a process evaluation of set up and delivery and the piloted use of JPM at the Liverpool centre 6-months after it opened (Saini et al., 2019); an evaluation of effectiveness of the JPM prior and during the COVID-19 pandemic (Saini et al., 2021) and more recently effectiveness of the JPM is reducing CORE-OM and entrapment scores of men accessing James' Place following introduction of the entrapment short-form questionnaire (deBeurs & O'Connor, 2020) into routine clinical outcome measures (Saini et al., 2022). Collectively, the differences outlined indicate the unique, novel, and timely contribution this thesis makes to the field of suicide prevention for men.

2.5.3. Outline of Studies

Five studies were completed to seek to address the aims of this thesis and are shown in Figure 1. Each study is formatted according to the publishing guidelines of the journal it is either published in or has been submitted to for publication. The five studies featured broadly relate to three categories feeding into feasibility and effectiveness of the JPM; James' Place's role in community-based suicide prevention (service position within community-based suicide prevention services), JPM delivery (service components) and JPM effectiveness (service impact) as shown in Figure 1.

Figure 1: Overview of PhD Studies and their Individual Relevance to the Feasibility and Effectiveness of James' Place



2.5.4. Data Sources and Methods Employed

The data sources and methods used within this thesis are shown in table 1.

Table 1: Method and Analysis Approach

Methods	Study Number	Data Collection and Source	Data Analysis
Quantitative	3	James' Place case records of men who received the JPM and used LYCT	Multiple regression
	4	James' Place case records of Questionnaires completed by men who received the JPM	Descriptive statistics and Wilcoxon matched pairs signed ranks tests
	5	James' Place written case notes for 30 randomly selected men who received the JPM	Descriptive statistics
Qualitative	2	Semi-structured interviews with men and therapists	Thematic analysis
	4	Semi-structured interviews with men	Thematic analysis
	5	Semi-structured interviews with James' Place therapists	Thematic analysis

Table 1 highlights the different quantitative and qualitative methods used to collection data within this thesis. Several sources of quantitative data were used including:

1. Retrospective review of James' Place case records of individual men to extract LYCT data.
2. Questionnaires completed by men experiencing suicidal crisis who received the JPM
3. Retrospective review of James' Place case records to extract data pertaining to an audit to assess fidelity of delivery of the JPM as planned.

One source of qualitative data was used within this thesis, which was semi-structured interviews with men who had received the JPM and James' Place therapists who are trained to deliver the JPM to men experiencing suicidal crisis.

2.5.5. Evaluating the Role and Effectiveness of Co-Produced Community-Based Mental Health Interventions that Aim to Reduce Suicide Among Adults: A Systematic Review (Study 1: Published in Health Expectations: An International Journal of Public Participation in Health Care and Health).

Study 1 is a systematic review of the literature aiming to evaluate the role and effectiveness of co-produced, community-based suicide prevention interventions for adults that aim to reduce suicide to:

1. Understand how co-production is defined and operationalised.
2. Examine evidence for the role of co-production in these interventions.
3. Identify and evaluate co-production-related outcomes associated with these interventions.
4. Identify and evaluate intervention components associated with a reduction in suicide-related outcomes.

A proposal was developed and registered with PROSPERO (CRD42020221564 available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42020221564). Search terms were developed by scoping existing literature and used to search four electronic databases (PsycINFO, CINAHL, MEDLINE, Web of Science). Two data extraction sheets were created and used to derive information pertaining to the aims of the review including study characteristics (e.g., study aims and focus population of the intervention) and intervention characteristics (e.g., co-production methodological approaches and co-production and/or suicide-related outcomes).

For the systematic review, four electronic databases (PsycINFO, CINAHL, MEDLINE, Web of Science) were systematically searched using an a-priori search strategy (see appendix 1). Grey literature and backward reference searches were conducted also. Fourteen papers met the inclusion criteria from which data was extracted.

Undertaking this study provided an opportunity to explore different approaches used in co-produced, community-based suicide prevention interventions for adults experiencing

suicidal crisis and contextualised the JPM and service within the current landscape of such interventions.

A narrative synthesis approach was used to summarise and describe the findings in relation to the role of co-production in community-based suicide prevention interventions. This approach was chosen to report the findings due to heterogeneity in the types of studies identified in during the search. Culmination of the findings led to the development of several implications that need consideration when incorporating co-production in these types of community-based, suicide prevention interventions. The published version of this study is available at: https://onlinelibrary.wiley.com/doi/full/10.1111/hex.13661

2.5.6. James' Place Model: Application of a Novel Clinical, Community-Based Intervention for the Prevention of Suicide Among Men. (Study 2: Published in Journal of Public Mental Health).

As part of a special issue published in the Journal of Mental Health, this descriptive article of the James' Place service follows a public health case study as specified in accordance with the remit of this journal. The approach taken here contrasts with a formal case study approach which *"allows in-depth, multi-faceted explorations of complex issues in their real-life settings"* (Crowe et al., 2011, p.11). The present article is not a traditional empirical paper, and the text does not follow a specified structure. Rather, in following the author guidance of the publishing journal to *"inspire innovation in other populations or settings"* who may face similar challenges, this is a descriptive article the purpose of which is to describe within 1000 to 1500 words innovative developments within the field of mental health. Accordingly, this article does not adhere to the pre-defined structure that a conventional empirical study may use to report findings. Instead, a public health case study style as defined within the author guidelines of the Journal of Public Mental Health is followed. The purpose of this article is therefore to describe the James' Place service, and how it operates, including the referral pathways and clinical journey of men who engage with James' Place.

To support and illustrate how the JPM is delivered, four case studies are reported. Data for the case studies were extracted from two sources; the James' Place six-month evaluation report (Saini et al., 2019) and the James' Place one-year evaluation report (Saini et al., 2020). Two of the four case studies reported refer to two James' Place therapists and their perceptions of the James' Place service and experiences of delivering the JPM to men experiencing suicidal crisis. Data for these were derived from two of eleven semi-structured interviews conducted as the qualitative part of the James' Place six-month evaluation report (Saini et al., 2019). Each of the eleven interviews involved several stakeholders involved in the design, set-up and deliver of the James' Place service including James' Place staff, men with lived experience of suicide and men who had accessed James' Place and received the JPM and were conducted by a researcher (not the PhD candidate) between December 2018 to January 2019 (Saini et al., 2019). The remaining two case studies reported refer to men who accessed the James' Place service while experiencing suicidal crisis and reports on their perceptions of the James' Place service and their experiences of the JPM. Data for these were extracted from two of four semi-structured interviews conducted with four men and which comprised the qualitative element of the JP one year evaluation report (Saini et al., 2020). These interviews were conducted by a researcher (not the PhD candidate) between January and April 2020.

The remit of the publishing journal states that public health case studies are not considered "research" papers, and as such there is no prescribed structure to follow. Correspondingly, there was no requirement to perform a formal analysis of the data reported such as framework approach as might be used if the sample was much larger (Pope et al., 2000). Data extracted for the case studies had previously been thematically analysed (Braun and Clarke, 2006) and themes and subthemes developed to address the aims of the respective JP evaluation report. However, in creating and shaping a narrative consistent with the aims of this article (i.e., to describe the James' Place service and JPM) when integrating the data and creating the cases, an inductive (i.e., data-driven) and deductive approach (i.e., concept driven) were used. This ensured that cases studies reflected the purpose of this article and remained consistent and truthful of the accounts documented of James' Place therapists

and men documented within the respective JP evaluation reports (Saini et al., 2019; 2020). In this sense this article reflects Yin's (2009) interpretation of a case study in facilitating the description and exploration of phenomena within the context it occurs. Yet, contrasts to a conventional case study as data was not collected from multiple sources to allow for data triangulation (Crowe et al., 2011).

This study further contextualised the James' Place service in providing an overview of the JPM, clinical journey men experience at James' Place and the perceived impact of the model. A shortened version of this study is published and available at https://doi.org/10.1108/JPMH-09-2021-0123.

2.5.7. Psychological Risk Factors Predictive of Suicidal Distress of Men Receiving a Community-Based Brief Psychological Intervention for Suicidal Crisis (Study 3: Published in Suicide and Life-threatening Behaviour).

Using a cross-sectional design, study 3 aimed to determine psychological risk factors associated with men's suicidal crisis by examining the predictive utility of the LYCT component of the JPM in predicting suicidal distress. James' Place routinely collates information pertaining to psychosocial factors associated with each individual man's suicidal crisis. This broadly involves a clinical assessment by a specialised suicide prevention therapist trained to deliver the JPM during a welcome assessment, which the therapist repeats throughout the clinical journey for each man accepted to receive the JPM. It also involves administration of the LYCT component of the JPM at set timepoints as men progress through the clinical intervention.

The LYCT component of the JPM is comprised of four sets of cards, which resemble a pack of playing cards. Each individual card has a word or phrase written on it which relates to either a thought, feeling or behavioural factor associated with suicide (e.g., I can't stop thinking of killing myself, I can't sleep). Therapists introduce the LYCT to men during sessions to assist in the identification of factors driving their suicidal thoughts, feelings, and behaviours.

Data for this study was retrospectively obtained by extracting LYCT data from the James' Place clinical recording system. This involved accessing each individual man's case record to view which of the four LYCT sets had been utilised (what's happening now; how did I get here, what's keeping the problem going and how can I get through this) and, out of each set, which individual LYCT cards had been selected by each man. Typically, LYCT are administered by therapists in such a way that each man selects those individual cards that they feel are relevant to their experience of suicidal crisis. However, in keeping with the co-productive ethos of James' Place, therapists work with each individual man in the administration of LYCT to deliver them in a way men perceive is accessible and acceptable. Subsequently, while most men engage with LYCT as specified above, some men opt for the therapist to talk around the themes encompassed within the LYCT or a therapist may identify individual cards from a LYCT that appear to resonate with an individual man's experience of suicidal crisis. Alternatively, some men prefer to not utilise the LYCT as they wish to utilise the session in a different way such as to discuss something that has come up in the time from their last session. For this study, each individual card from LYCT which a man had selected were recorded onto SPSS with '1' denoting that a specific LYCT had been selected and '0' indicating that a card had not been selected. Data pertaining to LYCT selected by each individual man was extracted and merged with CORE-OM (CORE34 and CORE10) clinical outcome data routinely collected by the James' Place service.

Data of 511 men aged 18 to 69 years (M=35.59 years; SD=12.30) who had received therapy at James' Place were analysed. Descriptive and point biserial correlations were performed. Card variables significantly correlated against CORE-OM scores were then entered into a multiple regression model to test the predictive utility of each individual variable in predicting CORE-OM scores.

A shortened version of this study is published and available at: https://doi.org/10.1111/sltb.13055

2.5.8. An Evaluation of the Effectiveness of a Community-Based Suicide Prevention Service Delivering a Clinical Therapeutic Model for Men Experiencing Suicidal Crisis (Study 4: Under review at PloS One Mental Health).

Study 4 is a mixed methods longitudinal case study design. This study was initially conceived as a quantitative based study aiming to determine the short- and long-term effectiveness of the JPM in reducing suicidal distress, entrapment, loneliness and improving resilience, hope, generalised self-efficacy, self-compassion, and perceived social support. To achieve the aims and objectives of this study, a baseline questionnaire comprised of standardised measures of resilience, hope, generalised self-efficacy, self-compassion, loneliness, perceived social support were given to men. In addition, data from CORE10 and entrapment questionnaires completed by each a man when they attended their initial welcome assessment at James' Place was used as a baseline measure of psychological distress to reduce burden upon men. Follow-up questionnaires comprised of standardised measures of resilience, hope, generalised self-efficacy, self-compassion, loneliness, perceived social support and CORE10 and entrapment were sent to men at 3-, 6- and 12-month follow-ups. However, the Covid19 pandemic meant that the study had to be adapted as it was not possible for the researcher to recruit participants as planned due to Government restrictions and social distancing rules. Low uptake at baseline and high attrition rates at 3-, 6- and 12-month follow-up meant that an insufficient sample size was achieved to provide adequate statistical power for inferential statistics to meet the aims and objectives of this study as originally planned. Also, no men completed a 12-month follow-up questionnaire, therefore data analyses involved baseline, 3- and 6-month follow-up data.

Additional data pertaining to psychological, motivational, and volitional factors of men's suicidality which is routinely collated by James' Place was used to supplement the questionnaire data collated. This included frequencies on precipitating factors and psychological factors, which are informed by the IMV model of suicidal behaviour and in turn, has informed the development of the JPM. Referrers assessment form a record of the precipitating factors associated with each man's suicidal crisis. While psychological factors are assessed and recorded by James' Place therapists on each man's case file at the end

of each session. Psychological factors recorded by therapists during the welcome assessment were used for the purpose of this study. Whilst these factors have been subjectively assessed and are open to interpreter bias, each therapist has received specialised suicide prevention training and training on how to subjectively evaluate and record these factors and recording them at immediately following the session limits the effects of recall bias.

Data was further supplemented with thematically analysed case study data obtained from two semi-structured interviews with men who had accessed James' Place. Perceptions of the effectiveness of the JPM and its perceived acceptability, and factors influencing involvement of men who have experienced suicidal crisis in longitudinal research were explored. The case studies involved two men who had received the JPM and who had completed a baseline questionnaire for the study. Baseline, 3-, and 6-month follow up questionnaires were distributed to 28 men receiving the JPM for suicidal crisis, measuring resilience, hope, generalised self-efficacy, self-compassion, social isolation, perceived social support, entrapment, and clinical outcomes (CORE-OM).

Case studies support the perceived acceptability, and short- and long-term outcomes of the JPM. Men discussed continued use of coping strategies developed during their therapeutic journey at James' Place. It was not possible to conduct inferential statistics due to the small sample size. Instead, descriptive analyses of data suggest a mean reduction in suicidal distress and social isolation, while protective factors appear to develop such as social support. However, this relationship could not be statistically tested at the inferential level due to poor study uptake and retention.

2.5.9. A Mixed Methods Evaluation of the Acceptability and Fidelity of the James' Place Model for Men Experiencing Suicidal Crisis (Study 5: Published in Health Psychology & Behavioural Medicine).

The final study (study 5) of this thesis fostered a mixed methods design to explore the fidelity of delivery of the JPM within a therapeutic setting for men experiencing suicidal crisis.

Analyses of internal audit records formed the quantitative phase of this study. A total of 30 completed cases were evaluated against an audit tool developed in-house at James' Place (Appendix 13). This tool was used by three auditors (the researcher and two staff from James' Place) to record components of the JPM delivered (e.g., number of sets of the LYCT and number of sessions). This was done to determine level of adherence by James' Place therapists in their delivery of the JPM compared to the planned delivery.

Audit data was obtained from the clinical records of 30 men who had accessed James' Place. Individual case records for each man included in the audit were examined and data pertaining to the audit criteria were retrospectively extracted from James' Place's clinical recording system. Thirty cases were extracted by James' Place staff and the researcher (CH) conducted a secondary audit on 15 cases. Cases were randomly selected by an administrator at James' Place and 5 cases per therapist at James' Place Liverpool were selected. Data extracted included number of sessions attended, number sessions recorded as did not attend, whether a safety plan and LYCT component of the JPM were completed, and adherence scores.

Semi-structured interviews with James' Place therapists (*N*= 8) formed the qualitative phase of this study. A semi-structured interview schedule was created which focused upon therapist views on fidelity of delivery of the James' Place Model, including barriers and facilitators that may influence their adherence in delivery of the model in practice. Therapists perceived acceptability of the JPM was also explored with the aim of understanding the perceived service-user related factors that influence fidelity to the JPM. All interviews were transcribed verbatim and analysed using reflexive thematic analysis (Braun & Clarke, 2006; 2018).

Reflexive thematic analysis is described as a qualitative method involving active and iterative engagement with data in the development of themes which allows patterns to be identified, analysed, and reported (Braun & Clarke, 2019., Clarke & Braun, 2018). The decision to use this approach in this study was guided by the study aims (exploring therapist views and perspectives in relation to fidelity and men's acceptability of the JPM). For

example, grounded theory was not appropriate for this study since the purpose of the study was not to develop a theory of a phenomenon. Similarly, interpretative phenological analysis was not suitable since the study was not concerned with how individuals interpret, experience, and make sense of phenomenon. Thematic analysis is a flexible yet robust method of analysis which is not tied to a specific theoretical stance, thus is flexible across diverse research questions (Braun & Clarke, 2006). As the research aim of this study was broadly evaluative in nature, thematic analysis allowed inductive (data-driven) and deductive (theory-driven) coding and theme development by the researcher actively engaging with the data in a reflective process of refining and defining codes and themes (Braun & Clarke, 2006; 2019; Clarke & Braun, 2018). Additionally, thematic analysis enables dissemination to a wider audience beyond academia due to its accessible nature (Braun & Clarke, 2006).

The researcher independently developed codes and themes. The data, codes and themes developed were then reviewed by the supervisory team to ensure transparency and agreement within the codes and themes. The shortened, published version of this paper is available at: https://doi.org/10.1080/21642850.2023.2265142

2.6. Ethical Considerations

Ethical approval was sought and granted by Liverpool John Moores University (LJMU) research ethics committee for each study comprising this PhD [20/NSP/043; 21/PSY/007]. Pre-existing data sharing agreements between LJMU and James' Place had been established before the commencement of this PhD. This means that informed written consent is obtained from men entering the James' Place service during their initial welcome assessment. Ethical approval [18/NSP/024 & 19/NSP/057] under this shared data agreement in the present thesis applies to quantitative data analysed in studies 2, 3 and 5. All data were anonymised to ensure individual men and James' Place therapists involved in studies of this thesis were not identified.

Informed written consent was obtained from James' Place therapists prior to commencement of the qualitative and quantitative element of this thesis. Participants were made aware that the study was entirely voluntary and of their right to withdraw, that all data would be anonymised and were debriefed after their participation. In the case of the online questionnaire comprising study 4, participants were signposted to support services (Samaritans and James' Place) in a debrief sheet attached to the end of the questionnaire. As James' Place is a new service with a small number of qualified therapists trained to deliver the JPM there is a risk that therapists participating in semi-structured interviews for study 5 could be indirectly identified. To minimise this risk, pseudonyms were assigned to each participant and all identifying information was removed from the interview transcripts and select quotes have been used within this PhD.

All quantitative and qualitative data were stored electronically on LJMU secure one drive storage facility, except for the consent forms obtained from therapists from James' Place Liverpool in study 5 (note, written informed consent was obtained online for therapists in James' Place London in this study). Hard copies of consent forms were stored in a lockable filing cabinet at LJMU.

Reflective note

Conducting suicide-related research understandably creates several ethical concerns. Our priority as researchers is first and foremost to the wellbeing of our participants. That said, obtaining ethical approval for study 4 which focussed upon the short- and long-term effectiveness of the James' Place Model did present several concerns highlighted by LJMU ethics committee in their review of my ethics application. These included concerns relating to the level of distress that participants may experience while completing an online questionnaire and that questions within the standardised measure may be "triggering". Despite the concerns expressed, I felt confident that the study was well-designed and that I had prioritised the wellbeing of the men throughout the planning and design of the study. Research has shown that asking people about suicide thoughts and behaviours does not significantly harm individuals (DeCou & Schumann, 2018). The

questionnaire given to men was comprised of validated and standardised scales that have been used in suicide-related research and/or is used by James' Place themselves (i.e., the CORE-OM). As described earlier, the views and perspectives of James' Place staff, clinical lead and steering group has been sought in the design and development of studies and study materials. James' Place felt satisfied that the procedure in place for this study which involved James' Place therapists identifying potential participants for the study by using their clinical expertise and judgment would safeguard the well-being of the men. Also, men accessing James' Place routinely complete questionnaire-based data for their clinical records so are familiar with processes associated with completing questionnaires. However, on reflection of the University Research Ethics Committee (UREC) concerns and in reviewing my original ethics application it became apparent that I had not gone into as much detail regarding mitigation of the risks as I could have done. This may have given the impression that I was under-estimating any risks associated with the study. Research has confirmed that higher education ethics committees are supportive of research that advances understanding of suicide (Barnard et al., 2021). However, balancing the risks and benefits of suicide research is a primary concern of higher education ethics committees and less experienced suicide researchers may be less inclined to address such concerns (Barnard et al., 2021). Indeed, on reflection this was true of me! Subsequently, ethical approval was granted for this study through liaising and open discussion with UREC and providing an explicit account of the steps taken to safeguard the wellbeing of the participants. I have also learned not to gloss over these important details and to be willing to seek advice directly from UREC for future suicide research.

Chapter 3: Evaluating the Role and Effectiveness of Co-produced Community-Based Mental Health Interventions that Aim to Reduce Suicide Among Adults: A Systematic Review.

Co-production is advocated in mental health provision and is increasingly becoming an important feature within the commissioning, design, development, and implementation interventions (National Collaborating Centre for Mental Health (NCCMH), 2019). Collaborative working and shared knowledge exchange between individuals who design, deliver, and commission services and use and need the service is promoted within co-production (NCCMH, 2019). In this way, co-production aims to redress power imbalances and bring equity within the collaborative working relationship, on the premise that individuals who use and work within a service have greater understanding of better working practices (Slay and Stephens, 2013).

As co-production becomes more widely used within community-based mental health service provision, including suicide prevention, there is a need to understand how this may be applied and implemented, and how contentious issues surrounding co-production (e.g., its definition) are addressed. Therefore, this next study aimed to understand the role of co-production in suicide prevention for adults by systematically reviewing existing literature within the field.

Note: This chapter is formatted in line with the formatting requirements of the journal in which it has been published, and is available at: https://doi.org/10.1111/hex.13661

Structured Abstract

Background: Suicide is a major public health risk requiring targeted suicide prevention interventions. The principles of co-production are compatible with tailoring suicide prevention interventions to meet individual's needs.

Aims: This review aimed to evaluate the role and effectiveness of co-produced community-based suicide prevention interventions among adults.

Methods: Four electronic databases (PsycInfo, CINAHL, MEDLINE and web of science) were systematically searched. A narrative synthesis was conducted.

Results: From 590 papers identified through searches, fourteen met the inclusion criteria. Most included studies elicited the views and perspectives of stakeholders in a process of co-design / co-creation of community-based suicide prevention interventions.

Conclusion: Stakeholder involvement in the creation of community-based suicide prevention interventions may improve engagement and give voice to those experiencing suicidal crisis. However, there is limited evaluation extending beyond the design of these interventions. Further research is needed to evaluate the long-term outcomes of co-produced community-based suicide prevention interventions.

Keywords: Suicide; Suicide prevention; Co-production; Community-based; Systematic review; Adults Mental Health.

Patient and Public Involvement**:** This paper is a systematic review and did not directly involve patients and/or the public. However, the findings incorporate the views and perspectives of stakeholders as reported within the studies included in this review, and the findings may inform future involvement of stakeholders in the design, development, and delivery of community-based suicide prevention interventions for adults.

Introduction

Co-production is advocated within mental health policy and has garnered increasing attention.[1-3] This is highlighted within health care initiatives including person-centred care[4], the "*Five Year Forward View for Mental Health*" policy strategy[5] and more recently *"The Community Mental Health Framework for Adults and Older Adults – Support, Care and Treatment. Part 1 & 2".*[6-7] Within a co-production framework, multiple stakeholders work in collaboration, including commissioners, service providers and servicer users.[8-9] Emphasis is placed upon shared decision-making and information exchange within a mutually equitable relationship.[2] Subsequently, equal value is placed upon contributions by service users, and service providers and professionals.[2-3]

It is argued that co-production produces meaningful knowledge within the context to which it is to be applied.[9-10] This creates services that are more contextually specific, promoting engagement and bridging the translational gap between research evidence production and real-world implementation.[9,11] Relatedly, co-production improves quality of care[3,12], having considered service user needs and priorities during the co-production process[1,13] leading to cost-efficient and cost-effective services.[14]

Despite the highlighted benefits of co-production, several limitations have been identified. There remains a lack of consensus in how co-production is defined leading to interchangeable language used to describe co-production processes.[2,13,15-16] For example, undefined collaborative roles have led to a plethora of collaborative working activities marketed under a co-production umbrella including co-creation and co-design.[13,17-18] This "*one size fits all*" approach is attributed to different interpretations in how co-production is operationalised within policy, knowledge creation and subsequently implemented in practice within service delivery.[2,19-20] There is a paucity of evaluation considering the extent co-productive approaches cultivate meaningful outcomes[20-22] and whether positive outcomes associated with co-production are sustained over time.[23] Further, reluctance to relinquish professional roles and responsibilities, such as those held by researchers or

practitioners, may lead to a power-imbalance that could threaten the integrity of the mutually equitable relationship.[9,12]

Mental health services have striven to harness the innovative and transformative potential of co-production in a quest to improve service user inclusivity in decision-making, and service delivery and experience.[1] Suicide is a major public health problem, accounting for over 700, 000 deaths worldwide.[24] Help-seeking remains a significant barrier for those at risk of suicide with fewer than one third of individuals seeking help for their mental health.[25] The reasons individuals experiencing suicidal thoughts and behaviours do not seek help from mental health services vary but include high self-reliance, a low perceived need for treatment and stigmatising attitudes towards suicide and/or mental health problems and seeking professional help.[26] In recognition of such barriers, there has been a call for suicide prevention interventions to be tailored to improve reach and increase effectiveness.[27]

The principles of co-production are congruent with tailoring suicide prevention interventions to suit the needs of individual servicer users and are aligned to recovery orientated services which emphasise individualised care and recognise the value of experiential knowledge.[6-7,28] Research is emerging which supports implementation of co-produced mental health service provision. For example, studies evaluating the impact of recovery colleges featuring co-production have reported positive outcomes upon service-user wellbeing such as improved self-esteem or confidence[29], improved employment opportunities[30], and reduced use of mental health services.[31] Additionally, applying co-production to tailor delivery of mental health services such as the Improving Access to Psychological Therapies to improve reach among black and minority ethnic communities has shown increased accessibility and retention.[32] Further, Pocobello and colleagues[33] reported a 63.2% reduction in hospitalisations, and a 39% decrease in psychiatric medication use or withdrawal, among service users of an experimental co-produced mental health service versus traditional mental health services. Findings such as these are encouraging, however qualitative findings pervade this field and there remains a paucity of quantitative research assessing the impact of co-production within mental health service provision[34], even less so in relation to suicide prevention. While studies focusing upon the preventative aspect of co-produced

mental health services assert that they prevent service user mental health from reaching crisis point[34], validated assessment of this impact is lacking.

As highlighted, co-production does have its limitations which need to be mitigated for the potential of co-production in suicide prevention to be fully embraced. Key to furthering understanding of the role of co-production within suicide prevention relies upon understanding the language used to define co-production; evaluating how and to what extent service providers and services users contribute to the co-produced service; and how information is synthesised, and outcomes are assessed. Therefore, this review aims to evaluate the role and effectiveness of co-produced, community-based suicide prevention interventions for adults that aim to reduce suicide to:

1. Understand how co-production is defined and operationalised.
2. Examine evidence for the role of co-production in these interventions.
3. Identify and evaluate co-production-related outcomes associated with these interventions.
4. Identify and evaluate intervention components associated with a reduction in suicide-related outcomes.

Methods

The protocol for this review was registered on the University of York, Systematic Review database PROSPERO (CRD42020221564)[35]. The research questions and inclusion and exclusion criteria were generated using the patient/problem or population, intervention, comparator, and outcome (PICO) framework.

Eligibility Criteria

Studies were eligible for inclusion if they fulfilled the following criteria:

1. *Population:* Adults aged 18 years or older.

2. *Intervention:* Co-produced community-based mental health interventions that aim to reduce suicidal risk, thoughts and/ or behaviour, and/or those that include sub-analyses for participants described as experiencing suicidal crisis or at risk of suicide were included. Treatment studies focusing upon clinical populations were excluded, however co-produced community-based studies examining the effects of prevention interventions to reduce suicide risk (e.g., self-harm, depression) were included if this data were reported as a separate sub-analyses. In addition, studies that broadly focussed upon mental health but clearly reported co-produced outcomes and suicide prevention outcomes were included.

3. *Comparator*: It was unnecessary for included studies to have control group comparators. However, it was expected that some studies such as randomised controlled trials that met the inclusion criteria would compare intervention outcomes with a control group (e.g., usual care). Therefore, comparators could be no intervention or control group, or comparison with a different intervention group.

4. *Outcomes*: As the goal of suicide prevention interventions is to prevent suicide changes in suicide risk and/or suicide-related behaviours (e.g., suicide ideation) comprised the primary outcome. Both qualitative and quantitative studies (including cross-sectional and longitudinal studies) which assessed changes in suicidal risk and behaviour were assessed against the eligibility criteria. Quantitative studies using both standardised and non-standardised measures were eligible for inclusion. Intervention-based studies measuring outcomes over a period of follow-up were included only if suicide risk was reported (e.g., self-reported) at baseline and at each follow-up point and were re-revaluated at follow-up at least one week beyond baseline. Number of follow-ups and type of suicide risk behaviour assessed were not determinants for inclusion. A narrative evaluation of service features of interest (e.g., co-production definition and operationalisation) were reported. Secondary outcomes were changes in psychological wellbeing and quality of life.

Only studies published in English were included and no geographical or publication date restrictions were imposed. This was to capture the breath of co-production-based studies within the literature.

Search Strategy

Four electronic databases (PsycINFO, CINAHL, MEDLINE, Web of Science) were searched. Studies published in English to the 21st March 2022 were eligible for inclusion. Filters were not applied during the search for type of study. Systematic reviews were excluded, but back searches of reference lists were checked for additional relevant studies that met the inclusion criteria.

Search Terms

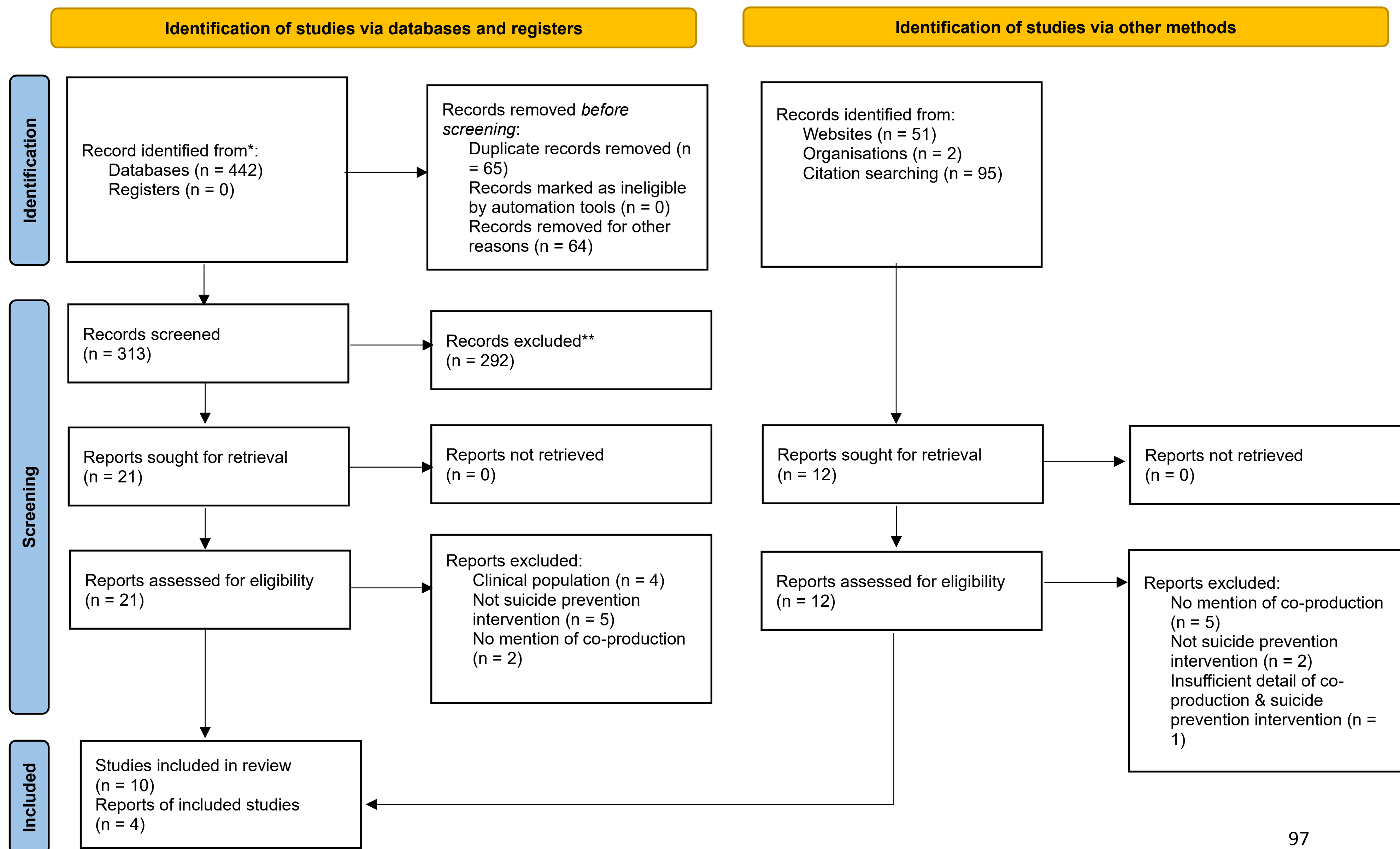
Scoping of the literature was undertaken in the development of the search terms exploring the extent of co-production in the context of community mental health. Consequently, a broad search strategy was developed to ensure all relevant papers were captured. The search strategy utilised relevant terms for co-production (e.g., *"co-product*", "co-design*", "co-create")*, suicide (e.g., "sucid*") and community mental health (e.g. "*community mental health"*) (see appendix 1 for example search terms).

Study Selection

The primary author removed duplicate studies from the final search and independently screened the titles and abstracts of the remaining studies against the eligibility criteria. Co-authors also independently screened titles and abstracts according to the inclusion and exclusion criteria. Full text studies meeting the eligibility criteria were retrieved and reviewed for inclusion by the primary author. Two co-authors reviewed all full text papers for comparison. Disagreements were resolved through discussion within the team at title

and abstract stage, and by one co-author at full text screening stage. PRISMA flowchart documents the screening process (see Figure 1). Fourteen papers were identified as eligible for inclusion.

Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram for Search Outcomes and Screening.



Data Extraction and Quality Assessment

Data were extracted by the primary author and transferred unto a data extraction sheet which was created and piloted before use. The following details were extracted: (1) study characteristics including study design and co-production definition if included (table 1); (2) intervention characteristics including intervention type and study outcomes (table 2).

Table 1: Study Characteristics

Author (Year)	Study Aims / Purpose	Design and Methods (inc. measures used to assess suicide risk/behaviour)	Focus population of intervention	Age range	Community setting	Quality Assessment Rating
Bruce & Pearson (1999) Country: US	To describe the aims and methodology to be used to test and evaluate the PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) intervention, a model of depression recognition and treatment aimed at preventing and reducing suicide among older adults.	Descriptive paper, including a fictional case study, which describes a longitudinal study design planned to be used to test and evaluate the PROSPECT intervention. Proposed use of the Centers for Epidemiologic Studies Depression (CESD) scale to screen potential participants for depression during recruitment. Eligible participants would undergo further in-person assessment for depression and other clinical, neuropsychological, and social variables. Telephone follow-ups at 4- and 8-months and bi-annual administration of the full research assessment battery proposed. It is unclear what measures would determine depression- and suicide-related risk/behaviours beyond screening participants for inclusion.	Community-dwelling elderly depressed primary care patients from 18 sites within 3 geographical areas in the US were the focus population, with collaborative working between physicians and health care specialists.	Focus population age range: 780 aged 60 - 74 years and 600 aged 75 years and over.	18 primary care sites located in 3 geographical areas.	*MMAT = 20% **QuADS Q = 1
Buus et al., (2019) Country: Australia & Denmark	To examine stakeholders' suggestions and contributions to the design, function, and content in the development of an existing app called MYPLAN aimed towards individuals in or at risk of suicidal crisis.	An instrumental case study involving qualitative study using focus groups and participatory workshops.	People in, or at risk of suicide crisis. Study participants, including MYPLAN app users, relatives, and clinicians, worked collaboratively with the researchers and software developers revised the app.	Reported mean age range of participants: 16 to 46 years.	Online – A Safety planning mobile phone app.	*MMAT = 80% **QuADS Q = 2

Cheng et al., (2020) Country: Hong Kong	Aimed to investigate the impacts of promoting suicide prevention using social media and to evaluate the co-creation process involving a popular YouTuber.	Mixed methods. Qualitative analysis of the co-creation process in the development of a YouTube suicide prevention short film. Video statistics (e.g., views) generated online, an online survey, and online public comments evaluated video impact and effectiveness. Suicide risk/behaviours assessed within the online survey using two questions about suicide thoughts in the past 12-months and help-seeking.	Social media users (e.g., YouTube)	Viewers of the YouTube short film ages ranged from 13 - 44 years. Respondents to an online survey - ages are reported to have ranged from 12 to below 65 years.	Online - You-tube video	*MMAT = 80% **QuADS Q = 1
Chopra et al., (2022) Country: UK	Aimed to evaluate the effectiveness of James' Place Model and to conduct a social value assessment of the service to provide an understanding of the potential social, economic, and environmental impact of James' Place.	Case series study involving quantitative assessment of James' Place Model effectiveness. Suicide risk assessment conducted collaboratively between a therapist and service user with a safety plan, CORE-OM self-report questionnaire, referrer evaluation of precipitating factors (e.g., relationship breakdown) and therapist assessment of various psychological, motivational, and volitional factors (e.g., entrapment, perceived burdensomeness).	Adult men experiencing suicidal crisis.	Adults aged 18 years and older.	Community-based, face-to-face.	*MMAT = 80% **QuADS = 1
Ferguson et al., (2021) Country: Australia	This study aimed to explore the perspectives and experiences of workers providing case management, support, or counselling to refugee and asylum seeker clients on co-developed personalised safety plans.	Qualitative study involving semi-structured interviews with workers from non-government organisations providing case management, support or counselling to refugees and asylum seekers.	Refugees and asylum seeker clients.	Age not given	Unclear	*MMAT = 100% **QuADS = 1

Hetrick et al., (2018) Country: Australia	This study aimed to co-design with young people a mobile phone app-based self-monitoring mood tool that facilitates communication of this with a clinician.	Participatory design and studio design method was used in the development of the app which followed human-centred principles. This involved workshops and focus groups with young people and clinicians.	Young people experiencing depression	Young people aged 18-24years	Online community	*MMAT = 100% **QuADS = 3
Richardson et al., (2013) Country: Ireland (both Northern & Southern Ireland)	The Young Men and Suicide Project (YMSP) aimed to develop a range of mental health initiatives to promote positive mental health among young men in Ireland, and to assess the efficacy of these.	Mixed methods involving a literature review to identify best practice, online surveys with stakeholders including community-based services, education services and prisons, and focus groups service providers and men to understand what works with young men in mental health service provision. Findings informed development and piloting of two initiatives called "Mind Yourself" and "Work out". Pre- and post-measures of self-esteem, depression, and resilience were assessed in the Mind Yourself programme. Validated psychometric tests (e.g., six items from the General Health Questionnaire-12 (GHQ-12)) taken pre-, during, and post-intervention in the 'work out' programme assess changes in mental fitness.	Young men	Northern Ireland initiative targeted adolescents (age not specified) Sothern Ireland initiative targeted young men (age not specified)	School Online	*MMAT = 60% **QuADS = 2
Saini et al., (2020) Country: UK	This study aimed to evaluate the effectiveness of the James' Place Model on reducing suicidality in men using the service; and to conduct a social value assessment of the service to provide an	Mixed methods. Qualitative methods included semi-structured interviews with men who had used the service and written responses to interview questions from a GP. Quantitative analyses of pre- and post-outcome data. Quantitative and qualitative findings were	Adult men experiencing suicidal crisis.	18 years and older	Community-based, face-to-face delivery of a suicide prevention model.	*MMAT = 100% **QuADS = 1

	understanding of the potential social, economic, and environmental impact of James' Place.	triangulated to understand the wider social value of James' Place. Suicide risk assessment conducted collaboratively between a therapist and service user with a safety plan, CORE-OM self-report questionnaire, referrer evaluation of precipitating factors (e.g., relationship breakdown) and therapist assessment of various psychological, motivational, and volitional factors (e.g., entrapment, perceived burdensomeness).				
Saini et al., (2021a) Country: UK	This study aimed to evaluate the effectiveness of the James' Place Model on reducing suicidality in men over a two-year period and to compare the findings pre- and post-COVID19 pandemic.	Mixed methods. Semi-structured qualitive interviews with therapists. Quantitative analyses of pre- and post-CORE-OM outcome data to assess the effectiveness of the James' Place Model. Suicide risk assessment conducted collaboratively between a therapist and service user with a safety plan, CORE-OM self-report questionnaire, referrer evaluation of precipitating factors (e.g., relationship breakdown) and therapist assessment of various psychological, motivational, and volitional factors (e.g., entrapment, perceived burdensomeness).	Adult men experiencing suicidal crisis.	18 years and older	Community-based, face-to-face service temporarily moved to online delivery during the covid-19 pandemic.	*MMAT = 100% **QuADS = 1
Saini et al., (2021b) Country: UK	Aimed to evaluate an innovative suicidal crisis intervention for younger (18-30 years) versus older men (31 years and older).	Case series study involving quantitative assessment CORE-OM scores and clinical records of psychological, motivational, and volitional factors associated with participants suicidal crisis and CORE-OM scores.	Adult men experiencing suicidal crisis.	18 years and older (age range 18-66 years)	Community-based, face-to-face delivery of a suicide prevention model.	*MMAT = 40% **QuADS = 3

		Suicide risk assessment conducted collaboratively between a therapist and service user with a safety plan, CORE-OM self-report questionnaire, referrer evaluation of precipitating factors (e.g., relationship breakdown) and therapist assessment of various psychological, motivational, and volitional factors (e.g., entrapment, perceived burdensomeness).				
Thorn et al., (2020) Country: Australia	This study aimed to improve dissemination of and engagement with the #Chatsafe guidelines by including young people in the design and development of a social media campaign to promote safe web-based communications about suicide. Objectives of the study were to document key elements of the co-design process, evaluate young people's experiences of the co-design process and capture young people's recommendations for the #Chatsafe suicide prevention campaign.	Mixed methods. Participatory co-design approach involving 11 workshops with young people. Workshop activities included a warm-up, co-design activities evaluation and cooldown. At the end of each workshop participants were invited to complete a quantitative evaluation survey including questions on demographics, perceived benefits from participation, and workshop acceptability and safety. Safety protocols (e.g., wellness plan) and monitoring (e.g., workshop evaluation survey/debrief) were included.	Young people accessing the web	17 - 25 years	Online community	*MMAT = 80% **QuADS = 3
Wilcock et al., (2019) Country: UK	Evaluation of the Offload programme, a men's rugby-league community-based mental health programme.	Mixed methods involving pre-and post-intervention questionnaires (n = 699) exploring aspects related to health and wellbeing (e.g., resilience, social support). Also, focus groups and case studies with men who engaged with the Offload programme.	Community, sport-based intervention for men experiencing mental health illness (anxiety and depression) to prevent developmental of	Men aged 16 years or older	Community-based	*MMAT = 60% **QuADS = 3

		Provision was available to assess men using the Patient Health Questionnaire-9 (PHQ9) and/or General Anxiety Disorder scale (GAD7) if facilitators delivering the intervention were concerned about a participant's wellbeing. Facilitators were also able to seek advice from a mental health clinician. These measures were not routinely given for the assessment of suicidal risk/behaviours. Men did however self-report mental health conditions/diagnoses.	complex mental illness and suicide.			
Wilcock et al., (2021) Country: UK	This study aimed to explore stakeholder perspectives of the key design characteristics, and the roles played by delivery staff in the conception and development of a community-based men's rugby mental health programme called Offload.	Qualitative study involving one-to-one semi-structured interviews with 18 programme designers and delivery staff.	Community, sports-based intervention for men experiencing mental health illness (anxiety and depression) to prevent developmental of complex mental illness and suicide.	Intervention targets men aged 16 years or older.	Community-based	*MMAT = 100% **QuADS = 2
Zealburg et al., (1992) Country: US	To describe the development of the collaboration between emergency psychiatric services and the police.	Descriptive paper outlining development of a mobile crisis program involving collaboration between emergency psychiatric services and the police, which includes case studies to illustrate collaboration. It is unclear how suicidal risk/behaviours were determined. However, it appears this involved a subjective or clinical assessment (e.g., a clinical history) of the situation made by police and/or psychiatric team members responding to incidents.	Community population experiencing psychiatric crisis.	Age of focus population not specified.	Community-based.	*MMAT = 40% **QuADS = 1

*MMAT refers to the mixed methods appraisal tool[36] **QuADS Q refers to the question derived from the quality assessment with diverse studies quality assessment tool[37]

Table 2: Intervention Characteristics

Study Author (year)	Intervention Details	Co-Production Methodological Approach	Co-production and/or suicide-related outcomes
Bruce & Pearson (1999)	Delivery of a comprehensive treatment algorithm for depression adapted from the Agency for Health Care Police and Research (AHCPR) guidelines. Anti-depressant therapy, or Interpersonal Therapy (IPT) if antidepressants were unwanted by the patient, was to be recommended. A health specialist (e.g., nurse, social worker, or clinical psychologist) was to “prompt” physicians to facilitate timely and recommended treatment decisions by advocating for patients (e.g., obtaining and feedbacking information on patient symptoms and treatment experiences to the physician). Education was also to be provided to patients, families and physicians on depression and suicide ideation. However, it is unclear who delivered this aspect of the intervention.	Collaboration between a health specialist (e.g., nurse, social worker, or clinical psychologist) and physician to facilitate timely and targeted identification and treatment of depression among older adults. It was proposed the health specialist would liaise with the patient, help the physician to recognise depression and make treatment recommendations within the remit of the PROSPECT intervention guidelines based upon patient information/monitoring, and encourage treatment adherence among patients.	No co-production outcomes(s) provided. Outcomes proposed to assess the effectiveness and impact of the intervention relate to depressive symptomatology (e.g., suicide ideation, hopelessness, depression, and suicidal risk behaviours including substance abuse and disturbed sleep). Authors estimated 18% of participants would experience depression at baseline. No evaluation of suicide-related outcomes provided.
Buus et al., (2019)	App based intervention called MYPLAN combining three preventative strategies around safety planning, help-seeking from peers and professionals, and restriction of access to lethal means. An additional feature promotes help-seeking behaviour by including a map and directions to an emergency room nearest to the users' location.	Focus groups and participatory workshops were used to further develop the MYPLAN intervention. This involved engagement between participants, software developers and researchers in the design, evaluation, and revision of MYPLAN app prototypes in response to participant feedback. Emphasis was placed upon personal experiences of using MYPLAN and evaluation of its wireframe, functionality and whether the app was culturally suited to an Australian user audience. Software developers revised and developed prototypes in response to user feedback.	Thematic analysis led to the development of 3 phases of user-involvement in the development of the MYPLAN app relating to "suggestions of core functions", "refining functions" and "negotiating finish". Increased participant engagement with researchers and software developers during the later stages of user-involving processes as the app became increasingly revised. The revised MYPLAN app included the suicidal ideation attributes scale (SIDAS) to measure suicide ideation, a mood ratings tracker, and a customisable list of personal warning signs of crisis. No evaluation of the impact of the intervention upon suicidal risk/behaviours reported.

Cheng et al., (2020)	Short film designed to reduce suicidality and promote help-seeking behaviours. The storyline of the film focused upon a suicidal university student and a taxi driver who encourages the former to seek help. Also featured is an obscured scene of a suicide method (hanging).	Co-creation of a YouTube short film involving a popular YouTuber and researchers. To inform this process, the YouTuber engaged with literature, online material, and staff and clients from a local suicide survivor service.	Thematic analyses of the co-creation process identified three facilitating factors of "shared concern about youth suicide prevention", "enriched knowledge of lived experience with suicide" and "preserve the uniqueness of the YouTuber", and one barrier "the balance between realism and appropriateness of content”. Overall, positive perceived changes in audience suicide prevention knowledge, attitudes, and behaviours reported. Mixed views received from qualitative feedback and public comments. Some respondents who had suicidal thoughts and provided qualitative feedback (n = 22) reported the storyline resonated with their situation (e.g., academic and life stress; n = 6), one felt the film helped to alleviate stress, and another that it motivated them to live. Three respondents criticised the film. Public comments (n = 164) generally supported the film (e.g., 10.8% showed support to people in distress). Eight commentators reported past suicidal thoughts, four had attempted suicide. Two commentators with suicide intent reported abandoning their suicide plans after watching the film. One commentator displayed current suicidal thoughts and another endorsed suicide as an option.
Chopra et al., (2022)	A community-based suicide prevention intervention underpinned by three prominent suicidal theories (interpersonal theory of the suicide, collaborative assessment and management of suicidality, and integrated motivational-volitional theory of suicide). Emphasis is on the therapist and service user co-producing the therapeutic intervention together. Brief therapeutic approaches and interventions (e.g., behavioural activation, sleep hygiene) focussed upon reducing suicidal distress and developing resilience and coping are delivered.	Co-production of the suicide prevention intervention and safety planning with men engaged in the service and therapists delivering the James’ Place Model. Co-production with stakeholders (including academics, clinicians, commissioners, therapists, and experts-by-experience) also informed service inception, design, and delivery.	Feedback evaluations completed by 18% of men (39/212) indicated the James’ Place service was perceived as a safe and welcoming therapeutic setting and improved overall mental wellbeing and coping. No formal evaluation of co-production reported. Significant mean reduction in CORE-OM scores for men who completed assessment and discharge questionnaires. No relationship found between the precipitating factors and levels of general distress, or between those with or without each precipitating factors.
Ferguson et al., (2021)	To explore the perspectives and experiences from workers who provide case management, support, or counselling to	Co-production discussed in context of co-creating safety plans. Theme from worker interviews, “safety planning as a co-created, personalised activity”	Four themes developed: “Safety planning as a co-created, personalised activity for the client”; “therapeutic benefits of developing a safety plan”; “barriers to engaging in safety planning”; and “strategies to enhance safety planning

	refugee and asylum seeker clients on co-created personalised safety plans.	highlights the workers perspectives that safety planning should be a collaborative process and personalised to the individual.	engagement". Overall, these highlight the perceived facilitators, barriers, and strategies to enhance safety planning as a suicide prevention intervention for refugees and asylum seekers. Benefits of co-production reported included equitable working relationship between the client and worker, recognition of the client's expertise, flexibility and creativity to tailor and co-creation safety planning using alternative modes (e.g., photographs, drawings). Perceived therapeutic benefits of co-created safety planning included increased awareness of distress triggers among clients and coping strategies, use of personalised strategies to interrupt suicidal thoughts, and normalisation of their suicidal experience. No formal evaluation of suicide-related outcomes provided.
Hetrick et al., (2018)	Development of a mobile phone app designed to enable monitoring of mood with feedback for users and clinicians. Users able to customise the app to suit their preferences. Features included mood monitoring (named "wellbeing checker") with space to record factors influencing users mood; brief personalised interventions to support young people in the time between face-to-face appointments linked to the wellbeing tracker such as distraction techniques to reduce stress (e.g., meditation, games and breathing techniques) and a photo album to promote positive emotion (e.g., photos, supportive messages from friends and loved ones, music playlists); lastly, a one-touch safety feature enabling users to contact emergency services and their supporters.	Co-design workshops with young people and two focus groups with clinicians designed to elicit information sharing and generation of concepts for the app. Young people sketched design features of the app and gained feedback from the group on their individual design. The group created a design using the best ideas from individual designs in a process called feature prioritisation. This informed subsequent co-design rounds until consolidation of best ideas resulted in the final design. Clinicians proposed their needs and concerns of monitoring young people using an app before the co-design workshops took place. In a second focus group with clinicians a young person involved in the co-design workshops presented the app wireframes, and clinician feedback gained on the app design and its use in practice.	Various app features supported co-production between the app-user and clinician (e.g., the onboarding process, tailoring of trigger points within the wellbeing checker). The wellbeing tracker mood rating function incorporated trigger points for high distress to assess suicide risk/behaviours. No formal evaluation of the effectiveness of the app in reducing suicidal risk/behaviours was reported, but it was proposed that it could enhance help-seeking.
Richardson et al., (2013)	Northern Ireland: "First Instinct" a whole community approach, aimed to encourage help-seeking among the young men. This	Various components of intervention design, development and delivery involved co-production. An advisory	Facilitators of Mind Yourself perceived the programme as effective, but some barriers identified (e.g., literacy issues hindering questionnaire completion). Positive feedback

	involved development of the "Mind Yourself" brief mental health intervention; young men's advisory/reference group; training programmes for practitioners focused upon developing work with men; and creation of a 'working with men' resource library offering off-the-shelf resources for practitioners. Southern Ireland: "Work Out", a mental fitness app, was developed which aimed to improve help-seeking, social connectedness, and mental health literacy. Comprised of a series of brief online interventions (called "missions") and underpinned by cognitive behavioural therapy principles which aimed to address four areas: being practical, building confidence, taking control and being a team player.	group of key men's health and suicide prevention representatives supported and overseen intervention development. Local stakeholder (e.g., from community-based services, education services, prisons, and young men) views on the extent and nature of mental health/suicide prevention initiatives for young men in Ireland, and the perceived facilitators and barriers of working with young men elicited through surveys and focus groups informed intervention development. Northern Ireland: Local community members delivered the Mind Yourself programme. A young men's advisory forum/reference group was set up by staff from a local organisation and involved local youth leaders as 'co-workers' as facilitators in its delivery. Southern Ireland intervention development involved collaborative working between developers of the Irish version of 'work out' (a mental health service provider) and developers of the Australian version. Focus groups involving young men provided feedback on 'Work out' during intervention development and testing.	from the young men advisory/reference group reported suggesting participants reflected positively upon their involvement (e.g., welcomed the opportunity to focus on issues affecting men in an equitable way with other stakeholders). Mind Yourself evaluation showed no significant change in pre- and post-measures of self-esteem, depression, and resilience. Feedback suggested Work Out was perceived as acceptable and accessible. No suicide-related outcomes reported.
Saini et al., (2020)	A community-based suicide prevention intervention underpinned by three prominent suicidal theories (interpersonal theory of the suicide, collaborative assessment and management of suicidality, and integrated motivational-volitional theory of suicide). Emphasis is on the therapist and service user co-producing the therapeutic intervention together. Brief therapeutic approaches and interventions (e.g., behavioural activation, sleep hygiene) focussed upon reducing suicidal distress and	Co-production of the suicide prevention intervention and safety planning with men engaged in the service and therapists delivering the James' Place Model. Co-production with stakeholders (including academics, clinicians, commissioners, therapists, and experts-by-experience) also informed service inception, design, and delivery.	Elements of co-production was evident in the design and delivery of the James' Place Model. For example, men spoke of the utility of the "lay your cards on the table" component for exploring factors underpinning their suicidal crisis and for exploring coping strategies, and described improved mood, motivation, and family relationships. No formal evaluation of co-production provided. Impact of the intervention on suicidal crisis evaluated using CORE-OM scores. Initial overall mean CORE-OM score on entry to the service reported as 85.5 (n = 137) and mean overall discharge score reported as 38.9 (n= 60). Mean reduction in CORE-OM scores reported as 46.6. Psychological factors relating men's suicidality (e.g.,

	developing resilience and coping are delivered.		impulsivity, thwarted belonginess, hopelessness) reported. No relationship between precipitating factors (and general distress levels found at initial assessment, or between those with and without each precipitating factors found.
Saini et al., (2021a)	A community-based suicide prevention intervention underpinned by three prominent suicidal theories (interpersonal theory of the suicide, collaborative assessment and management of suicidality, and integrated motivational-volitional theory of suicide). Emphasis is on the therapist and service user co-producing the therapeutic intervention together. Brief therapeutic approaches and interventions (e.g., behavioural activation, sleep hygiene) focussed upon reducing suicidal distress and developing resilience and coping are delivered.	Co-production of the suicide prevention intervention and safety planning with men engaged in the service and therapists delivering the James' Place Model. Co-production with stakeholders (including academics, clinicians, commissioners, therapists, and experts-by-experience) also informed service inception, design, and delivery.	Co-production evidenced within therapist interviews in the management of men engaged in the service during remote delivery of the James' Place Model. Formal evaluation of co-production was not assessed. Impact of the intervention on suicidal crisis evaluated using CORE-OM scores. Evaluation of two-year intervention effectiveness showed initial overall mean CORE-OM score on entry to the service reported as 86.56 (n = 322) and mean overall discharge score reported as 35.45 (n= 145). Mean reduction in CORE-OM scores reported as 50.9. Evaluation of CORE-OM scores suggested the James' Place model was as effective, if not more, during COVID19.
Saini et al., (2021b)	A community-based intervention underpinned by three prominent suicidal theories (interpersonal theory of the suicide, collaborative assessment and management of suicidality, and integrated motivational-volitional theory of suicide). Emphasis is on the therapist and service user co-producing the therapeutic intervention together. Brief therapeutic approaches and interventions (e.g., behavioural activation, sleep hygiene) focussed upon reducing suicidal distress and developing resilience and coping are delivered.	Co-production of the suicide prevention intervention and safety planning with men engaged in the service and therapists delivering the James' Place Model. Co-production with stakeholders (including academics, clinicians, commissioners, therapists, and experts-by-experience) also informed service inception, design, and delivery.	A clinically significant reduction in mean CORE-OM scores between assessment and discharge for both younger and older men engaged with the James' Place Model intervention reported. No significant difference in distress scores between younger versus older men at assessment and discharge. However, younger men showed lower levels of distress compared to older men at initial assessment and lower levels of wellness than older men at discharge. No formal evaluation of co-production. Assessment of psychological, motivational, and volitional factors reported. Younger men were less affected by entrapment, defeat, not engaging in new goals, and positive attitudes towards suicide than older men at assessment. Older men at discharge were significantly more likely to have an absence of positive future thinking, less social support, and entrapment than younger men.
Thorn et al., (2020)	A social media campaign aiming to promote safe web-based communication about suicide.	An iterative process of co-design whereby learning from workshops informed the next workshop. Workshop facilitators (e.g., researchers and designers) guided design activities. Co-design activities facilitated peer-to-peer	Overall, co-design workshops were perceived by participants as acceptable, beneficial, and safe, although some participants reported feeling suicidal (n = 8) or unsure whether they felt suicidal (n = 6) after workshops. Findings support the feasibility of safe involvement of young people in the development of co-designed

		mapping of young people's social media usage and communication of suicide on the web, idea generation (e.g., campaign themes and content) and testing and feedback on design protocol for the campaign. Three key elements comprised the co-design process: 1. "Define" - involved mapping young people's social media usage, their communication about suicide, and determined how young people wanted #Chatsafe guidelines to be integrated into the campaign; 2. "Design" involved integrating young people's perspectives and addressing their wants and needs in the campaign development including campaign themes and delivery methods; 3. "User-testing" involved prototype testing and gaining feedback. A collaborative approach ensured participant safety (e.g., a researcher accompanied distressed participants to a private space to enact the young person's wellness plan).	recommendations (e.g., content and format) for a web-based suicide prevention campaign to enhance its acceptability among young people. Positive outcomes of feelings of improved ability to communicate online about suicide and to identify others who may be at risk of suicide were reported.
Wilcock et al., (2019)	Ten-week, education-based intervention which uses the rugby league brand to address low level mental health problems (e.g., low self-esteem, depression, and anxiety). Rugby-related language is used to normalise mental health, promote intervention accessibility, acceptability, engagement, and adherence. Comprised of 10 sessions (called "fixtures") aimed at raising awareness of mental health problems (e.g., low self-esteem, anxiety, depression), tackling stigma, and encouraging the development of coping strategies. Sessions were comprised of two, 40-minute halves.	Coproduction is evident in the design and delivery of Offload. The design phase involved collaborative working partnerships between Rugby League Cares, State of Mind, three Rugby League Club's charitable foundations (Salford Red Devils Foundation, Warrington Wolves Foundation and Vikings Sports Foundation), and over 200 men from the targeted population who participated in interviews, focus groups and questionnaires exploring their views of mental health intervention provision. Findings from men's participation informed the intervention name, where (i.e., from rugby stadiums) and when the intervention is delivered, language used (i.e., rugby-centric) and	The co-produced programme content was perceived as more relatable. Accessibility, use of non-clinical language and informal setting (i.e., rugby league stadiums) were perceived to encourage help-seeking and to remove stigma. Additional reported benefits include increased confidence and self-esteem, improved coping, social connectedness, increased social support, willingness to talk about mental health and reduced suicide ideation and/or attempts. Pre- and post-intervention questionnaire findings showed positive improvement in nine outcomes reported relating to areas including coping, resilience, engagement in sport and identification of support around the men. For example, approximately three-quarters of participants reported improved awareness of how to look after their health and wellbeing, coping, and better able to manage setbacks and challenges.

		content of the intervention (e.g., type of self-care tools to use). Foundation managers/lead, formers players and coaches, officials, mental health, and mindfulness specialists were involved in delivery of Offload.	
Wilcock et al., (2021)	Ten-week, education-based intervention which uses the rugby league brand to address low level mental health problems (e.g., low self-esteem, depression, and anxiety). Rugby-related language is used to normalise mental health, promote intervention accessibility, acceptability, engagement, and adherence. Comprised of 10 sessions (called "fixtures") aimed at raising awareness of mental health problems (e.g., low self-esteem, anxiety, depression), tackling stigma, and encouraging the development of coping strategies. Sessions were comprised of two, 40-minute halves.	Coproduction is evident in the design and delivery of Offload. The design phase involved collaborative working partnerships between Rugby League Cares, State of Mind, three Rugby League Club's charitable foundations (Salford Red Devils Foundation, Warrington Wolves Foundation and Vikings Sports Foundation), and over 200 men from the targeted population who participated in interviews, focus groups and questionnaires exploring their views of mental health intervention provision. Findings from men's participation informed the intervention name, where (i.e., from rugby stadiums) and when the intervention is delivered, language used (i.e., rugby-centric) and content of the intervention (e.g., type of self-care tools to use). Foundation managers/lead, formers players and coaches, officials, mental health, and mindfulness specialists were involved in delivery of Offload.	Thematic analysis generated three themes reflecting the importance of co-production in the co-design of the intervention: "tacit forms of knowledge are essential to initial programme designed"; "stigma-free and non-clinical environments appeal to and engage men"; and "lived experience and the relatability of personal adversity". Co-production was perceived to improve intervention reach and engagement by using non-stigmatising language and delivering the intervention in a non-judgmental, non-clinical environment. Delivery of solution focused activities delivered by men with lived experience was perceived to promote relatability and trustworthiness. Suicide-related outcomes were not formally evaluated. Delivery of the intervention by former professional sportspeople who recalled their lived experience of mental illness/adversity was perceived to possibly promote modelling of alternative masculine behaviours which could potentially enhance mental health and help-seeking.
Zealburg et al., (1992)	An emergency psychiatry-mobile crisis program linking key professionals, specifically mental health professionals (e.g., Master's-level clinicians in nursing, counselling, psychology, social work) with the police to provide mobile, crisis intervention. Clinicians supported police officers in a consultative role during police incidences involving people experiencing serious mental health illness. Clinicians would obtain a history from the individual,	Collaboration between the police and clinicians allowed clinicians to liaise with the individual experiencing crisis to encourage a peaceful resolution to specific situations. This was facilitated through regular meetings with law enforcement officials, reclarification of mutual responsibilities and expectations, and reviewing of critical situations. This partnership was further affirmed through debriefing of police	Outcomes reported relate to 3 case studies and involve de-escalation of police incidents with individuals experiencing crisis.

	neighbours, family and friends, drug and alcohol use, establish trust and therapeutic alliance with the individual. Details on three case studies are provided and intervention techniques, for example developing a rapid therapeutic alliance with a woman threatening to jump from a ledge and holding her there while police assembled a safety net below.	officers following incidents, providing mental health referrals for police officers, and being informal consultants.	

Results

The PRISMA diagram (figure 1) illustrates the screening process. Five hundred and ninety papers were identified through searching databases (n = 442) and other methods (148). After removal of duplications and non-relevant papers (e.g., book titles, conference submissions), Four hundred and forty-nine titles and abstracts were screened. Of those, thirty-three papers were retrieved for full text screening. Fourteen studies met the inclusion criteria.

Description of Studies

Table 1 provides a description of the characteristics of included studies. Studies either fostered a qualitative (n = 6), mixed methods (n = 6) or quantitative design (n = 2). Notably, some studies (n = 5) focused upon the delivery of suicide prevention interventions online, including via apps (e.g., mobile phone apps) (n = 3), YouTube (n = 1) or to inform safe online web-based communications (n = 1). Most of the remaining studies were community-based and delivered the intervention face-to-face (n = 9). Most studies focussed upon suicide prevention among younger to older adults aged 16 years or older (n = 10). One study targeted older adults aged 60 years or older (n = 1), another focussed upon intervention delivery for adolescents and young men (n = 1), and two studies did not stipulate the age of the target population (n = 2).

Methodological Quality

The Mixed Methods Appraisal Tool (MMAT)[36] and an additional question taken from the Quality Assessment with Diverse Studies (QuADS) quality assessment tool[37] to evaluate stakeholder inclusion through co-production, was used to assess methodological quality. All studies were independently assessed by the first author (CH) and last author (PS) independently assessed the quality of 10% of included studies. MMAT revealed a range in methodological quality assessment (see Table 1). However, most studies assessed were

of high-quality, with nine studies scoring 80 to 100%. Studies scored low to moderate in quality in terms of co-production inclusion, appraised using the QUADS as described. No studies were excluded from this review based on quality assessment.

Synthesis of Findings

Findings were synthesised to produce a narrative summary describing the role of co-production in community-based suicide prevention interventions.

Definition and Operationalisation of Co-production

Half of the studies directly refer to co-production as a methodological approach in the design of the suicide prevention intervention.[38-39,41-43,45-46] None of the studies provide an explicit definition of co-production. Rather, most individual studies were found to integrate key elements of co-production within the design and/or delivery of an intervention by involving stakeholders, representing the diverse modes in which co-production can be applied. All studies featured stakeholders working collaboratively towards some shared goal as a function of co-production. Most studies mention stakeholder involvement in the development and design of suicide prevention interventions (n = 13). In five studies[40,44-47] stakeholders, including health professionals and those with lived experience, delivered the suicide prevention interventions. Also in five studies, those trained to deliver the suicide prevention intervention worked collaboratively with the recipient, adapting the intervention (e.g., safety plans and talk therapy) to suit their individual needs.[38-39,41-43] A diverse range of stakeholders participated in the studies. Stakeholders included health professionals, clinicians, mental health specialists, police officers[38-49], community representatives including sporting representatives (e.g., ex-rugby players) and community leaders[38,40-43,45-46], YouTuber[50], those that are representative of the targeted population and/or with lived experience.[38,40-43,45-46,48-51]

Facilitators of co-production

Stakeholders mainly engaged through an iterative process to elicit their perspectives on functional aspects and/or content of the design and development of the suicide prevention intervention (n = 13). This was facilitated either through focus groups / workshops[40,45-46,48-49,51] and/or one-to-one discussions with stakeholders including researchers, those with lived experiences and a YouTuber.[38-39,41-43,45-46,50] Seven studies[38-39,41-44,47] integrated co-production that was discursive in nature between key partners during delivery of the suicide prevention intervention. In Bruce and Pearson's[44] study, a health professional was nominated to advocate for the patient and to assist physicians in the recognition of depression to allow timely intervention. In contrast, discussions around the intervention and to troubleshoot potential problems that may occur during implementation were held between local police agencies prior to and during intervention delivery in Zealburg et al.,.[47] Conversely, co-production informed service design and delivery of four studies focusing upon a suicide prevention intervention for men experiencing suicidal crisis.[38,41-43] Co-production was integrated in the creation of personalised safety plans for asylum seekers and refugees.[39]

Discussions acted as a forum for rapport building, enabling improved collaboration between diverse professional disciplines and people with lived experience. For example, Zealburg et al.,[47] attribute *"prior working discussions"* with local police agencies to redressing problems and building trust within the collaborative working relationship, a key factor in the successful implementation of their suicide prevention intervention. Studies identified that discussions among stakeholders provided an opportunity for negotiation and consensus seeking when addressing disagreements that may arise during intervention development or delivery.[40,47-50] Cheng et al.,[50] report researchers expressed concern over the inclusion of a suicide scene of hanging in the co-creation of a suicide prevention video with a YouTuber for example. The YouTuber felt inclusion of this scene was imperative to maintaining authenticity of the video's storyline. However, the YouTuber adapted the scene once the researchers explained the potential for contagion effects.

Challenges of co-production

The evidence highlights some challenges that may hinder the inclusion of co-production in the design and/or implementation of suicide prevention interventions. During co-production, both parties must be willing to engage when working collaboratively. This issue is highlighted in Ferguson et al.'s[39] study exploring the views and perspectives of workers supporting asylum seekers and refuges in the co-creation of safety planning. Workers perceived a lack of "client readiness" to engage in safety planning (e.g., unwillingness to write a safety plan down) as a potential barrier hindering the co-production of personalised safety planning.

A reluctance of professionals to relinquish power was evident. Hetrick et al.,[48] reported clinician resistance towards the inclusion of service users in shared decision making and accessing a mobile App (mApp). Similarly, Buus et al.,[49] reported software designers included a suicidality rating scale against the wishes of stakeholders involved in the design and development of an mApp. Conversely, three studies emphasise the importance of each stakeholder maintaining the boundary of their individual area of expertise when working in partnership.[47-49] Failure to do so could affect the safety of professionals and service users during intervention delivery[47] and unduly burden parents/clinicians with notifications alerting them to the suicidality risk of their child/patient[49], particularly out of working hours.[48] Some safeguarding concerns were highlighted. These centred around whether participation may have induced suicidal feelings.[50-51] Also, the implications of clinicians being alerted to client suicidality out of hours and not being able to report this.[48] Similarly, Thorn et al.,[51] highlight some challenges of gaining ethical approval to undertake co-productive methodologies in suicide prevention research, and the additional burden on resources that safety protocol development and the monitoring of stakeholder wellbeing may have.

Benefits of Co-production

Integrating co-production within the methodological approaches provided opportunity for knowledge sharing between partners to create new knowledge which could be applied to

shape aspects of the suicide prevention intervention design and/or delivery. Areas of new knowledge included identification of gaps in existing suicide prevention approaches, the adaptation of suicide prevention interventions to better suit intervention user needs, and to improve reach among the targeted population. For example, Thorn et al.,[51] used new learning generated in stakeholder workshops to inform the schedule of subsequent workshops during the design and development of a suicide prevention campaign associated with the #Chatsafe project to improve reach among the targeted population.

The consultation of stakeholders, whether they have professional or lived experience expertise, encourages consideration of suicidality and suicide-related risk factors through a different lens. Including stakeholders with lived experience promotes reaching back to gain deeper understanding of the issues that matter, informing the adaptation of suicide prevention interventions to suit the needs and preferences of their targeted population. This effect is reported within eleven studies.[38-43,45-46,48-49.51] Richardson et al.,[40] undertook an extensive consultative process involving an advisory group, with the views of service providers and young men considered. This revealed to the researchers' issues men experience that may pose them at risk of suicide such as "*resistance to connection*" and "*stigma attached to mental illness and mental health*" and ways to better engage and reach young men within community settings. This acquired new learning informed intervention development that engaged community partnerships and young men from the targeted population. For example, "*train the trainer*" within the Mind Yourself intervention enabled facilitators to consider different ways of engaging the targeted population prior to formal delivery. Similarly, in setting up a suicide prevention service for men, diverse stakeholder views informed service inception, design and delivery of James' Place reported in Chopra et al.,[38] and Saini et al.,.[41-43]

New knowledge acquired through stakeholder involvement led to intervention development with content adapted to suit the targeted population. Buus et al.,[49] described how participants involved in the co-design adapted features of their mApp-based suicide prevention intervention. This included mood descriptors that could be customised by the user and changes non-clinical language used to describe core functions of the app (e.g.,

"warning signs" was changed to "wellbeing checker"). This is also evident in the delivery of the James' Place Model, where co-production is used to tailor the suicide prevention intervention to suit the individual needs of men.[38,41-43] Similarly, Ferguson et al.,[39] reported that participants in their study recognised individuals as being the expert of their own life when co-creating and co-developing safety plans with refugees and asylum seeker clients. Also, the rugby-themed Offload programme[45-46] was perceived as more relatable as it was delivered by those with lived experience of mental health conditions, used non-clinical language and was implemented within an informal, non-clinical environment (i.e., Rugby stadiums). In this sense co-production provides voice and autonomy in decision making for individuals accessing a suicide prevention intervention.

Outcomes Associated with Co-produced Community-based Suicide Prevention Interventions

Eleven studies reported participants gaining positive and enriching experiences from their involvement in co-production-based methodologies irrespective of the nature of this involvement (e.g., co-design, co-production of the suicide prevention intervention etc.). These included beneficial/suicide literacy[51], enthusiasm[48], therapeutic benefits including normalising suicidal experiences and being able to identify unique triggers and coping strategies[39], rapport and trust building[47], enriching process[50], sharing of experiences in focus groups/debrief[49], receiving psychological support within a safe and supportive therapeutic environment[41], improved relationships, coping and understanding of health and wellbeing needs[45] and being involved in decision making process alongside the therapist during the co-production of therapy.[38,41-42]

A lack of formal evaluation of outcomes associated with the suicide prevention intervention is evident. This is likely in part due to the type of studies included, the majority of which focused upon the co-design of the intervention. Nine studies[38,40-45,47,50] propose or report some evaluation of the intervention impact. However, only half embedded formal evaluation of outcomes pre- and post- delivery of the intervention.[38,40-45] Bruce and Pearson[44]

proposed baseline measurement of various measures in their study, including depression and social variables to allow monitoring by health professionals, and anticipated approximately 18% of their cohort would present at baseline with suicide ideation. They go on to report that these measures would be repeated at two annual follow-up interviews and anticipated a reduction in depressive symptomatology and suicide ideation and behaviour. Cheng et al.,[50] report that participants gained improved web-based suicide literacy skills. Zealburg et al.,[47] provide case studies to illustrate how three lives were saved by their emergency crisis support team intervention. Richardson et al.,[40] found no significant change in self-esteem, depression, and resilience in their "*Mind Yourself*" suicide prevention intervention. However, they report gaining valuable understanding of barriers related to procedural aspects of intervention delivery including extending the programme duration and the need to consider literacy levels among the target population. Lastly, four studies evaluating a suicide prevention intervention specifically for men assessed pre- and post-intervention changes using the CORE-OM clinical assessment tool.[38,41-43]

Mechanisms of Behaviour Change Associated with Co-production

None of the included studies explicitly identify the mechanisms of behaviour change associated with the inclusion of co-production. Subsequently, it is impossible to determine whether any potential behaviour change related to suicide and/or mental health can be definitively attributed to the inclusion of co-production. Nevertheless, all studies link reported outcomes to positive changes engendered by engagement in the suicide prevention intervention such as self-monitoring of mood/wellbeing[48], improved help-seeking[39-42,45-46,48-50], rapid access[41-42,44-48], and improved coping strategies.[38-42,45-46,48-49]

Most studies do not specifically report on the theory underpinning the suicide prevention interventions, despite a wide range of techniques being used to reduce suicidality. Four studies describe three models of suicide underpinning the suicide prevention intervention[38,41-43]; namely the interpersonal theory of suicide[52], the collaborative assessment and management of suicidality[53] and the integrated motivational volitional

theory of suicide[54-55]. However, these studies each focus upon evaluating the same suicide prevention intervention, the James' Place Model. Similarly, Hetrick et al.,[48] link functionality of the content of their mApp to Dialectical Behavioural Therapy and Thorn et al.,[51] relate features of their #chatsafe to resilient-focussed Papageno effect. In addition, while not explicitly theory-based, Buus et al.,'s[49] mApp and the safety planning intervention used by Ferguson et al.,[39] is based upon Stanley and Brown's[56] safety planning tool.

Discussion

This review has synthesised research evidence to understand how co-production is defined and operationalised, and to examine how co-production is implemented. In addition, to evaluate the outcomes assessed and to identify core components within community-based suicide prevention interventions that aim to reduce suicide among adults. The study findings show most included studies were qualitative (or were mixed methods including a qualitative element), aiming to elicit the perspectives and opinions of service users to inform the design and development of the community-based suicide prevention interventions. Few studies reported quantitative findings.

The rationale for why and how a co-productive approach was to be implemented was mostly explained (e.g., to elicit stakeholder perspectives to inform intervention development). However, some studies omitted a clear definition of the nature of co-production applied. This finding is consistent with the literature, where an agreed definition of co-production is yet to be determined.[2,17-18] As a result, the concept of co-production is interpreted to mean different forms of activities, commanding different levels of involvement, responsibility and resources within shared decision making that are couched under the umbrella of co-production[16,18-19]. This points to a wider issue within the field of co-production research as a lack of consensus in how to define co-production means there is no clear metric against which to evaluate the multi-level components of co-production. Smith et al.,[13] argue that researchers should abandon efforts to define co-production in favour of embracing heterogeneity co-production offers within research and instead provide a contextually

specific definition suited to their research objectives. Others echo this and go further by advocating the abandonment of the pursuit for a gold standard definition of co-production arguing different approaches are needed to allow tailoring of the co-productive approach to suit the context in which it is implemented.[57] Instead, they urge researchers to be more reflective upon their application of co-productive approaches and be more explicit in their reporting to overcome issues associated with poor operationalisation of co-production.[57] Indeed, co-production has been applied across different health-related contexts including mental health.[58] However, it is important for researchers to identify distinct measurable components of co-production approach used to facilitate evaluation of any potential outcomes associated (i.e., you need to know you are evaluating to evaluate it).[2]

Involvement of stakeholders from diverse disciplines and backgrounds, and the collaborative working relationships formed were viewed as positive. Iterative discussions between stakeholders were the lynchpin to the success of this collaborative working partnership, giving voice to stakeholders in shaping the suicide prevention interventions. Equity within collaborative working partnerships in co-production are the cornerstone of this approach. [11,34,59] Yet, resistance from some researchers, developers, and clinicians towards relinquishing power was evident. For example, a software developer in Thorn et al's.,[51] study included a safety feature despite the users explicitly expressing that they wished for this feature to be omitted. This power differential is common within co-production literature[59-61] and can lead to tokenistic approaches in co-production-based research.[59,62-63] Redressing power imbalances is important for promoting a culture which empowers stakeholders, particularly users, to share their knowledge. Failure to do so risks undermining equity within the collaborative relationship, leading to professional knowledge being prioritised over lay knowledge.[63] However, methods to integrate key values of co-production to avoid potential pitfalls, including power in-balance, have been proposed (e.g., INVOLVE).[10]

Within this review, participants' preferences of intervention content challenged researchers and clinician's preconceived ideas of what intervention elements should be included (e.g., Hetrick et al.,[48]). A shift away from "one size fits all" approaches in suicide prevention

interventions towards a tailored approach has been called for.[27,65] Co-production offers an opportunity to work with the individual to identify and address their unmet needs in developing tailored intervention approach to suicide prevention. Research evidence supporting the implementation of a co-productive approach within service design and delivery of a suicide prevention intervention is emerging. This is highlighted by studies involving the James' Place Model which aims to support men experiencing suicidal crisis and has been found to significantly reduce suicidal distress.[38,41-43] Relatedly, participants in Ferguson et al's.,[39] study noted the value of co-creation in formalising personalised safety planning with their clients for the recognition of unique triggers of distress and coping strategies to mitigate this.

The focus of this review was upon co-production within community-based suicide prevention interventions for adults. Several papers identified within the search referred to mobile app or online suicide prevention interventions. The authors determined it to be appropriate to include these studies as technological advances towards web-/app-based suicide prevention highlights a new, burgeoning community that warrants research to understand the potential effectiveness of these types of interventions. Web-/app-based suicide prevention could facilitate rapid access to support for individuals experiencing suicidal crisis. However, increased accessibility may add additional burden to those who monitor such interventions as highlighted by some included studies (e.g., Hetrick et al's.,[48]). Additionally, the very nature of web-/app-based suicide prevention interventions require users to have the relevant access to technology to support their ability to access such interventions. Therefore, whilst web-/app-based technology provides a conduit for remote delivery of rapid suicide prevention intervention, it also may further widen health inequalities for the most vulnerable including those of low socioeconomic status and the elderly.[65-66]

A key strength of this review was the broad inclusion criteria used to capture multiple modes of co-production implementation (e.g., co-design, co-create, co-production). Second, the PRISMA reporting guidelines have also been followed. Thirdly, a second reviewer has been involved during each phase of this review, thus reducing risk of bias within the results. The findings of this review should be interpreted with caution due to the small number of included

papers, inclusion of only papers published in English and homogeneity of the study populations (i.e., westernised populations). Lastly, while multiple modes of co-production were included in the search criteria, the searches of databases were limited to title searches which may have led to some studies being inadvertently omitted.

Implications for Policy and Practice

The present review findings provide some evidence that co-production can work in practice to engender positive outcomes. However, a lack of universal definition and established model for co-production implementation may pose some problems when creating policy and practice guidance for the implementation of co-production within suicide prevention interventions. For example, different modes and levels of stakeholder involvement in co-production activities were evident within the included studies, but their involvement was predominantly limited to the co-design aspect of the intervention. Stakeholder involvement generally did not extend to other stages of the research process. This finding has been reiterated in other reviews within a health-related context[58], including suicide prevention.[68] Inclusion of stakeholders within the research process prior to implementation of suicide prevention intervention may allow tailoring of the intervention to suit a specific service users' needs and preferences.[68] Yet, exclusion beyond these formative stages removes the stakeholder from decision making processes that may be pertinent to implementation aspects of the suicide prevention intervention (e.g., delivery and intervention evaluation and impact).[68] Co-produced related outcomes are often context-specific.[57] Therefore, involvement of stakeholders within the latter stages of the research process, including the evaluation of research findings, is warranted.[68] This could prevent tokenistic involvement of stakeholders by legitimising the translation of their knowledge and expertise into research evidence that meets the intervention objectives, and the creation of evaluation approaches that measure meaningful impacts associated with co-produced suicide prevention interventions.[68]

Implications for Future Research

Future research should clearly define how co-production is implemented and formally evaluate corresponding outputs from co-production in the delivery of suicide prevention interventions. This is important for understanding the impact on potential outcomes, if any, associated with a co-production approach. While it is likely that there are wider impacts associated with co-produced community-based suicide prevention interventions, further research is needed to understand the theoretical components of co-produced community-based suicide prevention interventions. This would allow for the development of validated evaluation measures that can determine the intervention effects on suicide.

While some positives were reported for the inclusion of co-production in community-based suicide prevention interventions, particularly from the perspective of participants, there is some evidence that some professionals (e.g., clinicians) are reticent to relinquish their paternalistic roles. Future research should seek to understand the views/ perspectives of those implementing co-produced services to understand any potential barriers and facilitators to intervention delivery.

Conclusion

The present review found most studies fostering a co-productive approach within community-based suicide prevention interventions elicit the views and perspectives of stakeholders in a process of co-design / co-creation. Positive evaluation attributed towards this co-productive approach indicates some benefits in the creation of suicide prevention intervention that recognises and values each stakeholder and redress potential power imbalances within the therapeutic relationship. This may improve engagement and give voice and control to those experiencing suicidal crisis. However, there is limited evaluation extending beyond the design aspects of the co-productive approach to understand its effects within community-based suicide prevention interventions.

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Data Availability Statement

Data sharing not applicable – no new data generated.

Appendix 1: Example of Search Terms

	Search Term	Search Field
1.	co-product*	Title search
2.	collaborat*	Title search
3.	“collaborative approach”	Title search
4.	co-design*	Title search
5.	co-creat*	Title search
6.	co-develop*	Title search
7.	co-evaluat*	Title search
8.	“action research”	Title search
9.	“lived experience”	Title search
10.	“user experience”	Title search
11.	“user involvement”	Title search
12.	“patient involvement”	Title search
13.	“patient participation”	Title search
14.	“patient engagement”	Title search
15.	“patient cent* care”	Title search
16.	“person cent* care”	Title search
17.	“shared decision making”	Title search
18.	MH suicide [MESH]	Title search
19.	suicid*	Title search
20.	Suicide [keyword]	Title search
21.	MH “community mental health services” [MESH]	
22.	“community mental health services” [keyword]	Title search
22.	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17	
23.	18 OR 19 OR 20 OR 21 OR 22	
24.	23 AND 24	

4. Chapter 4: James' Place Model: Application of a Novel, Clinical, Community-Based Intervention for the Prevention of Suicide Among Men

Findings from the systematic review of chapter 3 revealed co-production has been integrated into several different community-based suicide prevention interventions for adults. Including those targeted towards men. However, few studies incorporated an evaluation of impacts and outcomes of the service into their routine clinical practice. James' Place is a community-based suicide prevention service for men experiencing suicidal crisis that was identified within the systematic review as having embedded evaluation of men's clinical outcomes relating to their suicidality. Using a theoretical approach, specialised suicide prevention therapists at James' Place record precipitating and psychological factors contributing to a man's suicidal crisis and deliver a co-produced clinical intervention, recording changes in men's suicidality during their clinical journey. This study sought to describe the characteristic features and implementation of the James' Place Model in the format of a public health case study. Note, the public health case study approach used in this study does not follow the traditional format of a case study. Rather, it follows the public case study approach as defined by the journal in which this article is published (see chapter 2 for more details). This study provides important insight into clinical practice of a community-based suicide prevention service which offers rapid access to a clinical brief psychological intervention which may further understanding of redressing well-documented issues around help-seeking among men experiencing suicidal crisis.

Note: The formatting style of chapter 4 is as required the Journal of Public Mental Health where a shortened version of this paper is available: https://doi.org/10.1108/JPMH-09-2021-0123

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 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.

Method

Design

The design of this study follows a public health case study approach. While case studies can be approached in several ways and guided by the epistemological viewpoint of the researchers (Crowe *et al.*, 2011), arguably the present public health case study approach is in contravention with traditional case study methodology. This is because the method used in this article is unstructured and draws upon previously collated qualitative data. Nevertheless, the unstructured public health case study style fostered affords an opportunity to creatively draw upon previously obtained semi-structured interview data collected as part of on-going JP evaluation to provide a descriptive narrative of the service to illustrate how it operates, including the referral pathways and clinical journey of men who engage with JP.

Participants

Data from four participants are reported within four case studies. Two participants were men who had accessed JP and received the JP model. The other two participants were JP therapists. JP receives referrals from several sources including Emergency Departments, Primary Care, Universities, or self-referrals. It is not possible to specify which service men featuring within the case studies of this article were referred from as each man entering the service is assigned an anonymous identifier and this was not linked to the interview data at when it was collected. Similarly, it is not possible to state the exact date the two men were referred to JP. However, it is most likely they will have been referred to JP and received and completed the JP model at some point during the period from when JP began receiving

referrals until approximately the month before the interviews were conducted (i.e., between August 2018 to December 2019).

Table 1 shows the sources of referral from 1st August 2018 to 30th April 2020. The timeframe reflects the period during which data used within this article was collated. During this time, 200 men were referred to JP of which 60 men (30%) attended a welcome assessment and 40 men (40%) went on to engage in therapy. It is not possible to show referral data which reflects the precise timeframe of when semi-structured interview data used within this article was collated because the service did not record the dates referrals were received during the first year of being operational (i.e., from 1st August 2018 to 31st July 2019).

Table 1: Sources of Referral to James' Place From 1st August 2018 to 30th April 2020

Referral Source*	**N***	**%***
Mental Health Practitioner	64	32
GP	37	18.5
Self-referral	35	17.5
Support Worker	2	1
College or University	1	.5
Nurse Practitioner	5	2.5
IAPT Talking Therapies Service	5	2.5
Occupational Health	1	.5
A&E	2	1
Other (voluntary & third sector organisations)	48	24

*Data Source: Saini et al., 2019; 2020

Table 1 shows that James' Place received referrals from several sources. Most men were referred to James' Place from a mental health practitioner (n=64), whereas the fewest were referred from college or University (n=1) and occupational health (n=1).

Procedure

Data for the case studies were derived from one of two sources; either semi-structured interviews conducted as part of the JP six-month process evaluation report or semi-structured interviews conducted as part of the JP one-year evaluation report (Saini et al., 2019; 2020). Specifically, from the JP six-month process evaluation report, data of two JP therapists were extracted from eleven semi-structured interviews with several stakeholders involved in the JP service inception, design, and delivery of the JP model (including men with lived experience of suicide and JP therapists) and used to create the two JP therapist case studies. These semi-structured interviewed were conducted between December 2019 and January 2020. Similarly, data of two men were extracted from four semi-structured interviews with men which were conducted as part of the JP one year evaluation between January and April 2020, and used to create the two men's case studies. Case studies aimed to capture and describe JP therapist's and men who had accessed and received the JP model perceptions of the JP service delivery, including nuanced aspects of the JP model such as the environment cultivated at JP and lay your cards on the table.

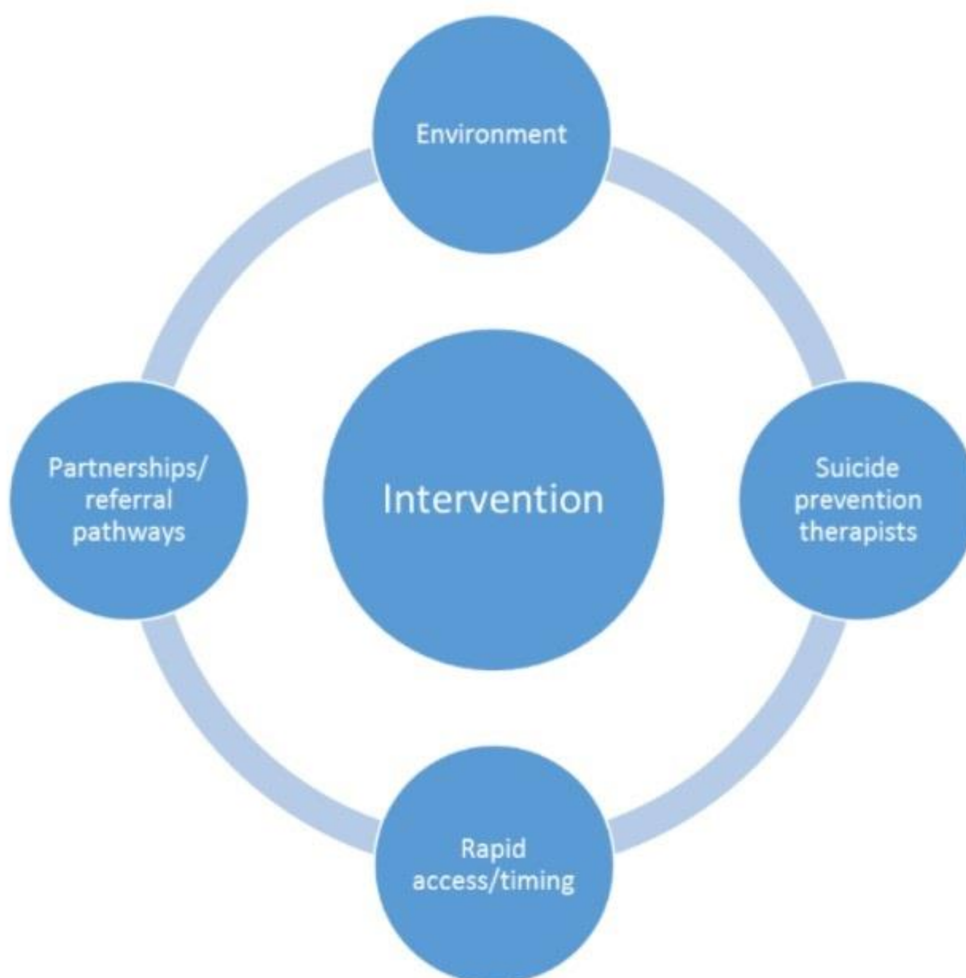
Analysis and Case Study Construction

Qualitative data for both the JP six-month and one-year evaluation report had previously been analysed using thematic analysis (Braun and Clarke, 2006) and themes and subthemes developed reflective of the aims of either the six-month or one-year JP evaluation report. As the sample within the present article includes four case-studies, it was not necessary to implement a framework approach typically used for larger data sets for the purpose of practicality (Pope *et al.*, 2000). However, in creating the case studies from the thematically analysed data, an inductive and deductive approach was used to reflect the accounts of JP therapists and men who formed the case studies and the pre-determined purpose of the paper (i.e., to describe the JP service and JP model).

Ethical approval was granted by the Liverpool John Moores University Research Ethics Committee (18/NSP/024 & 19/NSP/057).

The James' Place Model

<u>Figure 1: The James' Place Model</u>



Source: Saini *et al.*, 2021b.

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 kind of support services required 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 that 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 James' Place Therapeutic Journey

Figure 2: The Clinical Journey of Men Referred to the JP Service

Source: Saini *et al.*, 2021b

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.

<u>Photograph 1: Lay your Cards of the Table component of the JP Model</u>

Source: No Source (photograph taken of lay your cards on the table)

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 James' Place 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 CORE34 was initially used but was replaced by the CORE10 and administered more frequently during the third year also. The CORE10 is as effective as the CORE34 but reduces the burden upon the men completing the questionnaire. The CORE10 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). CORE10 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 (Seidler *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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5. Chapter 5: Psychological Risk Factors Predictive of Suicidal Distress in Men Receiving a Community-Based Brief Psychological Intervention

Chapter 4 describes the James' Place Model and how it was delivered, with case studies from men who have received the JPM and specialised suicide prevention therapists who deliver it. In describing the JPM, it is evident that co-production through delivery of the lay your cards on the table component of the JPM is a significant feature of the JPM. For example, the lay your cards on the table appear to support men in communicating their suicidal distress to their therapist for the co-production of strategies to mitigate suicidal distress. The lay your cards on the table are a novel tool used within the JPM and their clinical significance has not yet been tested among men experiencing suicidal crisis who receive the JPM. Therefore, this next study examines the predictive utility of the lay your cards on the table in predicting suicidal distress among men who were accepted to James' Place service and subsequently went on to receive the JPM. Low engagement with mental health services among men experiencing suicidal crisis is well-documented, and this study highlights an innovative approach for communicating with men using non-clinical, lay language which has been shown to be men's preferred language in therapeutic approaches.

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Abstract

Introduction: Adaptable community-based approaches for assessment and delivery of suicide prevention interventions for men experiencing suicidal crisis are needed. The lay your cards on the table (LYCT) component of the James' Place Model is a novel therapeutic approach comprised of card variables that correspond with suicidal risk factors. This study investigated the LYCT in predicting suicidal distress among men.

Methods: Cross-sectional data of 511 men aged 18 to 69 years (M=34.59 years; SD=12.30) collected between 1st August 2018 and 29th July 2021 were assessed to predict suicidal distress measured using the CORE Clinical Outcome Measures (CORE-OM) using linear and multiple regression.

Results: From four categories comprising the LYCT, correlational analyses demonstrated that 19 associations emerged as statistically significant (.12 to .19). When these were included in regression analyses, effect sizes explained 2-5% variance in CORE-OM outcomes (R^2). Six LYCT variables ("*I think about killing myself all of the time*", "*My friends don't talk to me anymore", "I have lived through terrible experiences", "I can't sleep", "I can't relax", "use of relaxation/mindfulness techniques"*) significantly predicted CORE-OM scores (ß= -.17 to .19). Adjusting for confounders of age and ethnicity within the regression models were not found to have added unique variance at the bivariate level to regression models predicting the effects of LYCT variables on CORE34 and CORE10 scores.

Conclusion: Use of LYCT is supported for engaging men in the assessment of suicide risk factors and to inform tailoring of intervention delivery to suit the individual needs of men experiencing suicidal crisis.

Introduction

Suicide remains a significant global public health risk (WHO, 2021), particularly for men, who account for approximately three quarters of all suicide deaths in England and Wales 2020 (ONS, 2021). Risk factors associated with suicide among men are complex and diverse. This is highlighted by a systematic review reporting 68 risk factors associated with male suicide, which can fluctuate across the life course (Richardson, 2021). Additionally, it is widely documented that men are less likely to seek help when experiencing suicidal crisis (Cleary et al., 2017; Gilgoff et al., 2023; Sagar-Ouriaghli et al., 2019). A host of psychosocial factors have been proposed to account for low rates of help seeking rates among men experiencing suicidal distress. These include greater tolerance of mental distress, subscription to conventional masculine ideals promoting stoicism, self-reliance, and men's reluctance to disclose feelings of emotion and maladaptive coping such as alcohol and drug use (Biddle et al., 2004; Courtenay, 2000; Feigelman et al., 2021; Perkis et al., 2017; Seidler et al., 2016).

While it may be tempting to characterise men as poor help-seekers, research exploring men's social experience of suicide is accumulating which challenges the perpetuation of the "*men do not seek help*" narrative. For example, 91% of men were found to have contacted front line services, most often primary care (82%), in the period prior to their suicide ranging from 1 week (38%) to three months prior to death (49%) (Appleby et al., 2021). However, just 5% of men in this study were engaged in talk therapies (Appleby et al., 2021) despite such interventions being equally considered effective among men and women (NHS Digital, 2019). This, along with research examining barriers to engagement in mental health services among men, highlight differences in the expression of mental health problems such as depression among men compared to women (Brownhill et al., 2005). Findings such as these suggest that current mental health service provision lacks sufficient reach among men experiencing suicidal crisis. Improving accessibility to timely suicide prevention for men is vital. Evidence is growing supporting the development of community-based, tailored suicide prevention interventions that are responsive to the social experience of men in suicidal crisis

to broaden accessibility and acceptability (Chopra et al., 2022; Hanlon et al., 2022; Seidler et al., 2018; Struszczyk et al., 2019).

Several studies have identified a wide spectrum of biopsychosocial risk factors associated with increased suicide (e.g., Turecki et al., 2019), including those specifically among men (Richardson et al., 2021). Overall, the risk factors most predictive of suicidal behaviour among men across from both retrospective and prospective studies were alcohol and/or drug use; being unmarried, single, divorced or widowed; and having a diagnosis of depression. Identification of risk factors has proven useful for recognising drivers of suicide and for supporting dominant theories of suicide that attempt to explain translation of suicidal thoughts and ideation to suicide behaviours (e.g., Integrated Motivational Volitional theory of suicide (IMV); O'Connor, 2014; O'Connor and Kirtley, 2018). However, examination of the predictive utility of risk factors found they barely improved prediction of suicide outcomes beyond that of chance (Franklin et al., 2017). Franklin et al., (2017) concluded that research determining risk factors for suicide thoughts and behaviours is constrained by several methodological limitations, including long follow-up intervals and a focus upon isolated rather than multiple occurring risk factors. Yet, experiences and dominance of different suicide risk factors can fluctuate across individual men's life span (Richardson et al., 2021) with mid-life posing a significant period of lifetime related risk for men (NCISH, 2021).

James' Place is the first community-based suicide prevention centre for men, with qualified therapists delivering a clinical intervention called the James' Place Model (JPM) (Hanlon et al., 2022). The JPM consists of approximately nine sessions. A key component of the JPM is the lay your cards on the table (LYCT) intervention. This aspect of the model is comprised of four sets of cards that each resemble a stack of playing cards, called 'what's happening now' (WHN), 'how did I get here' (HDIGH), 'keeping the problem going' (KPG), and 'how can I get through this' (HCIGTT) respectively. Each card within each pack 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 set of LYCT cards have been designed to prompt discussion around specific issues and correspond to specific stages of the JPM. 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 WHN 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 HDIGH and KPG 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 HCIGTT cards, that relate 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. Further details of the JPM and service are available (e.g., Chopra et al., 2022; Hanlon 2022; Saini et al., 2020;2021a;2021b;2022).

Understanding of the archetypical psychosocial risk-factor profile presentation of men engaging with suicidal crisis services, and changes of this throughout the duration of their suicidal crisis and subsequent therapeutic intervention is lacking. Existing service evaluations of the James' Place service have focussed upon psychological distress (CORE-OM; Beck et al., 2014) and have consistently shown that the JPM significantly reduces suicidal distress (Saini et al., 2020; 2021a., 2021b; Chopra et al., 2022). However, less is known about the effect the LYCT intervention has upon clinical outcomes. Clinicians have been found to overestimate anxiety- and depression-related outcomes (Harmon et al., 2007), emphasising the need for objective evaluation of change during the therapeutic journey. Determining how psychological risk factors associated with men's suicidal crisis across their therapeutic journey change will highlight the differential effect of the James' Place model upon these factors and the men's subsequent outcomes through the period of their intervention. Findings such as these may inform better tailoring of the JPM to better suit men exhibiting specific characteristics related to their suicidal crisis.

The present study aims to identify risk factors predictive of suicidal distress among men who utilise the LYCT component of the JPM during their therapeutic journey at James' Place. This will highlight new knowledge in this area as multiple risk factors highlighted by men during therapy will be examined. Data from a community-based suicide prevention service for men will be used to determine the psychosocial risk factors most associated with help-seeking and engagement with suicide prevention services.

Materials & Methods

Design

A cross sectional design was used to extract data of men who received the JPM. Ethical approval was given by Liverpool John Moores University (Ref: 19/NSP/057). Written consent was given by men accessing the service during their initial welcome assessment.

Participants

Data were collected from a cohort of men experiencing suicidal crisis over a three-year period who had been referred to James' Place between 1st August 2018 and 29th July 2021 (n=511). Referrals of men into the service were received from multiple sources including hospital emergency departments, primary care, universities, or self-referral.

Measures

Primary outcome measures

The CORE34 and CORE10 clinical outcome measures (CORE-OM) formed the outcome measure in this study, with the CORE10 replacing the CORE34 measure in the service from September 2020. CORE-OM is a self-report measure routinely administered by therapists during men's first and final session of therapy. The CORE34 is comprised of 34 questions. Respondents are required to rank 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".* Four sub-scales comprise the CORE34; subjective wellbeing (4 items), problems/symptoms (12 items), life functioning

(12 items), and risk harm (six items). An overall score of global distress is calculated by summing the four subscales. CORE10 is a shortened version of CORE34 consisting of 10 questions each beginning with the prefix of "*Over the last week*" followed by statements such as *"I made plans to end my life"* and *"I have felt unhappy"*. For both the CORE34 and CORE 10 higher scores indicate higher levels of psychological distress. A score of 51 or above on the CORE34 corresponds to the clinically significant range and less than 20 to the non-clinical range. Within the clinically significant range of the CORE34 21 to 33, 34-50, 51-67, and 68-84 correspond to low-, mild-, moderate- and moderate to severe psychological distress respectively. Scores of 85 or above indicates severe psychological distress. For the CORE10, a total score of 11 or higher shows the clinically significant range with scores of 11-14, 15-19 and 20-24 corresponding to mild-, moderate, and moderate-to-severe psychological distress respectively. A score of 25 or more indicates severe psychological distress. Total CORE34 and CORE10 scores and not individual item scores were used during data analyses. Also, it was not possible to perform reliability checks of either CORE34 or CORE10 as the service only provides a total score for CORE-OM (either the CORE34 or CORE10 scores) and does not provide individual item scores for either scale.

CORE34 and CORE10 were and are recorded for each man upon entry into James' Place during their first assessment and during their final therapy session. Occasionally, a therapist may record a CORE10 score midway during the therapeutic journey (e.g., for reflection and/or monitoring purposes so as men can see how they have progressed). For this study the initial CORE34 and initial CORE10 scores collected during each man's initial assessment were used in the analyses. The initial CORE34/CORE10 score was chosen as the purpose of this study is to examine the predictive utility of LYCT in predicting suicidal distress and later CORE34/CORE10 scores would likely not reflect psychological distress as men would have received the JPM.

Each set of LYCT are typically delivered during the JPM. It is not possible to specifically state the timepoint each set of LYCT will have been delivered as the service does not record this data on their clinical recording system spreadsheet used for analyses. When James'

Place initially opened, therapists would occasionally upload a photograph of delivered LYCT sets onto individual clinical case notes for men to reflect upon during future therapy sessions. This practice was soon stopped as it was burdensome for therapists to manage alongside additional administrative tasks (e.g., clinical case notes, therapy letters etc.) and deemed unnecessary as men wishing to reflect on their LYCT take photographs on their own phones. As James' Place has transferred to a new clinical recording system and early clinical case notes have not yet been migrated onto the new clinical recording system, it was not possible for the researcher to access the individual cases of the sample of men in this study to see if a photograph of the LYCT had been uploaded. However, the CORE34/CORE10 scores will have been recorded approximately when each man commenced the JPM until they were discharged from James' Place. This corresponds to between the 1st August 2018 and 22nd October 2021 whereby the former date corresponds with when James' Place began receiving referrals thus recording data, and the latter date corresponds with the latest date a man was discharged from the service.

The decision whether to, and when to administer the LYCT is co-produced between the individual man and their therapist. Similarly, the decision to administer all or some of the sets of LYCT is also co-produced by the individual man and their therapist. Sometimes the therapist will make a clinical decision not to deliver the LYCT to a man. Reasons underpinning this decision varies from individual-to-individual man. However, common reasons include that men do not wish to use LYCT as they would prefer to talk, they may be deeply entrenched within their suicidality and their cognitive focus may be hampered, or because they are unable to read. In such instances, therapists may adapt delivery of LYCT to suit individual needs. For example, they may discuss IMV-model related themes (e.g., threats to self-moderators, motivational moderators) contained within pertinent sets of LYCT or read to the man the card variable names of a set of LYCT. However, during a typical therapeutic journey consisting of 9 sessions, WHN cards generally are delivered in the first three sessions: HDIGH and KPG in the following 3 sessions, and the HCIGTT at some point during the final 3 sessions.

As each individual man and their therapist co-produce therapy, including LYCT it is important to note that therapists work alongside each man to decide when and how to administer the LYCT. This may involve the men choosing a selection of individual cards from one or more sets of LYCT sets they feel are pertinent to their suicidal crisis, or picking a card or multiple cards they feel resonates with them on some level such as a strong feeling (e.g., guilt), emotion (sadness) or issue in their life they find is affecting them mentally or physically (e.g., bullying, physical health issue, not being able to sleep). It is therefore feasible that an individual man could receive either each set of LYCT once or multiple times, specific sets of LYCT on one, two or three or more occasion, or no sets of LYCT at all. In the present study, the first delivery of a set of LYCT was used for the purpose of analyses.

Data Analysis

Data were analysed using IBM SPSS statistics for windows v28. Descriptive analyses were conducted to identify means, standard deviations, and frequencies of card variable selection from each category of LYCT. Frequencies of the use of each card variable from each LYCT set were also calculated (appendix 1). Selection of a card was coded as 1 and absence of a card was coded 0.

Quality of the data was assessed for correlation analyses and multiple regression. Tolerance and VIF values were examined for correlated items feeding into the multiple and linear regression models for each set of LYCT's. Tolerance and VIF values were found to be acceptable (i.e., above .10 and below 3 respectively) for each card variable with the exception the tolerance value of WHN card variable embarrassed vs. CORE10. Normality was further assessed, along with linearity, multicollinearity, and homoscedasticity. Inspection of normal probability plots (P-P) of the regression standardised residual showed points followed a straight line. Outliers were further checked by examining mahalanobis distances which were confirmed to below the respective critical value for each multiple regression model. Notably, a few outlier cases were identified, however Cook's distances confirmed that these posed no issue to the quality of data.

The outcome variable of CORE-OM scores is continuous, reliable, and normal, as has been confirmed in previous research (e.g., Barkham et al., 2013). Skewness and kurtosis values for CORE10 and CORE 34 dependent variable of fell within the acceptable range of -1.96 to 1.96. This is confirmed by eyeball analyses of histograms. James' Place replaced CORE34 with CORE10 measure in September 2020 to facilitate the administration of the questionnaire at more time points. Correspondingly, analyses are presented for both CORE34 and CORE10 measures and multiple regression was used to assess whether significant WHN, HDIGH, KPG, and HCIGTT card variables predicted CORE34 and CORE10.

The strength and direction of relationships of each card within each set of LYCT and CORE scores were explored using point biserial correlational tests. Also, the strength and direction of relationships of potential cofounders and CORE scores were assessed using point biserial correlation tests. Card and confounding variables significant at the bivariate level from each LYCT category were included within multiple regression analyses if they achieved a bivariate significance level of .05 or less.

Results

Sample Characteristics

Table 1 shows the demographic characteristics for men referred to the James' Place service. Men ranged in age from 18 to 69 years (M=34.59 years; SD=12.30). Seventy six percent of men were white British (n=390) and eleven per cent were of other ethnicities (n = 56). Ethnicity of the remaining sample (n=66) is unknown or not coded. At the time of data capture, the service relied upon ethnicity data being recorded by referral services as they did not routinely collate this data. Employment status data showed most men were employed (40.3%; n = 262). Approximately, a quarter of men were unemployed (25.8%; n=132), while just 2% were a full-time carer (n=1). Almost half of men reported they were single (49.5%; n=253), while the fewest number of men were widowed (4%; n=2). Again, completeness of employment and relationship status data is limited due to missing/unspecified data (15.5% (n=72) and 102% (n=20) respectively). Demographic

information for men were obtained from completed referral forms that were received from referral services (EDs, General Practitioners [GP], universities, etc.) or by the men for self-referrals. Therapists may also have completed this information where it was missing and if it was considered relevant to a man's suicidal crisis experience.

Table 1: Demographic Characteristics for Men Referred to the James' Place Service

Variable	CORE34 (*N*=339)	CORE10 (*N*=172)	Total N (%) (*N*=511)
Ethnicity			
White British	259 (76.4%)	131 (76.2%)	390 (76.3%)
Other ethnicity	35 (10.3%)	21 (12.2%)	56 (11%)
Missing	45 (13.3%)	20 (11.6)	21 (4.1%)
Relationship status			
Single/Non-cohabiting	167 (49.3%)	86 (50%)	253 (49.5%)
Married	37 (10.9%)	29 (16.9%)	66 (12.9%)
In a relationship	20 (5.9%)	40 (23.3%)	60 (11.7%)
Divorced	6 (1.8%)	2 (1.2%)	8 (1.6%)
Separated	13 (3.8%)	7 (4.1%)	20 (3.9%)
Widowed	2 (0.6%)	0	2 (4%)
Missing	94 (27.7%)	8 (4.7)	102
Employment Status			
Employed	120 (35.4%)	86 (50%)	206 (40.3%)
Unemployed	88 (26%)	44 (25.6%)	132 (25.8%)
Students	47 (13.9%)	29 (16.9%)	76 (14.9%)
Self Employed	8 (2.4%)	0	8 (1.6%)
Retired	4 (1.2%)	4 (2.3%)	8 (1.6%)
Carer	0	1 (0.6%)	1 (2%)
Missing	72 (21.2%)	0	72 (21.2%)

Descriptive Analyses of Lay your Cards on the Table sets

Table 2 shows the number of men using each set of LYCT, the mean number of cards selected, and their respective standard deviations selected by men from each set of LYCT.

Of the four sets of cards, men more frequently used WHN cards compared to any other LYCT category (M=9.96; SD=11.09). In contrast, HCIGTT cards were selected less frequently than any of set of LYCT card variables (M=3.65; SD=6.78). The frequency of which each individual card variable of each of the four sets of LYCT was selected is shown in appendix 1. Examination of frequency tables (see appendix 1) shows that each individual card variable within each LYCT set was endorsed by men to varying degrees with some cards selected more frequently than others.

Table 2: Means and Standard Deviations of Lay your Cards on the Table

Variable	*N* (%)	No. Cards Mean/SD	No. Cards Range (Min-Max)
What's happening now (WHN)	270 (52.8)	9.96 (11.09)	0 – 39
How did I get here (HDIGH)	158 (30.9)	2.48 (4.13)	0 – 16
What's keeping the problem going (KPG)	156 (30.5)	2.06 (3.58)	0 – 16
How can I get through this (HCIGTT)	131 (25.6)	3.65 (6.78)	0 – 25

Correlational Analyses

Tables 3 shows the results of significant point-biserial correlation analyses for the card variables of each category of the LYCT component of the JPM and CORE-OM scores (CORE34 and CORE10) and CORE34 versus CORE10. Point-biserial correlations revealed small positive significant relationships across each of the four sets of LYCT, suggesting these risk factors are associated with higher suicidal distress as indicated by either CORE10 or CORE34 scores. The remaining cards within the LYCT component of the JPM were not significantly correlated with the CORE-OM.

Additional analyses were conducted to assess the potential confounding effects of age, postcode deprivation scores, relationship status, occupation, and ethnicity within the regression models for each LYCT set variable versus the CORE34 and CORE10 respectively. Age, postcode deprivation scores and ethnicity were already dichotomised

within the data provided by the service such that age was grouped into young (18-30 years) versus older men (aged 31 years or older). Postcode deprivation scores were calculated using indices of multiple deprivation decile scores with 1-5 and 6-10 corresponding to most deprived and least deprived respectively. Ethnicity was grouped into white British and all other ethnicities. Each remaining potential confounder (i.e., relationship status and occupation) were dichotomised in preparation for regression analyses. Relationship status was categorised into two groups of single versus all other relationship status and occupation into employed versus all other employment status.

Table 4 shows point-biserial correlation performed with each potential confounding variable to assess the significance of their association with CORE-OM scores. Multiple and linear regression were carried out to determine if any card variables were predictive of CORE-OM scores. Only card variables showing a significant correlation with CORE-OM scores with a significance level equal to or less than .05 were inputted into the regression model. However, results reported at $p < .05$ should be interpreted with caution to allow for the possibility of type 2 errors.

Table 3: Point Biserial Correlation Coefficient of Lay Your Cards on the Table Variables

Variable	Correlation co-efficient CORE34	Correlation co-efficient CORE10
WHN cards		
I think about killing myself all the time	.15**	
No-one cares	.16*	
Humiliated		.17*
Slow		.17*
Embarrassed		.16*
Ashamed		.16*
I'm not seeing my friends anymore		.18*
Exhausted		.17*
I don't want to be here		.17*
Butterflies		.17*
HDIGH cards		
I feel overwhelmed by my responsibilities	.14*	
I can't tell anyone how I am feeling	.12*	
My friends don't talk to me	.18**	
I'm struggling to make ends meet	.12*	
My relationship is not good	.14**	
I have lived through terrible experiences	.12*	.17*
KPG Cards		
I can't sleep	.12*	
I can't relax		.19*
HCIGTT cards		
Use of relaxation or mindfulness techniques		.17*

**Significance at .05 *(two-tailed); **Significance at .01 (two-tailed)*

From four categories comprising the LYCT, correlational analyses demonstrated that 20 associations emerged as statistically significant (r= 0.12-0.19, p< .05). There was a small, positive correlation between each card variable and CORE-OM scores, except for the HDIGH card variable of *"use of relaxation or mindfulness techniques"* which was found to have a small, negative correlation with CORE10 scores. It was not possible to run

correlations between the CORE34 and CORE10. This is because no men completed either the CORE34 or CORE10 (i.e., one or the other, not both the CORE34 and CORE10). There is no conceptual sense comparing mean scores and variances of CORE34 versus CORE10 because the parameters of the scales are different. However, previous work by Barkham et al., (2013) showed CORE10 is psychometrically valid and that the CORE34 and CORE10 scores correlated at r= .92 in a non-clinical sample and r= .94 clinical sample.

Table 4: Point Biserial Correlation Coefficients of Potential Confounder Variables

Variable	Correlation co-efficient CORE34	Correlation co-efficient CORE10
Age	.09	.14
Postcode deprivation	-.01	-.03
Ethnicity	.01	-.15
Occupation status	.07	-*
Marital status	-.02	-.08

*Note: No occupation status was recorded for participants who completed the CORE10 within the data provided by James' Place

The potential confounder variables of age, postcode deprivation scores, ethnicity, occupation status, and marital status were not significant in predicting either CORE34 or CORE10 scores. Despite this, each potential confounder was included within a regression model assessing their relationship with CORE34 and CORE 10 respectively. As expected, the regression model with the confounding variables of age, postcode deprivation scores, ethnicity, occupation status and marital status as predictors and CORE34 as the outcome emerged as statistically non-significant (F (5, 220) = .80, p= .55).

The regression model with the same confounding predictors, excluding occupation, was significant in predicting CORE10 scores (F(4, 156)= 2.59, p= .04) accounting for 6% variance as indicated by R^2 ($adj.R^2$= .04). Note, occupation status was excluded in this regression model as none of the participants who had completed CORE10 outcome measure had occupational status data recorded within the data set (i.e., n=0 for occupation versus CORE10 scores). At the bivariate level age and ethnicity versus CORE10 had a significant effect on CORE10 scores (ß= .16, p= .05 and ß= -.18, p= .04). Therefore, age

and ethnicity were included within the regression models predicting CORE10 scores below as additional analyses.

Regression Analyses

What's Happening Now Card Variables Predictive of CORE-OM Scores

Multiple regression was used to assess whether WHN cards of "*I think about killing myself all of the time"* and *"No-One cares"* predicted CORE34 scores. R^2 for the overall model was 2.7% with an adjusted R^2 value of 2.1%. Both "*I think about killing myself all of the time"* and "*no-one cares"* significantly predicted CORE34 scores (F (2,322) = 4.48, p = .01. The WHN card *"no-one cares"* did not make a significant unique contribution in predicting the CORE34 scores (ß = .07, p = .24). However, the WHN card *"I think about killing myself all of the time"* was found to make a significant and unique contribution to variance in CORE34 scores (ß = .13, p = .03).

The first regression model with WHN cards of "*humiliated", "slow", "embarrassed", "ashamed", "I'm not seeing friends anymore", "exhausted", "I don't want to be here",* and *"butterflies"* were tested in predicting CORE10 scores. R^2 for the overall model was 6.8% with an adjusted R^2 value of 1.9%. Overall, the model was non-significant in predicting CORE10 scores (F (8,152) = 1.38, p = .21).

The regression model was run with the range of WHN predictors and age and ethnicity as potential confounders. R^2 for the overall model was 9% with an adjusted R^2 value of 2.9%. However, the model remained redundant and emerged as statistically non-significant (F(10, 150) = 1.48, p =.15) and no incremental variance was explained by either the WHN variables or confounders of age and ethnicity which negated each other when added to the regression model (ß = .08, p = .33 and ß = -.12, p = .15 respectively).

How Did Get Here Card Variables Predictive of CORE-OM Scores

Multiple regression was used to assess whether "*I feel overwhelmed by my responsibilities", "I can't tell anyone how I'm feeling", "my friends don't talk to me", "I'm struggling to make*

ends meet", "my relationship is not good", and *"I have lived through terrible experiences"* predicted CORE34 scores. R^2 for the overall model was 4.5% with an adjusted R^2 value of 2.7%. Overall, the model significantly predicted CORE34 scores (F (6,318) = 2.51, p = .02). Only the HDIGH card variable *"My friends don't talk to me"* made a significant unique contribution in predicting the CORE34 scores (ß = .13, p = .05 (.049)). The remaining HDIGH card variables did not make a significant and unique contribution to variance in CORE34 scores.

"I have lived through terrible experiences" HDIGTT card variable was found to account for 2.9% of the overall model with an adjusted R^2 value of 2.3%. Overall, the linear regression model was significant in predicting CORE10 scores (F (1,159) = 4.8, p = .03 with *"I have lived through terrible experiences"* HDIGH card variable making a significant and unique contribution to variance in CORE10 scores (ß = .17, p = .03).

The regression model with *"I have lived through terrible experiences"* and age and ethnicity versus CORE10 as predictors was found to be significant accounting for 6% variance as shown by the R^2 value ($adjR^2$= .04) (F(3, 157) = 3.44. p = .02). However, when *"I have lived through terrible experiences"* was controlled for, neither age or ethnicity added any unique variance to the model (ß= .12, p = .14 and ß= -.12, p = .12 respectively). Only *"I have lived through terrible experiences"* HDIGH card variable made a significant and unique contribution to variance in CORE10 scores at the bivariate level (ß= .16, p= .04).

Keeping the Problem Going Predictive of CORE-OM Scores

R^2 for the overall model of *I can't sleep"* to predict CORE34 was 1.3% with an adjusted R^2 value of 1%. Overall, *"I can't sleep"* significantly predicted CORE34 scores (F (1,323)= 4.3, p= .04, with a significant contribution in predicting the CORE34 scores at the bivariate level (ß= .12, p= .04).

In relation to CORE10 score, *"I can't relax"* predicted CORE10 scores. R^2 for the overall linear regression model was 3.5% with an adjusted R^2 value of 2.9%. Overall, the model

was significant in predicting CORE10 scores (F(1,159)= 5.79, p= .02), making a significant contribution to variance in CORE10 scores at the bivariate level (ß= .19, p= .02).

The regression model with *"I can't relax"* and age and ethnicity versus CORE10 as predictors was found to be significant accounting for 6% variance as shown by the R^2 value ($adjR^2$= .05; F(3, 157)= 3.59, p= .02). However, when *"I can't relax"* was controlled for age and ethnicity were not found to not add any unique variance to the model at the bivariate level (ß= .12, p= .12 and ß= -.10, p = .20 respectively). Only *"I can't relax"* KPG card variable made a significant and unique contribution to variance in CORE10 scores at the bivariate level (ß= .17, p= .03).

How Can I Get Through this Predictive of CORE-OM Scores

None of the HCIGTT card variables were found to significantly predict CORE34 scores. However, linear regression found that the HCIGTT card variable of "*use relaxation/mindfulness techniques*" predicted CORE10 score. R^2 for the overall model was 3% with an adjusted R^2 value of 2.4%. Overall, the model significantly predicted CORE10 scores (F (1,159) = 4.83, p = .03), with a significant contribution in predicting the CORE10 scores at the bivariate level (ß= -.17, p= .03).

When the regression model *"use of relaxation or mindfulness techniques"* and age and ethnicity as a predictors and CORE10 as the outcome was run, it emerged as statistically significant (F(3, 157)= 4.00, p= .01, accounting for 7% variance within the model as shown by R^2 ($adjR^2$= .05). Significant unique contributions to variance were not made either by age nor ethnicity when *"use of relaxation or mindfulness techniques"* were controlled for (ß = .15, p= .06 and ß = -.12, p= .13 respectively). Only *"use of relaxation or mindfulness techniques"* was found to add variance in predicting CORE10 scores at the bivariate level (ß = -.19, p= .02).

Table 5 summarises four linear and multiple regression analyses with significantly correlated card variables from each set of cards (WHN, HDIGH, KPG, and HCIGTT) and CORE34 and CORE10 scores.

Table 5: Multiple Regression Model Coefficients for Significantly Correlated LYCT Card Variables against CORE34 and CORE10 scores.

	CORE34				CORE10			
Predictor	**B**	**SE B**	**B**	**Sr**	**B**	**SE B**	**β**	**Sr**
WHN+ variables								
I think about killing myself all the time	6.01	2.82	.13*	.12				
No-one cares	4.14	3.54	.07	.06				
Humiliated					1.19	1.31	.09	.07
Slow					.55	1.35	.04	.03
Embarrassed					-.12	1.33	-.01	.04
Ashamed					.21	1.28	.02	.02
I'm not seeing my friends anymore					1.14	1.33	.08	.07
Exhausted					.23	1.25	.02	.02
I don't want to be here					.75	1.22	.07	.06
Butterflies					1.22	1.26	.09	.08
	F(2,322)=4.48*, AdR^2=.02,R^2=.03							
HDIGH+ variables								
I feel overwhelmed by my responsibilities	2.9	3.52	.06	.05				
I can't tell anyone how I am feeling	1.06	3.88	.02	.02				
My friends don't talk to me	10.21	5.17	.13*	.11				
I'm struggling to make ends meet	4.01	4.3	.07	.05				
My relationship is not good	4.04	3.67	.07	.06				
I have lived through terrible experiences	-2.65	4.38	.06	-.03	2.31	1.05	.17*	.17
	F(6,318)=2.51*, AdR^2=.03 R^2=.05				F(1,159)=4.8*, AdR^2=02,R^2= .03			
KPG+ variables								
I can't sleep	5.06	2.44	.01*	.12				
I can't relax					2.37	.99	.19*	.19
	F(1,159)=4.8*,AdR^2=.02,R^2=.02				F(1,159)=5.79*,AdR^2=0.03,R^2=0.04			
HCIGTT+ variables								
Use relaxation/mindfulness techniques					-2.22	1.01	-.17*	-.01
					F(1,159)=4.85*,AdR^2=.02,R^2=.03			

**p*<.05; *WHN = What's Happening Now; HDIGH = How did I get Here; KP = Keeping the Problem Going; HCIGTT = How Can I Get Through This"; Sr=semi-partial correlation*

Discussion

Summary of Findings

The purpose of this study was to determine the predictive utility of the novel LYCT component of the JPM on suicide distress outcomes, recorded using CORE-OM. The results confirmed the WHN card "*I think about killing myself all of the time"* made a unique, significant contribution to variance in CORE34 outcome scores. No WHN cards predicted CORE10 outcome scores. The HDIGH card, "*My friends don't talk to me anymore",* significantly predicted CORE34 scores, while "*I have lived through terrible experiences" significantly* predicted CORE10 scores. Of the KPG cards, *"I can't sleep"* and *"I can't relax"* predicted the CORE34 and CORE10 scores respectively. None of the HCIGTT cards significantly predicted CORE34 cores, but "*use of relaxation/mindfulness techniques"* significantly predicted CORE10 outcomes.

Confounder analyses were performed to determine their effects within the linear and multiple regression models. Correlational analyses revealed that age, ethnicity, occupation status, marital status and post-code deprivation were not significantly associated with CORE34 scores at the bivariate level. While it was not possible to include occupation status in correlational analyses versus the CORE10, it was found that age, ethnicity, marital status and postcode deprivation were not significantly associated with CORE10 scores at the bivariate level. When these variables were input into a multiple regression model alone, age and ethnicity emerged as significantly predicting CORE10 scores. The addition of age and ethnicity to the WHN variables were not found to significantly predict CORE10 scores (i.e., the model remained redundant). However, the addition of age and ethnicity alongside HDIGH, KPG, and HCIGTT categories of LYCT within regression models predicting CORE10 were found to be significant ($p < .5$). Yet, the incremental variance added by age and ethnicity for each category of the LYCT was non-significant at the bivariate level ($p > .5$).

Interpretations of Findings

The findings affirm the wide-ranging, complex nature and significant role of psychological factors in the emergence of suicidal distress among men as men endorsed psychological variables encompassed across each set of LYCT. It was found that men selected more WHN card variables compared to any other set of LYCT. In contrast, HCIGTT card variables were less frequently selected. WHN cards are typically delivered to men at the beginning of their therapeutic journey, suggesting that men are more likely to be experiencing a greater number and comprehensive range of psychological risk factors when they enter James' Place than during therapy or when they are discharged. Indeed, the WHN set of LYCT comprise forty-five card variables. This finding is consistent with previous research that has shown the multi-faceted nature of the drivers of suicide among men (Bennett et al., 2023; Richardson et al., 2021a). For example, Richardson et al., (2021a reported 68 risk factors associated with suicide among men.

The findings also seem to indicate a change in focus of psychological risk factors as men progressed through the JPM as indicated by fewer card variables being selected from HDIGH, KPG, and HCIGTT. It could be suggested this corresponds with a reduction in the prominence of psychological risk factors driving the men's suicidal distress as they progress through their therapeutic journey. For example, each significant risk factor corresponds with components featured within the IMV model, which provides an ideation-to-action framework to explain the development and transference of suicide risk through three distinct phases (i.e., pre-motivational-, motivational, and volitional-phases) (O'Connor, 2014; O'Connor & Kirtley, 2018). It is proposed that movement through the IMV model leads to increased suicidality due to the cumulative effect of different risk factors of suicide upon feelings of defeat/humiliation, thwarted belongingness, and entrapment (O'Connor, 2011; O'Connor & Kirtley, 2018). In considering movement away from suicidality within the context of the IMV model of suicide, a reduction in the number of card variables from LYCT sets selected by men as they progressed through the JPM could be suggestive of the occurrence of a psychological shift in which the cumulative effect risk factors is attenuated.

However, this is only speculative as it is feasible not every man will have received the LYCT in chronological order and further research would be needed to determine this.

In further supporting the prominent role psychological risk factors within prominent theories of suicide such as the IMV model (O'Connor, 2014; O'Connor & Kirtley, 2018), is the finding of specific LYCT card variables in significantly predicting CORE-OM scores. The *"I have lived through terrible experiences"* card captures the potential impact of biopsychosocial background and triggering events (e.g., negative/stressful life events, early life adversity) that poses an individual more susceptible to suicide risk (O'Connor & Kirtley, 2018). Pre-motivational factors are conceptualised to influence suicide risk by exerting their effects upon components described in the motivational and volitional phases. Theoretically *"my friends don't talk to me anymore"* encompasses social support and thwarted belonginess, which features as a motivational moderator within the IMV model with the capacity to strengthen or attenuate the strength of the entrapment and suicide ideation/intent relationship (O'Connor & Kirtley, 2018). Therefore, use of theoretical models of suicide such as the IMV model could guide the appraisal of individual suicide risk and adapt intervention delivery among men within community-based therapeutic settings to deliver nuanced, targeted brief psychological therapy to address specific areas driving an individual's suicidality (Sandford et al., 2022).

The significance of the WHN card, *"I think about killing myself all the time"* in predicting suicidal distress is unsurprising as an inclusion criterion of James' Place is that men are actively experiencing suicidal crisis. According to the IMV model, suicide ideation arises during the motivational phase due to feelings of defeat and/or humiliation that engender entrapment (O'Connor, 2014; O'Connor & Kirtley, 2018), which can be perceived as either internal (i.e., arising from own thoughts and feelings) or external (i.e., from external situations) (Gilbert & Allen, 1998; O'Connor & Portzky, 2018). While neither defeat/humiliation nor entrapment significantly predicted suicidal distress, the HDIGH cards of *"my friends don't talk to me anymore"* and *"I have lived through terrible experiences"* and KPG cards of *"I can't relax"* and *"I can't sleep"* did significantly predicted suicidal distress. On the surface, these findings appear partially inconsistent with the IMV model as it posits

a defeat/humiliation and entrapment pathway to suicide ideation and intent (O'Connor and Kirtley, 2018). However, it is important to note that men who took part in this study had been accepted to receive the JPM. Subsequently, there is a strong likelihood they had begun to receive strategies to maintain their safety as they embarked upon the JPM (e.g., safety planning). It is possible these strategies may have dissipated the prominence of some risk factors. While further research would be required to confirm this supposition, the findings support research highlighting the complex interplay of risk factors that drive suicidal distress among men (e.g., Richardson et al., 2021) and the need for tailored interventions to address the unique vulnerabilities and needs of men experiencing suicidal (e.g., Seidler et al., 2018). Furthermore, they add support to the use of evidence-based models of suicide such as the IMV model to inform the clinical assessment of suicidal risk and delivery of targeted suicide prevention intervention to individuals (Sandford et al., 2022).

The findings of the HDIGH card *"my friends don't talk to me anymore"* in predicting the greatest variance of suicidal distress contributes additional support to the key protective role men's friendship and peer group has in mitigating risk of suicide among men (Richardson et al., 2022). Past research has shown that levels of social support distinguish between men and women with suicidal ideation only versus suicide attempt (with or without suicide ideation) (Richardson et al., 2022). Specifically, higher levels of social support were associated with reduced risk of suicide attempt among men (Richardson et al., 2022). In relation to the present findings, the relevance of *"my friends don't talk to me anymore"* in predicting suicidal distress suggests men were experiencing loss and/or rejection within their social support network. Recent qualitative research offers further insights into the mechanisms underpinning the buffering effects of peer social support for men. For example, Richardson et al., (2021b) findings highlight the importance of social connectedness and value from others has among men who have attempted suicide and during their recovery. In particular, the potential role friends/family have in broaching men's mental health needs with them since men reported they had recognised their mental health needs but struggled to seek help independently (Richardson et al., 2022). While Seidler et al., 2023) findings suggest that friendship provides a source of distraction allowing men to

channel their attention away from their suicidal distress (Seidler et al., 2023). Supporting men to develop and sustain social connectivity with peers to reduce social isolation proffers a therapeutic approach to reduce suicidality (Seidler et al., 2023).

Inability to relax and sleep (i.e., *"I can't relax"* and *"I can't sleep"*), and *"use of relaxation/mindfulness techniques"* were identified through the KPG and HCIGTT cards to be a significant predictor of suicidal distress respectively. While it would be expected that *"use of relation/mindfulness techniques"* would predict reduced suicide, identification of this card with *"I can't relax"* and *"I can't sleep"* cards underscore the significance anxiety and inability to sleep has upon suicidality. For example, sleep problems, including insomnia, have been associated with suicidal thoughts and behaviours including suicide deaths (Littlewood et al., 2017; Lui et al., 2020). Another study found one hour of lost sleep was associated with increased risk of suicidal thoughts and behaviours (Winsler et al., 2015). A recent systematic review and meta-analysis examining sleep disturbance as a risk factor for suicidal thoughts and behaviours reported small-to medium and medium pooled effect size of 41 included studies (Liu et al., 2020). It has been posited that the relationship between sleep dysregulation and suicidality is mediated by defeat and entrapment (Littlewood et al., 2016; Russell et al., 2018). However, little is known about the short-term impact of sleep dysregulation upon acute risk of suicide (Lui et al., 2020). Nevertheless, the present study findings indicate a significant and sustained effect of sleep disturbances, accompanied by feelings of inability to relax, upon suicidal distress among men receiving the JPM as they progressed through the clinical pathway. From a therapeutic perspective, this knowledge could inform delivery of brief psychological intervention that can effectively modify these risk factors of suicide among men.

Strengths and Limitations

A major strength of this study is that reported data relates to men accessing a community-based therapeutic suicide prevention centre in the UK which was collated whilst they were actively experiencing suicidal crisis. As such, the study sample represents a high-risk sub-population for suicide. Obtaining data while men are experiencing suicidal crisis is

important for shedding understanding of the real-world psychological risk factor profile of men experiencing suicidal crisis. This is important for informing development of effective suicide prevention policy and interventions. The findings add support for assessing individual risk factors of suicide in when adapting intervention delivery of the JPM to suit the individual needs of men experiencing suicidal crisis. Additionally, administration of the LYCT component at specific points during the therapeutic journey further enlightens understanding of the complex interplay of psychological risk factors associated with suicide and how these may change through the trajectory of suicidal crisis. As such LYCT provides James' Place therapists with a picture of how different drivers of a man's suicide crisis fits together and what it means to them as an individual. Lastly, the LYCT component of the JPM has allowed a comprehensive range of risk factors and their impact upon men's suicidality during delivery of the JPM to be considered in this study.

Limitations of this study mean that the results should be interpreted with caution. Reported data relates to men accessing the James' Place service, therefore wider generalisability of the results is unknown. However, it is important to note that the James' Place service is currently undertaking an ambitious expansion which will significantly increase the reach to men living across England by 2026. Psychological predictors of CORE-OM outcomes were restricted to data routinely collected by James' Place via the LYCT. The effect sizes reported within the regression models are not large as shown by the levels of variance accounted for in the regression models (typically between 2-3%), although these are beta weights and are thus robust from multiple predictors. Consideration of the mean number of cards selected from each LYCT set suggests that some card variables within the LYCT sets may be redundant. Yet, men were found to endorse the full range of card variables within each set of LYCT to varying degrees suggesting each card possesses relevance in terms of the risk factors for suicide experienced by each individual men, such that some LYCT variables cards will be relevant to some men but not to others. Arguably, reducing the number of cards variables available within each set of LCT could reduce burden upon men when they are being delivered by therapists and improve the variance accounted for when predicting CORE-OM scores. However, men who have received the James' Place model

report that they want more LYCT as indicated by requests for blank cards to allow men to write their own perceived risk factors on during therapy. Also, LYCT data were found to be incomplete for some cases, the timings of when the LYCT sets were delivered and in what order they were delivered in for each man is unknown as this data was not provided by the service. For example, data were often recorded for one or two sets of LYCT for men and findings elsewhere have reported that therapists and men in co-producing therapy may choose to alter the order of delivery of LYCT (e.g., HCIGTT cards may be delivered as the first set if a man presents with very high suicide risk) (Hanlon et al., 2023). Whereas for other cases, no LYCT data were reported at all. Understanding of the conditions under which the LYCT component may be administered is needed to understand fidelity in implementation of the JPM. Lastly, the cross-sectional designs limits inferences of causality, the temporal relationship between LYCT sets and individual card variables with CORE-OM scores (i.e., CORE34 and CORE10). Nevertheless, this study is largely exploratory in nature and has allowed for collection of a large sample of men while they are actively experiencing suicidal crisis and the findings.

Future Research

The data revealed some inconsistency in delivery of the LYCT component of the JPM with some men receiving each set of cards, others receiving one or two sets, and others no sets. Emphasis within the JPM is placed upon co-production of therapy with individual allowing therapists to adapt the model to address each person’s needs. It is feasible that therapists make a clinical and/or a co-produced decision with each individual man to omit specific or all sets of LYCT during the therapeutic process. Future research should seek to understand the acceptability of the JPM both from the perspective of therapists and men. This could offer insights into facilitators and barriers to delivery of the LYCT.

Of note was the significant effect sleep problems had upon suicidality as men progressed through the JPM. This indicated a potentially enduring, yet modifiable risk factor for men seeking suicide prevention support within a community-setting. Little remains known of the

role of sleep problems upon acute suicidal crisis (Liu et al., 2020). Future research should seek to examine the impact of sleep dysregulation upon suicidality among men within a community-based suicide prevention setting to enhance understanding of its clinical implications in the assessment and prevention of suicide among men within community-settings.

Conclusion

Understanding the risk factors experienced by men in suicidal crisis and how these determine intervention response can inform the development of targeted and effective suicide prevention interventions which are sensitive to the challenges experienced by men when seeking help for suicide. The findings of this study support exploration of psychological risk factors using the LYCT component of the James' Place model. Use of LYCT during the therapeutic journey contextualises the drivers of suicide an individual presents with and how these may fluctuate as an individual progresses through the JPM. This information informs adaptation of the James' Place Model to suit individual needs.

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Appendix 1: Frequency Tables of Lay your Cards on the Table Sets

What's Happening Now Card Variable Frequencies

WHN Card Variable	Selected (Yes/No)	Frequency	Frequency Percentage (%)
WHN1	*Yes*	179	35
	No	332	65
WHN2	*Yes*	139	27.2
	No	372	72.8
WHN3	*Yes*	75	14.7
	No	436	85.3
WHN4	*Yes*	20	3.9
	No	491	96.1
WHN5	*Yes*	117	22.9
	No	394	77.1
WHN6	*Yes*	35	6.8
	No	476	93.2
WHN7	*Yes*	133	26
	No	378	74
WHN8	*Yes*	122	23.9
	No	389	76.1
WHN9	*Yes*	31	6.1
	No	480	93.9
WHN10	*Yes*	129	25.2
	No	382	74.8
WHN11	*Yes*	170	33.3
	No	341	66.7
WHN12	*Yes*	103	20.2
	No	408	79.8
WHN13	*Yes*	105	20.5
	No	406	79.5
WHN14	*Yes*	69	13.5
	No	442	86.5
WHN15	*Yes*	116	22.7
	No	395	77.3

WHN16	*Yes*	117	22.9
	No	394	77.1
WHN17	*Yes*	126	24.7
	No	385	75.3
WHN18	*Yes*	157	30.7
	No	354	69.3
WHN19	*Yes*	67	13.1
	No	444	86.9
WHN20	*Yes*	75	14.7
	No	436	85.3
WHN21	*Yes*	131	25.6
	No	380	74.4
WHN22	*Yes*	104	20.4
	No	407	79.6
WHN23	*Yes*	93	18.2
	No	418	81.8
WHN24	*Yes*	162	31.7
	No	349	68.3
WHN25	*Yes*	141	27.6
	No	370	72.4
WHN26	*Yes*	130	25.4
	No	381	74.6
WHN27	*Yes*	126	24.7
	No	385	75.3
WHN28	*Yes*	89	17.4
	No	422	82.6
WHN29	*Yes*	125	24.5
	No	386	75.5
WHN30	*Yes*	100	19.6
	No	411	80.4
WHN31	*Yes*	149	29.2
	No	362	70.8
WHN32	*Yes*	97	19
	No	414	81

WHN33	*Yes*	134	26.2
	No	377	73.8
WHN34	*Yes*	55	10.8
	No	456	89.2
WHN35	*Yes*	138	27
	No	373	73
WHN36	*Yes*	51	10
	No	460	90
WHN37	*Yes*	153	29.9
	No	358	70.1
WHN38	*Yes*	73	14.3
	No	438	85.7
WHN39	*Yes*	91	17.8
	No	420	82.2
WHN40	*Yes*	77	15.1
	No	434	84.9
WHN41	*Yes*	173	33.9
	No	338	66.1
WHN42	*Yes*	88	17.2
	No	423	82.8
WHN43	*Yes*	141	27.6
	No	370	72.4
WHN44	*Yes*	128	25
	No	383	75
WHN45	*Yes*	114	22.3
	No	397	77.7
	Total	270	58.2

How Did I Get Here Card Variable Frequencies

HDIGH Card Variable	Selected (Yes/No)	Frequency	Frequency Percentage (%)
HDIGH1	*Yes*	102	20
	No	409	80
HDIGH2	*Yes*	44	8.6
	No	467	91.4
HDIGH3	*Yes*	85	16.6
	No	426	83.4
HDIGH4	*Yes*	146	28.6
	No	365	71.4
HDIGH5	*Yes*	34	6.7
	No	477	93.3
HDIGH6	*Yes*	80	15.7
	No	431	84.3
HDIGH7	*Yes*	96	18.8
	No	415	81.2
HDIGH8	*Yes*	36	7
	No	475	93
HDIGH9	*Yes*	36	7
	No	475	93
HDIGH10	*Yes*	57	11.2
	No	454	88.8
HDIGH11	*Yes*	63	12.3
	No	448	87.7
HDIGH12	*Yes*	26	5.1
	No	485	94.9
HDIGH13	*Yes*	34	6.7
	No	477	93.3
HDIGH14	*Yes*	55	10.8
	No	456	89.2
HDIGH15	*Yes*	43	8.4
	No	468	91.6

HDIGH16	*Yes*	110	21.5
	No	401	78.5
HDIGH17	*Yes*	93	18.2
	No	418	81.8
HDIGH18	*Yes*	44	8.6
	No	467	91.4
HDIGH19	*Yes*	32	6.3
	No	479	93.7
HDIGH20	*Yes*	49	9.6
	No	462	90.4
	Total	158	30.9

Keeping the Problem Going Card Variable Frequencies

KPG Card Variable	Selected (Yes/No)	Frequency	Frequency Percentage (%)
KPG1	*Yes*	87	17
	No	424	83
KPG2	*Yes*	31	6.1
	No	480	93.9
KPG3	*Yes*	104	20.4
	No	407	79.6
KPG4	*Yes*	23	4.5
	No	488	95.5
KPG5	*Yes*	82	16
	No	429	84
KPG6	*Yes*	26	5.1
	No	485	94.9
KPG7	*Yes*	99	19.4
	No	412	80.6
KPG8	*Yes*	22	4.3
	No	489	95.7
KPG9	*Yes*	105	20.5
	No	406	79.5
KPG10	*Yes*	79	15.5
	No	432	84.5
KPG11	*Yes*	83	16.2
	No	428	83.8
KPG12	*Yes*	43	8.4
	No	468	91.6
KPG13	*Yes*	40	7.8
	No	471	92.2
KPG14	*Yes*	58	11.4
	No	453	88.6
KPG15	*Yes*	39	7.6
	No	472	92.4
KPG16	*Yes*	64	12.5

	No	447	87.5
KPG17	*Yes*	23	4.5
	No	488	95.5
KPG18	*Yes*	19	3.7
	No	492	96.3
KPG19	*Yes*	27	5.3
	No	484	94.7
	Total	156	30.5

How Can I Get Through This Card Variable Frequencies

HCIGTT Card Variable	Selected (Yes/No)	Frequency	Frequency Percentage (%)
HCIGTT1	*Yes*	97	19
	No	414	81
HCIGTT2	*Yes*	83	16.2
	No	428	83.8
HCIGTT3	*Yes*		
	No	60	11.7
		451	88.3
HCIGTT4	*Yes*		
	No		
		107	20.9
HCIGTT5	*Yes*	404	79.1
	No		
		102	20
HCIGTT6	*Yes*	409	80
	No		
		64	12.5
HCIGTT7	*Yes*	447	87.5
	No		
HCIGTT8	*Yes*	71	13.9
	No	440	86.1
HCIGTT9	*Yes*	48	9.4
	No	463	90.6
HCIGTT10	*Yes*	70	13.7
	No	441	86.3
HCIGTT11	*Yes*	70	13.7
	No	441	86.3
HCIGTT12	*Yes*	84	16.4
	No	427	83.6
HCIGTT13	*Yes*	76	14.9
	No	435	85.1
HCIGTT14	*Yes*	79	15.5
	No	432	84.5
HCIGTT15	*Yes*	78	15.3
	No	433	84.7

HCIGTT16	*Yes*	79	15.5
	No	432	84.5
HCIGTT17	*Yes*	90	17.6
	No	421	82.4
HCIGTT18	*Yes*	110	21.5
	No	401	78.5
HCIGTT19	*Yes*	69	13.5
	No	442	86.5
HCIGTT20	*Yes*	80	15.7
	No	431	84.3
HCIGTT21	*Yes*	91	17.8
	No	420	82.2
HCIGTT22	*Yes*	39	7.6
	No	472	92.4
HCIGTT23	*Yes*	56	11
	No	455	89
HCIGTT24	*Yes*	76	14.9
	No	435	85.1
HCIGTT25	*Yes*	41	8
	No	470	92
HCIGTT26	*Yes*	46	9
	No	465	91
	Total	131	25.6

Chapter 6: A Mixed Methods Longitudinal Case Study Exploring the Effectiveness of a Community-Based, Brief Psychological Intervention for Men Experiencing Suicidal Crisis

The previous study in chapter 5 highlighted the predictive utility of the Lay your cards on the table (LYCT) component of the James' Place model (JPM). As a core component of the JPM routinely used by men during therapy. Previous evaluation reports have reported on the effectiveness of the JPM. However, little remains known about the sustained effects of the JPM for men following completion of the model. This study aimed to further explore the effectiveness of the JPM by examining the short- and long-term effectiveness of the JPM and is presented in the form a mixed-methods longitudinal case study. Low uptake of men into this study prevented multivariate analyses of outcomes. Advancement of understanding of the experience and effectiveness of suicide prevention for men experiencing suicidal crisis requires engagement from men, a population known to be under-represented in research. This presents a dilemma for generating evidence-based findings within the field of suicide prevention research. Therefore, this study also explored the perceptions of research involvement of men who had previously received the JPM for suicidal crisis, adding further knowledge of how recruitment among this population could potentially be improved for the purpose of suicide-related research.

Please note, while questionnaires were sent to participants at baseline, 3-, 6- and 12-month follow-up, no participants completed a 12-month follow-up questionnaire. Therefore, only baseline, 3- and 6-month follow-up quantitative data is reported within this study, which is further supplemented with service data and qualitative data as described within the chapter. A shortened version of the results of this study has been submitted to PloS One Mental Health and is currently under review. An extended version of this study is presented within this chapter.

Abstract

Background: Suicide is a leading cause of death among men globally, highlighting the need for acceptable and efficacious suicide prevention. This study examined the short- and long-term effects of the James' Place Model (JPM), a clinical intervention delivered within a community-setting for men experiencing suicidal crisis and explored acceptability of the JPM and factors influencing engagement of suicidal men in research.

Methods: A mixed methods longitudinal case study design was used. Quantitative data was collated through baseline, 3- and 6-month follow up questionnaires distributed to 28 men receiving the JPM. Measures of resilience, hope, generalised self-efficacy, self-compassion, loneliness, perceived social support, entrapment, and the 10-item clinical outcome measure were taken, and merged with routine service data. Two semi-structured interviews informed development of case studies exploring men's perceived acceptability and short- and long-term effectiveness of the JPM, and factors relating to suicide research engagement.

Results: Descriptive analyses showed decreased mean scores of entrapment, with development of self-compassion compared to baseline mean scores at 3- and 6-month follow-up. Case studies highlight the perceived acceptability, and short- and long-term effectiveness of the JPM suggesting use of the lay your cards on the table component help men to articulate the drivers of their suicidality. Men also discussed continued application of strategies developed during the JPM long-term including safety planning.

Conclusion: JPM is acceptable among men experiencing suicidal crisis and future work should seek to determine whether its short-term effectiveness is sustained long-term.

Introduction

Men are disproportionately at greater risk of suicide than women (Canetto & Sakinofsky, 1998; Naghavi, 2019). Office of national statistic (ONS) (2022) figures show men accounted for three quarters (4129 deaths) of all suicide deaths (5583 deaths) in England and Wales in 2021. Risk factors associated with suicide uncover a complex interplay of diverse biopsychosocial and behavioural factors (Franklin et al., 2017; O'Connor & Nock, 2014; Richardson et al., 2021a; Turecki et al., 2019). Richardson et al., (2021a) found sixty-eight risk factors associated with suicide behaviours (including attempts and death) among men. These included sociodemographic characteristics (e.g., marital status, low education); physical health and illness (e.g., smoking, diabetes); mental health problems and psychiatric illness (e.g., anxiety and depression); psychological factors - personality and individual differences (e.g., poor emotional control and aggression); negative life events/trauma (e.g., bereavement and adverse childhood experiences); and characteristics of suicidal behaviour (e.g., history of suicide attempts) (Richardson et al., 2021). Research has advanced understanding of which factors potentially may drive suicidal thoughts, feelings, and behaviours among men. However, this also highlights the challenge of creating effective suicide prevention approaches that adequately meet men's needs given the diversity of risk factors (Richardson et al., 2021a).

Men are typically portrayed as poor help-seekers who endure greater distress before seeking support symptoms for mental health difficulties (e.g., Addis & Malik, 2003; Biddle et al., 2004; Galdas et al.,2005., Cleary et al., 2017). Research findings attribute subscription to dominant masculine norms, including stoicism and self-reliance, which undermines expressions of vulnerability and emotion for men's reluctance towards help-seeking (Levant et al., 2011; McDermott et al., 2018; Pirkis et al., 2017; Seidler et al., 2016; Vickery, 2021). However, research is growing which shows that men do seek help but in ways inconsistent with conventional help-seeking behaviours (Chandler, 2022; Cheshire et al., 2016; Seidler et al., 2016; Vickery, 2021). Vickery (2021) showed maintaining autonomy in disclosure of emotional distress to professionals who acknowledged the significance of this distress allowed men to reconstruct an alternative masculine ideal conducive to help-

seeking and disclosure of emotions. This highlights how content of disclosure and context in which it occurs may interact to influence when men do and do not talk, and what they feel able to disclose. For example, maintaining silence and non-disclosure of suicide may allow men to avoid stigma, but reaffirm masculine norms such as stoicism and control (Chandler, 2022). Findings such as these demonstrate men are willing to seek help and discuss mental health problems, including suicide, when service provision and delivery conditions are suited to their needs and preferences (Chandler et al., 2022; Chopra et al., 2022; Eggenberger et al., 2023; Seidler et al., 2018).

Research examining men's perspectives and experiences of mental health provision has shown that men prefer solution-focussed approaches that extend beyond just talking whereby symptoms and coping strategies are explored (Emslie et al., 2007; Seidler et al., 2018; Whittle et al., 2015). Moreover, informal, community-based suicide prevention settings perceived as trustful and which allow reframing of help-seeking to suit masculine norms are preferred (Chopra et al., 2022; Saini et al., 2021a; Struszczyck et al., 2019). In response to such evidence, there are growing calls for tailored men friendly suicide prevention services that consider the role of masculinity in the development and recovery from suicidality to improve acceptability and accessibility, and outcomes among men experiencing suicidal crisis (Fogerty et al., 2018; River, 2018; Sharp et al., 2022). However, clinical population-based research examining how suicide risk is managed has dominated, with less attention upon community-based suicide prevention (Sharp et al., 2022).

In considering the needs of men experiencing suicidal crisis, the James' Place suicide prevention service has been developed. James' Place a community-based suicide prevention service for men experiencing suicidal crisis (Hanlon et al., 2022). Therapists are trained to deliver the James' Place Model (JPM), a clinical, brief psychological intervention informed by three theories of suicide: the interpersonal theory of suicide (Joiner et al., 2009), the collaborative assessment and management of suicidality (CAMS) (Jobes, 2012) and the integrated motivational theory of suicide (IMV) (O'Connor, 2011; O'Connor & Kirtley, 2018). Each theory shares similarities of co-production of effective suicide prevention strategies and safety planning, and equipping the individual to manage their suicidal distress. Also,

therapists offer a range of therapeutic approaches and focus upon reducing suicidal distress while improving coping and resilience, consistent with the CAMS. Focus of sessions is broadly structured into three components delivered across three sessions each (nine sessions in total) corresponding to safety planning and risk management, delivery of brief psychological interventions (e.g., behavioural activation, sleep hygiene), and relapse prevention involving in-depth safety planning and reflection of progress through the clinical journey. Throughout the clinical journey, the lay your cards on the table (LYCT) component of the JPM is delivered. This novel aspect of the JPM is comprised of four stacks of cards which resemble playing cards. Each card within different sets describes either an emotion (e.g., sad, hopelessness), physical sensation (butterflies, dizziness), situation (e.g., someone is bullying me), life event (e.g., someone is bullying me) or coping approach (final set of cards only – e.g., walk 6000 steps; listen to some music). *What's happening now* and *how did I get here* cards are delivered during the first three sessions. Next, *keeping the problem going* cards are administered during sessions four to six. The final set of cards, *how I can get through this*, are delivered during the last three sessions. The purpose of the cards is to prompt discussion around specific issues and correspond to specific stages of the JPM as described. More detailed information about the James' Place service and JPM are available (Hanlon et al., 2022; Saini et al., 2020; 2021b; 2022a).

Evaluation is a key facet of James' Place practice and outcomes are routinely assessed using CORE10 and entrapment short form (E-SF) questionnaires (DeBeurs et al., 2020). Evaluation studies have shown that the JPM works is effective in supporting men experiencing suicidal crisis in the short-term (Saini et al., 2020; 2021b; 2022a). Most recently, evaluation of year three service data showed a significant reduction upon discharge from James' Place in CORE10 and entrapment scores, (Saini et al., 2022a). While evidence supports the short-term effectiveness of the JPM, less remains known about its effectiveness post-intervention and whether significant reduction in psychological distress and entrapment is sustained post-discharge from the service. This study therefore aims to determine the short- and long-term effectiveness of the JPM using data collected at baseline, 3- and 6-month follow up, by addressing the following research questions:

1. Does the JPM significantly reduce risk factors associated with suicide of psychological distress, entrapment, and loneliness among men experiencing suicidal crisis?
2. Does the JPM significantly improve protective factors of hope, generalised self-efficacy, perceived social support, and self-compassion among men experiencing suicidal crisis?
3. What are the experiences of men who have received the JPM during and after intervention delivery?
4. What factors influence the acceptability and feasibility of conducting long-term research among men who have received the JPM for suicidal crisis?

A 12-month follow-up questionnaire was sent to participants. However, none were completed. Therefore, baseline, 3- and 6-month follow up data is reported only.

Materials and Methods

Design

A mixed methods case study longitudinal approach was used. Questionnaire data from this study was merged with data routinely collected by the James' Place service. The qualitative phase included two case studies with men who had received the JPM. Ethical approval was given by Liverpool John Moores University research ethics committee (Ref:19/NSP/057 & 20/NSP/043).

Participants

Purposive sampling was used to recruit male participants who were in receipt of the JPM for suicidal crisis (see Hanlon et al., 2022 for further details). Twenty-eight men completed baseline questionnaires. Each was emailed an online follow-up questionnaire at 3- and 6-

month follow-up. Two men who completed baseline questionnaires also took part in a semi-structured interview.

Measures

Total mean scores of the following measures comprised baseline, 3- and 6-month questionnaires. Baseline measures of entrapment and CORE10 were omitted from the baseline questionnaire and obtained from James' Place routinely collected data. The decision to omit entrapment and CORE10 measures was taken by the request of James' Place to avoid over-burdening men as they collect this data from men when they are accepted into the service anyway.

Demographic characteristics: Information including age range, relationship status, preferred mode of delivery of the JPM (in-person, online, telephone) and alternative sources men would have sought support from if they had not approached James' Place (e.g., A&E, GP).

Resilience: The six-item brief resilience scale (BRS) (Smith et al., 2008). Items (e.g., *tend to bounce back and I usually come through difficult times with little trouble*) are assessed along a 5-point Likert scale ranging from strongly disagree to strongly agree. Items comprising the BRS are either positively (3 items) or negatively worded (3 items). BRS scores were acquired by calculating the mean of the total item scores, which were then used in the analyses. Good internal consistency was achieved within this scale in this study as indicated by a Cronbach alpha coefficient of .81.

Hope: Snyder et al's., (1991) 12-item adult hope scale (AHS). The AHS is comprised of two subscales including agency (4-items) and pathways (4-items) which correspond to goal-orientated energy and planning to accomplish goals respectively. Example items include *My past experiences have prepared me well for my future* (agency) and *I can think of many ways to get out of a jam* (pathways). Four filler items comprise the remaining items which have been removed from the analyses. Individual scores are ranked along an 8-point Likert scale ranging from *"definitely false"* to *"definitely true"*. Scores can be assessed at the

subscale level or as a total score. Total AHS scores were used in the present study. Moderately low internal consistency was recorded by the hope scale as indicated by a Cronbach alphas coefficient score of .67 in this study.

Generalised self-efficacy (GSE): The 10-item GSE (Schwarzer and Jerusalem, 1995) included items *"I am confident that I could deal efficiently with unexpected events"* and *"If I am in trouble, I can usually think of a solution"* which are measured along a 4-point Likert scale ranging from one to four representing *"not at all true"* and *"exactly true"* respectively. Total GSE scores range from ten to forty, with higher scores indicative of higher GSE. In the present study, total GSE scores were used in the analyses. A Cronbach alpha coefficient score of .92 shows this scale achieved strong internal consistency in the present study.

Self-compassion (SC): Neff's (2003) 26-item SC measure consists of six subscales: self-kindness, self-judgement, common humanity, isolation, mindfulness and over identification. Items (e.g., "*I'm tolerant of my own flaws and inadequacies"* and *"when I fail at something important to me I try to keep things in perspective"*) are assessed along a 5-point Likert ranging from *"almost never"* (1) to *"almost always"* (5). To ascertain a total score of SC, self-judgment, isolation, and over identification subscales were reverse scored. Mean scores of each subscale and then a total mean score of all six subscales was calculated and used in the analyses. Higher total mean scores were indicative of higher SC. A strong Cronbach alpha coefficient score was achieved (.89) for this scale indicative of strong internal consistency.

Loneliness: The revised UCLA loneliness scale (ULS) (Hays and DiMatteo, 1987) measured loneliness. Adapted from the revised UCLA-20 loneliness scale (Russell et al., 1980), eight items comprise the ULS-8. A 3-point Likert scale was used in the present study with values ranging from 1 to 3 representing *"hardly ever or never"* and *"often"* respectively. A Cronbach alpha coefficient score of .55 indicates low internal consistency for this scale in this study.

Perceived social support (PSS): The multidimensional scale of perceived social support (PSS) (Zimet et al., 1998) consists of 12-items with responses indicated using a 7-point

Likert scale ranging from *"very strongly disagree"* (1) to *"very strongly agree"* (7). Three subscales of family, friends and significant others comprise the scale, with mean total score representative of the perceived adequacy of social support from these sources. High internal consistency was achieved by this scale in this present study as demonstrated by a Cronbach alpha coefficient score of .90.

Entrapment: Entrapment short form scale (E-SF) (De Beurs et al., 2020) measured four items relating to external entrapment (e.g*., I am in a situation I feel trapped in*) and *internal entrapment (e.g., I want to get away from myself).* As a self-report measure respondents are asked to endorse their response along a 5-point Likert scale ranging from *"not at all like me" (0)* to *"extremely like me" (4)* providing a potential range of scores from 0 to 16. An overall score of entrapment is calculated by adding each item score with higher total scores indicative of higher levels of entrapment.

CORE10 Clinical Outcome Measure (CORE-OM): The CORE-10 assessed psychological distress and includes 10-items (e.g., "*I made plans to end my life*" and "*unwanted images or memories have been distressing me*"). The CORE-10 utilises a 5-point Likert scale ranging from 0 (*"not at all"*) and 4 (*"most or all of the time"*) and respondent scores give a total score ranging from 0 to 40. Higher CORE-10 scores indicate higher levels of psychological distress. CORE-10 scores of less than 10 corresponds to the non-clinical range; 11 to 14 mild psychological distress; 15 to 19 moderate psychological distress; 20 to 24 moderate-to-severe psychological distress; 25 or above severe psychological distress. A total score of 11 or above represents the clinically significant range.

Both the E-SF and CORE-10 correspond to routine outcome measures used by James' Place and were included in all follow-up questionnaires. It is not possible to calculate a reliability score for either the E-SF and/or CORE10 as James' Place does not record individual item scores for these scales. They only record total E-SF and CORE10 scores for each individual man.

Procedure

Men accepted into James' Place between 1st December 2020 and 15th April 2022 were invited to complete a questionnaire at baseline. Twenty-eight men completed a baseline questionnaire, with seventeen agreeing to be sent follow-up questionnaires. Of the men sent questionnaires at follow-up, twelve and three men completed 3- and 6-month follow-up questionnaires respectively.

Men who had completed the JPM and a baseline questionnaire, who had agreed to being contacted by a researcher for follow-up were invited to participate in an interview. Ten men agreed to be followed up for interview. Seven men were excluded because of re-engagement with the James' Place service (n = 4), they were deceased (n = 1) and for other reasons (n=2). The purpose of interviews was to explore men's views on how effective they perceived the JPM was in supporting them through suicidal crisis and in the period post-crisis. Response rate to the invitation to take part was poor (n=2; 20%). Subsequently, two men agreed to participate in an individual semi-structured interview. One interview was in-person and took place at James' Place Liverpool. The other interview was conducted over the telephone.

Data Analysis

Routine clinical information compiled by James' Place was accessed and merged with baseline and 3- and 6-follow-up data. Routine data includes sociodemographic details of men (age, ethnicity), and precipitating and psychological factors experienced by men upon entry to James' Place, and CORE- and entrapment data.

Semi-structured interviews were audio recorded using a Dictaphone and transcribed verbatim using a transcription service, generating 66 minutes of interview data. Resultant data was thematically analysed using Braun and Clarke's (2006) approach to explore

participants perceptions of the JPM and their experiences of participating in questionnaire studies in suicide prevention related research.

Results

Sample Characteristics

Between 1st December 2020 and 15th April 2022, James' Place received 742 referrals from ED, Primary Care, Universities, communities, or self-referrals. Of those, 494 (33.4%) who attended for a welcome assessment and 341 (46%) went on to engage in therapy. For those who did not attend the welcome assessment, the reason was usually because men were no longer feeling suicidal or there was no response when the service attempted to contact men to arrange the welcome assessment. During this period, one man was referred on to an alternative service. The service they were referred to and for what reason is unknown as this information was not recorded in the service data. Of 341 men who attended James' Place for therapy during this period, twenty-eight completed a baseline questionnaire. The questionnaire data for each man who took part in this study (*N*=28) was merged with routine data collated by James' Place using each man's unique identification case number.

Mean age of participants in the present study was 43 years (range 22-66years; SD=11.45years) and participants attended a mean number of seven sessions (SD=2.87; range 1-10). While the mean number of sessions is comparable to that which has previously been reported in James' Place evaluation reports (i.e., range=6-7 sessions), the mean age in the present study (43 years) is higher (33 to 36 years; Saini et al., 2020; 2021; 2022).

Follow-up questionnaires were completed by men in the present study from 12th February 2021 to 14th March 2022. Significant attrition was observed at follow-up with thirteen questionnaires completed at 3-month follow-up and three questionnaires completed at 6-month follow-up, representing an attrition rate of 54% and 89% respectively.

Table 1: Demographic Characteristics of Study Sample and James' Place Service Data from 1st December 2020 to 15th April 2022

Variable	*N* (%) Study Sample (*N*=28)	*N* (%) Service Data* (*N*=742)
Ethnicity		
White British	24 (85.7)	531 (80.5)
Other ethnicity	0	144 (19.5)
Not specified	4 (14.2)	0
Relationship status		
Single	9 (32.1)	408 (55.4)
Married	10 (35.7)	85 (11.5)
In a relationship	5 (17.9)	127 (17.2)
Divorced	1 (3.6)	8 (1.1)
Separated	0	31 (4.2)
Widowed	0	5 (.7)
Not specified	3 (10.7)	73 (9.9)
Sexual orientation		
Heterosexual	13 (46.4)	348 (47.9)
Homosexual	0	44 (6.1)
Bisexual	1 (3.6)	6 (.8)
Not specified	14 (50)	329 (45.2)
Employment status		
Employed	15 (53.6)	292 (39.4)
Unemployed	8 (28.6)	266 (35.9)
Students	0	78 (10.5)
Carer	0	10 (1.3)
Retired	2 (7.1)	4 (.5)
Not specified	3 (10.7)	0
Postcode deprivation		
Most deprived (1-5)	5 (17.9)	304 (43.7)
Least deprived (6-10)	23 (82.1)	392 (56.3)
Not Specified	0	0

Table 1 shows the study sample demographics (*N*=28) and service data demographics (*N*=742) for the period from 1st December 2020 to 15th April 2022. Most men in the present study identified as white British (n=24; 85.7%), were employed (n=15; 53.6%) and lived in the least deprived areas as indicated by IMD post-code scores (n=23; 82.1%). Relationship status varied among participants, but most men in the study sample were married (n=10; 35.7%). Of fourteen men who provided their sexuality, thirteen identified as heterosexual (46.4%). Some similarities and differences are seen when demographic data for men in the present study is compared to that of men referred to James' Place during the study period (i.e., 1st December 2020 to 15th April 2022). Of the 742 men referred to James' Place during the study period, most were White British (n=531; 80.5%), employed (n=292; 39.4%), reside in the least deprived areas (n=392; 56.3%) and heterosexual (n=348; 45.2%). However, in contrast to the study sample most men referred to James' Place during the study period were single (n=408; 55.4%).

Psychological Profile of Men

Men attributed several factors to precipitating their suicidal crisis upon entry to James' Place shown in Table 2.

Table 2: Precipitating Factors Pre-Baseline (Upon Entry to James' Place) Attributed to Suicidal Crisis (*N*=28).

Precipitating factor	***N*** **(%) Recorded by service***
Relationship problems	13 (46.4)
Financial issues	5 (17.9)
Housing issues	1 (3.6)
Health problems	7 (25)
University	1 (3.6)
Work	8 (28.6)
Sexuality	2 (7.1)
Victim of past abuse trauma	3 (10.7)
Legal problems	2 (7.1)
Family problems	2 (7.1)
Bereavement	6 (21.4)
Substance/alcohol misuse	3 (10.7)
Perpetrator of crime	1 (3.6)
Carer	2 (7.1)
Covid-related issues	4 (14.3)
Other	0

*Note: figures reflect collapsed variables, therefore it is feasible an individual's data has been recorded more than once

The two most prevalent precipitating factors were relationship problems and work. In contrast, other (including bullying and asylum-related issues) were the least prevalent precipitating issues. This suggests that men within the study sample had been experiencing relationship and work-related difficulties and highlights the important role of social and relational proximal factors in contributing to the men's suicidal distress. Please see appendix 1 for a more detailed breakdown of precipitating factors.

Table 3 shows the prevalence of psychological factors reported by men upon acceptance to James' Place, which have been group together according to the IMV model of suicide (O'Connor, 2011; O'Connor & Kirtley, 2018).

Table 3: Psychological Factors Pre-Baseline (Upon Entry to James' Place) Attributed to Suicidal Crisis (*N*=28).

Psychological variable	***N*** **(%) Recorded by service***	***N*** **(%) Missing data***
Motivational Phase		
Threat to Self-Moderators	52 (50.5)	9 (8.7)
Motivational Moderators	93 (40.6)	23 (10)
Defeat	15 (53.6)	2 (7.1)
Humiliation	10 (35.7)	3 (10.7)
Entrapment	21 (75)	2 (7.1)
Volitional Phase		
Volitional Moderators	70 (39.1)	17 (9.5)

*Note: figures reflect collapsed variables, and it is therefore feasible an individual's data has been recorded more than once

Examination of the psychological factors reveals that men reported a greater number of motivational moderators than threats to self-moderators. Closer inspection of the breakdown of the motivational moderators reported by men (see appendix 2 for a breakdown of psychological factors) social support (n=19) was the most, and social norms (n=1) the least, frequently reported respectively. Entrapment was the most reported psychological factor by men when they were accepted into the James' Place service (n=21; 75%). These findings are consistent with the theory underpinning the IMV model of suicide in that threats to self-moderators attenuate or amplify feelings of entrapment and that motivational moderators likewise will attenuate or amplify translation of suicide ideation to suicide behaviour (O'Connor, 2011; O'Connor & Kirtley, 2018). Therefore, the finding that entrapment was the most frequently cited psychological factor is to be expected since the men had entered the service while in suicidal crisis.

Questionnaire Completion Rates

Table 4 shows the number of participants who completed study questionnaires at baseline, 3- and 6-month follow-up. Significant attrition rates at 3- and 6-month follow-ups occurred across the study follow-up period (reported earlier).

Table 4: Completion Rates of Baseline, 3- and 6-Month Follow-Up Questionnaires (*N*=28)

Variable	**Completed at baseline (*N*=28)**	**Completed at 3-month follow-up (*N*=13)**	**Completed at 6-month (*N*=3)**
BRS	n = 28	n = 13	n = 3
Hope	n = 27	n = 13	n = 3
GSE	n = 27	n = 13	n = 3
ULS	n = 27	n = 10	n = 3
Self-compassion	n = 27	n = 10	n = 3
MPSS	n = 28	n = 10	n = 3
CORE10	n = 27	n = 12	n = 3
E-SF	n = 27	n = 12	n = 3

Baseline and Follow-Up Questionnaire Results

Table 5 shows the mean total scores and standard deviations for the baseline and 3- and 6-month follow-up scores for each psychological measure within the questionnaire. This data has been supplemented with service data from James' Place for study the period (i.e., 1st December 2020 to 15th April 2022).

Table 5: Mean and Standard Deviations of Baseline, 3- and 6-Month Follow-Up Questionnaires (*N*=28)

Variable		**Completion Rates (*N*)**	**Mean (SD)**	**Min. score**	**Max. score**
BRS					
Baseline		28	2.24 (.79)	1	4.17
3-month follow-up		13	2.87 (1.26)	1	5.33
6-month follow-up		3	2.33 (1.52)	1	4
Hope					
Baseline		27	55.78 (10.63)	30	76
3-month follow-up		13	55.62 (11.54)	36	74
6-month follow-up		3	45 (10)	35	55
GSE					
Baseline		27	23.26 (5.76)	11	34
3-month follow-up		13	24.69 (7.23)	10	34
6-month follow-up		3	20.67 (9.71)	10	29
ULS					
Baseline		27	18.30 (2.71)	12	24
3-month follow-up		10	13.40 (7.47)	4	24
6-month follow-up		3	16.67 (6.81)	9	22
Self-compassion					
Baseline		29	1.95 (.61)	1	3.08
3-month follow-up		10	3.14 (.54)	2.35	4.36
6-month follow-up		3	3.28 (.30)	3.07	3.63
PSS					
Baseline		28	3.63 (1.25)	1.0	5.83
3-month follow-up		10	4.26 (1.43)	2.17	6.08
6-month follow-up		3	3.72 (2.47)	1.42	6.33
CORE10					
Baseline		27	30.70 (6.01)	15	38
3-month follow-up		12	37.75 (5.10)	29	45
6-month follow-up		3	37.33 (11.37)	28	50
Service data*					
	Initial	278	29.35 (5.84)	20	40
	Discharge	156	18.72 (9.80)	0	40
E-SF					
Baseline		27	14.15 (2.44)	15	38
3-month follow-up		12	12.08 (3.92)	4	19
6-month follow-up		3	11.67 (8.02)	4	20
Service data*					
	Initial	258	13.10 (3.94)	0	31
	Discharge	156	7.57 (5.13)	1	16

*Service data extracted from James' Place for the period from 1st December 2020 to 15th April 2022

Study data (*N*=28) in table 5 shows mean total scores of resilience, GSE, SC and PSS increased during the period from baseline to 3-month follow-up, while loneliness mean total score decreased, and hope mean total score remained the same. Mean total scores from 3- to 6-month follow-up of resilience, hope, GSE and PSS decreased. In contrast, mean total scores of SC and loneliness increased from 3- to 6-month follow-up, with the SC recording higher mean total scores than those recorded at baseline. From baseline to 3-month follow-up, mean total CORE10 scores increased, but remained comparable at 3- and 6-month follow-up. While mean total entrapment scores decreased from baseline to 3-month follow-up, and from 3- to 6-month follow up also. It is difficult to discern a pattern with the study sample data owing to the small sample size, however data suggests fluctuations across various psychological variables in the 6-month period following discharge from James' Place.

Mean total baseline CORE10 scores for men in the present study (*N* =28) and mean total initial CORE10 scores of men referred to James' Place during the study period (i.e., 1st December 2020 to 15th April 2022) are similar (30.70 versus 29.35 respectively). Also, mean total baseline entrapment and mean total initial entrapment scores appear comparable (14.15 versus 13.10 respectively). Note, comparison of baseline and initial mean total CORE10 and baseline and initial entrapment scores is possible as data for both corresponds with data recorded by therapists for men during their welcome (i.e., first) assessment at James' Place. It is not possible to compare mean total CORE10 and mean total entrapment scores recorded for men from the present study against any other timepoints in the present study with that extracted from James' Place service data as the measurement timepoints differ.

Table 6 shows the median and range scores at baseline and 3-month follow-up for all psychological variables.

Table 6: Median and Range Scores at Baseline and 3-Month Follow-up for all Psychological Variables (*N=28)*

Variable		Median	Range
BRS	*Baseline*	2.17	3.17
	3-month	2.33	4.33
Hope	*Baseline*	58	46
	3-month	55	38
GSE	*Baseline*	25	23
	3-month	26	24
ULS	*Baseline*	18	12
	3-month	14	20
Self-compassion	*Baseline*	17.73	2.08
	3-month	3.08	2.01
PSS	*Baseline*	3.67	4.83
	3-month	4	3.91
CORE10	*Baseline*	33	23
	3-month	38.5	16
Entrapment	*Baseline*	15	8
	3-month	13	15

Wilcoxon matched pairs signed ranks tests were run to compare whether there was a significant reduction in risk factors of suicidal distress (i.e., CORE10 scores), entrapment and loneliness occurred at baseline compared to 3-month follow up. Results showed a significant difference in median scores at baseline versus 3-month follow-up for CORE10 scores (Z= -2.63, *p*=0.01) and for loneliness scores (Z= -2.37, *p*= .02). However, no significant reduction in entrapment scores was found (Z= -1.61, *p*= .12). This suggests that the JPM improves loneliness at baseline and 3-month follow-up, but not CORE10 and entrapment scores.

Wilcoxon matched pairs signed ranks tests were also performed to determine whether there was a significant difference in the factors of hope, GSE, PSS and SC at baseline compared to 3-month follow-up. Results showed significant difference in median scores between

baseline and follow-up scores for BRS (Z= -2.27, *p*= .02) and SC (z= -2.5; *p*= .01). However, non-significant differences in the median scores between baseline and follow-up scores for hope (z= -1.10; *p*= .27), GSE (z= -1.25, *p*= .21) and PSS (z = -1.58, *p*=.11). This suggests that the JPM increases resilience and SC between baseline and at 3-month follow-up. However, hope, GSE and PSS did not significantly change. Note, it was not possible to compare changes in each variable scores at 3-month versus 6-month follow-up due to the high rate of attrition at 6-month follow-up resulting in an extremely small sample size.

Descriptive Case Study Findings

Three themes were developed to capture men's experiences of the short-term and long-term impact of JPM following discharge from the service and the feasibility and acceptability of conducting long-term research with men following suicidal crisis and are reported in figures 1 and 2.

Figure 1: Case Study 1: John (56 years old)

Suicidal Experience

Having acquired a brain injury several years earlier when he was 21 years old in the line of duty, John has not been able to work and has struggled with his mental health. Resultantly, he approached James' Place for suicidal thoughts and feelings. "*When it got to the point where I thought, "No, I need some help here, otherwise I'm just going to end up doing something stupid," and I didn't want that."*

Perceived Short-Term Impact of the JPM

Prior to attending James' Place, John had only ever disclosed his suicidal thoughts and feelings to one friend, and his family remain unaware of his suicidal crisis today. John felt that having the opportunity to acknowledge and discuss his suicidal thoughts and feelings helped to destigmatise his suicidal experiences. *"It was finally speaking to somebody and acknowledging that I had a problem. I could relate with the person, the lady that I spoke to, and that. I was put at ease, and it was like, "Well, you're not the only one. There are a lot of men out there that hold it in." And I just felt so relaxed. So, it was then, everything just came out."* John was reassured by James' Place of his importance and self-worth, which led to his understanding of the impact taking his life would have upon significant others. *"I didn't worry about anybody else. It was just me and how I was feeling, and how best to get out of this and save everybody else. Then it wasn't until you come here [James' Place] and you realise how much…if you took your own life or disappeared, how much it would affect other people. Because at the time, it was just me, me, me, and not thinking. It was having blinkers. Everything else didn't matter. It was just all about me. But it's not all about me."*

John perceived writing his thoughts and feelings in a diary and bringing this to the therapy sessions each week helpful, even though it made him *"cry"* which he found *"embarrassing".* Doing this allowed John to open up about his feelings and helped him to develop coping mechanisms. *"I'd bring my book in and she'd [the therapist] read it. We'd talk about things like that. So, it just gave me coping mechanisms for when I'm feeling down."* Discussing his suicidal thoughts and feelings at James' Place was perceived by John to provide *"relief when I left here [James' Place]. It was just great to come in, offload everything and then, when I left, I felt so much better. It was like somebody had lifted a weight off my shoulders."*

Perceived Long-Term Impact of the JPM

John continues to implement the coping strategies that he developed when at James' Place, particularly the lay your cards on the table component of the JPM and a diary. *"The stuff that I was given to take away and little things that you could do, like the cards, writing a diary, I still do it when I'm bad, when I'm feeling- When I'm having a bad day, I get the cards and go through the cards. I've still got a diary…"* Since John has not disclosed his suicidal crisis to anyone apart from one friend, he finds implementing the diary and lay your cards on the table as a coping strategy to offload his negative thoughts and feelings onto paper which helps reduce ruminating on these. *"Because you're not speaking to anybody, because you're on your own, I thought, "Carry it on." It sounds stupid. Because I didn't want anybody else to see how I was feeling and what I was thinking. But it was nice to put it on paper, if you understand what I mean. Rather than just keep going over and over in my head, I'd get it written down on a bit of paper."*

In addition to the practical coping strategies gained at James' Place, John seems to suggest that normalisation of his suicidal crisis resonated with him, and reflecting upon this engenders some comfort when he experiences mental health difficulties. *"It helps put your mind at rest. When I'm having bad days, I think "[Name], you're not the only one." There are lots of other people out there who would like the help and are too embarrassed. But you've got to make the first step. Once you make it, it's much easier when you know you aren't the only man that's struggling."*

Engaging men in Long-Term Research

John explained he completed the questionnaire as an act of kindness for the support James' Place gave him. *"Well, it's the help that I received once I started coming here [James' Place]."* Completion of the questionnaires was perceived by John as a way of potentially helping other men. *"So, I thought, "Well, it's going to help me and if it helps me, then hopefully it'll help- Even if it only helps one person, then it's something."* John felt completing the questionnaire resembled writing an entry in his diary, which he had used as a coping strategy for managing his suicidal thoughts. *"It was like more of a diary and that. Read the question and then how you're feeling at specific [times]. Read the question, write how you're feeling. Sometimes, like I say, I'd do the questionnaire when I was low and that, and you'd see that by some of the answers. Then the next one, I was in a good place…That helped as well as coming here and doing the coping mechanisms...it was just like a continuous session for me."* This allowed John to offload and reflect upon his mental wellbeing and recovery in a structured and cathartic manner and may have averted rumination of negative thoughts.

John perceived the prospect of completing follow-up questionnaires as reassuring as it allowed him to assess his psychological wellbeing and he felt satisfied with the follow-up timepoints. *"…it was just great to know that "Right, I've done the three months. The six months one will come. The twelve months is coming" It was like coming here [James' Place] and speaking to somebody, but you were reading the question and then you were just answering it."* Questionnaire format and mode of delivery via email was perceived as acceptable by John. Receiving a text message or email reminder prior to receiving the questionnaire was perceived as a helpful prompt. Also, the questionnaire was a reminder of his progress within his therapeutic journey and that James' Place was there for him if he experienced suicidal crisis again. *"It's like you're getting prompted. "Listen, we're still here if you need us"…it was still nice to get the email or anything. Whether it be in text form or a letter. You're not alone. You're still here and there are people here for you."* However, the stigma associated with suicide was not far from John's mind as he offered his thoughts on why other men did not complete the questionnaires, suggesting they may *"still be embarrassed that they've had to come here, and they've kept it to themselves."*

Figure 2: Case Study 2: Peter (35 years old)

Suicidal Experience

Peter came to James' Place experiencing suicidal crisis. He suspected he might have an undiagnosed neurodevelopmental condition which they attributed to their present suicidal crisis and previous mental health difficulties in the past. "*I've been in and out with my mental health my whole life.*" They disclosed this to the James' Place therapist who adapted the JPM to suit their needs.

Perceived Short-Term Impact of JPM

Peter perceived the JPM rapidly reduced their suicidal distress in the short-term by providing an opportunity to *"offload each week"* concerns around their home and work life. It also equipped him with effective strategies to manage psychological and behavioural factors underpinning their crisis. *"I think in the short term it was very useful. Because I was getting a couple of different strategies, and I was getting the chance to offload each week which I didn't really get anywhere else."* While awaiting assessment for a neurodevelopmental condition and recognising this to be the primary driver of their suicidal crisis, Peter perceived tailoring of the JPM helped him to identify unhelpful behaviours. *"So, I was on the waiting list for [neurodevelopmental condition], so I felt like it was something, at the time, the strategies were useful. So even though I did have [neurodevelopmental condition], I parked that to one side. I was thinking, "At the moment, my motivation is low, so what can I improve?" And I think the things that they put out for me did help me recognise my own behaviours. I couldn't see my own behaviours because I felt low at the time."*

Peter felt the lay your cards on the table component of the JPM particularly *"piqued my [their] interest"*. He perceived these as a *"good technique"* for recognising his feelings and developing strategies at a time when they were struggling with motivation. *"There were certain things that weren't me at all, and then there were other things that I thought, "I can relate to these." So, we kind of separated them all. When you're feeling low anyway sometimes, you're that confused, you don't really know how I feel. And this kind of untangled that for me."* Peter recognised the lay your cards on the table as an effective tool for simplifying the complex issues and psychological factors driving an individual's suicidal crisis that may help men talk about their suicidal distress. *"I didn't feel myself and I wasn't thinking straight…by it being simple, it really helped me, because I wasn't in the frame of mind to be talking about complex issues."*

Perceived Long-Term Impact of the JPM

Peter experienced further suicidal crisis following discharge from James' Place and they attempted suicide which they attributed to having an undiagnosed neurodevelopment condition. He has since been diagnosed and perceived that receiving medication for their neurodevelopmental condition has been helpful and they feel they have *"no issues at all."*

Nevertheless, Peter reported that he continued to utilise the strategies learned at James' Place. For example, he would reflect upon a photo of the lay your cards on the table he selected during therapy. Similarly, he continues to reflect upon his safety plan which he has displayed at home. *"I did have the photos and stuff, and I thought I'd lost them, but I did do a safety plan. And I've still got it up on my wall now…When I look at it now, and there are certain things that I feel, I'll be like, "Go and meet the lads for a coffee," and I'll go and have a coffee with the lads for a bit. So, it just gives me that little nudge."* In this way, their safety plan prompts them to enact the strategies they learned at James' Place to sustain their wellbeing.

Engaging Men in Long-Term Research

Peter expressed his decision to take part in James' Place research following discharge was motivated by his first-hand experiences of the challenges of recruiting for research having previously been to university. *"I've obviously been at Uni myself…Because I've been in the situation myself where I've had to try and get the forms filled out. So that was the reason probably."* Peter felt that hosting the questionnaire online using a platform accessible via mobile phones rather than requesting completion of paper-based questionnaires was preferred and promoted accessibility to the questionnaire. *"I thought it was beneficial being online. I find stuff easier on the phone. Probably, if you'd have sent out a paper-based one, I don't think I would have done it."* In conducting long-term research, Peter was asked about follow-up periods of 3-, 6- and 12-months following discharge from James' Place. However, Peter proposed that shorter follow-ups such as *6 weeks, 12 weeks and then kind of couple up"* in the period following discharge would improve capture of changes in psychological wellbeing that may occur immediately after discharge from the service as they felt *"a lot can happen in the three months [after discharge]."* Administering a questionnaire in a shorter follow-up period could allow the service to identify if men require additional support and/or intervention. *"I think I would have gone for one six weeks after…Just to see what was going on and see if there was any intervention or any support that might be needed."* The importance of the therapeutic relationship was highlighted by Peter as an important factor in promoting uptake of the questionnaire. They suggested dissemination of research questionnaires should be championed by James' Place, specifically the therapist men receive the JPM from as they have built a rapport with the men in which they have shared their personal experiences and feelings around suicide. "*I think it could be beneficial if it's obviously the counsellor who you're speaking to at the time, or the person who is doing the treatment…you kind of build a rapport up with them, so it might be better doing [the questionnaire] from them, like that, than someone who you don't know…you've been opening up with someone."*

Discussion

Summary of Findings

This study aimed to determine the short- and long-term effectiveness of the JPM among men experiencing suicidal crisis. More specifically, whether the JPM reduced key risk factors associated with suicide including psychological distress (CORE10), entrapment and loneliness and potentially protective factors of resilience, hope, GSE, PSS and SC at baseline and 3-month follow up periods. Descriptive case studies further illustrate men's experiences of JPM during and post-intervention, and their perceived acceptability and feasibility of conducting long-term research among men following suicidal crisis.

Several precipitating factors and psychological factors were endorsed by men upon receiving a James' Place welcome assessment, of which relationship breakdown and work, and entrapment were reported respectively. Mean total scores of loneliness and entrapment decreased from baseline to 3-month follow-up suggesting men who had

received the JPM felt less isolated and trapped within their situation and thoughts and feelings of suicide. Mean total scores of hope and resilience remained unchanged between baseline and 3-month follow up. However, mean total scores of GSE, PSS, SC and CORE10 increased between baseline and 3-follow-up. This suggests improved self-efficacious beliefs, social support and self-kindness and humanity towards themselves and more mindful, yet increased psychological distress among men after they have received the JPM. Hope, PSS, GSE and entrapment mean total scores decreased at 6-month follow-up compared to 3-month follow-up scores, while loneliness mean total scores increased, and resilience, SC and CORE10 total mean scores remained equivalent at 6-month follow up also. This suggests that men experienced a decline across several psychological variables including those associated with improved coping at 6-month follow up indicating men felt less hope, social support, and generalised self-efficacy yet less trapped within their situation and feelings, and lonelier. However, levels of the ability to recover from stress, self-kindness, humanity and mindfulness and psychological distress were maintained at 6-month follow-up. Thus, highlighting the complexity of suicidal experiences and recovery following intervention.

Poor participant uptake and high attrition rates at follow-up prevented multivariate statistical analysis of questionnaire results, therefore it is not possible to establish causal relationships. However, Wilcoxcon paired signed rank tests confirmed men experienced significantly less loneliness, more resilience and more self-compassion yet also significantly more psychological distress from baseline to 3-month. Despite the varied and somewhat contradictory findings, descriptive case study findings showed that men perceived the JPM as an acceptable therapeutic approach among suicidal men.

Interpretation of Results

Frequency of the psychological factor of entrapment and precipitating factors of relationship breakdown and work-related issues in the present study is consistent with the IMV theory of suicide in explaining the development of suicide ideation and behaviours (O'Connor, 2011; O'Connor & Kirtley, 2018). The IMV explains the translation of suicidal thoughts and

feelings to behaviours using a tripartite ideation-to-action framework in which feelings of being trapped (entrapment) emerge from inescapable feelings of defeat/humiliation (O'Connor, 2011; O'Connor & Kirtley, 2018). Defeat/humiliation appraisals are triggered by background factors including acute life events and stressors such as relationship breakdown in the pre-motivational phase of the IMV (O'Connor, 2011; O'Connor & Kirtley, 2018). The present findings support integration of entrapment risk assessment in routine clinical assessment of suicidality and addressing factors contributing to feelings of entrapment (O'Connor & Portzky, 2018). Also, this highlights the need to explore the factors contributing to feelings of entrapment.

Relationship breakdown and work-related issues were frequently reported precipitating factors for suicide among men which aligns with previous research (e.g., Richardson et al., 2021a; Seidler et al., 2022). It was not possible to define the nature of relationship breakdown (e.g., divorce, separation) or work issues among the men (e.g., stress, job loss, job insecurity) as this detail had not been recorded by the service. However, men appear particularly susceptible to negative life events (Krysinska, 2014). For example, the separation period during relationship breakdown presents a particularly vulnerable period for men compared to women with an increased risk of suicide four times greater than non-separated men (Kloves et al., 2010., Wyder et al., 2009). Similarly, Mughal et al., (2023) in examining sociodemographic characteristics and antecedents of middle-aged men whose final GP consultation occurred 3-months prior to their death by suicide found 29% (n=30 of 105) and 33% (n=35 of 105) of middle-aged men reported experiencing recent work-related problems and were unemployed respectively.

Past research has attributed men's' vulnerability to suicide associated with relationship breakdown and work-related issues to dominant masculine norms (e.g., Scourfield & Evans, 2015; Oliffe et al., 2022; Seidler et al., 2021). Accordingly, feelings of shame may arise from undermined traditional masculine ideals such as being the provider (Knizek & Hjelmeland, 2018; Oliffe et al., 2022). Culmination of men's' propensity for restrictive emotional expression, overreliance upon independence and intimate partner emotional and social support limits adaptive help-seeking behaviours (Mackenzie et al., 2018; Scourfield

et al., 2015; Seidler et al.,2021). Subsequently, men perceive support for their distress as inaccessible and unavailable (Seidler et al., 2021). Nevertheless, the present findings demonstrate men do seek and engage with psychological support if the clinical setting is suitable. Thus, adding further support for the need for suicide prevention approaches that are sensitive towards men's help-seeking needs and preferences (Seidler et al., 2018).

It was not possible to test the effectiveness of the JPM due to poor uptake and follow-up rates. However, men perceived that the JPM was effective in reducing their suicidal crisis. Men described a pattern of avoiding help-seeking until they reached a critical moment where they were no longer able to cope, and for one man, they rationalised their reaching out for help from James' Place as necessary for their survival. Displays of self-reliance as reported here can be explained within the context of masculine norms, and the reframing of active help-seeking as necessity to safeguard survival once men reach their lowest point is consistent with previous research findings (e.g., Oliffe et al., 2012; Player et al., 2015; Rivers, 2018; Seidler et al., 2021). Importantly, this emphasises there is a window of opportunity during which engagement with mental health services could interrupt men's suicidal thinking and intent provided the intervention content and context is primed to men's needs (Cheshire et al., 2016; Chandler et al., 2022). It was reported that James' Place therapists worked with men in a way that allowed them to *"offload"* and normalised their suicidal experiences while collaboratively working with men to support development of coping strategies to manage their suicidal thoughts. Men particularly noted the dynamic nature of the LYCT component of the JPM in helping men to articulate and organise their thoughts and feelings around their suicidal thinking, as well as the solution-focussed approach of developing coping strategies men reported they continue to use. Case study findings support the feasibility and acceptability of the JPM for reducing suicide crisis among men experiencing suicidal crisis. Further, they highlight the importance of community-based services which promote therapeutic alliance and through shared decision-making, person-centred and solution-focussed approaches sensitive to the influence of masculinity upon suicide risk and help-seeking behaviour (Emslie et al., 2007; River, 2018; Seidler et al., 2018b).

Previous studies have shown the JPM significantly reduces suicidal distress among men experiencing suicidal crisis (Chopra et al., 2022; Saini et al., 2020; 2021a). It was not possible to test the effectiveness of the JPM in the present study due to the small sample size. However, examination of mean total CORE10 scores at baseline compared to 3- and 6-month follow-up revealed men were experiencing severe psychological distress at 3-month follow-up which remained equivalent at 6-month follow-up. Indeed, some men who had completed baseline questionnaires (n=4) were found to have re-engaged with James' Place for support for suicidal crisis. Yet, most men were found to have not re-engaged with James' Place. While it is possible that men may have sought support elsewhere, it is feasible men could have felt capable of keeping themselves safe during this period. In recognising the vulnerable period experienced by individuals following suicidal crisis (e.g., Vatne & Nåden, 2014), a key feature of the JPM is a focus on preventing recurrence of suicidal crisis. Therapists at James' Place work with men to co-produce coping strategies and a bespoke safety plan, and to develop men's self-awareness to recognise changing moods and feelings that may progress to suicidality. Research has shown that safety plan interventions and coping strategies that promote internal coping and resilience, particularly distraction/positive activity-orientated strategies (e.g., socialising and keeping busy) and those pitched to level of risk experienced by the individual, are effective in preventing suicide (Nuij et al., 2021; Player et al., 2015; Stanley et al., 2018; 2021). The final phase of the JPM involves therapists working with men to reflect upon their safety plan and the coping strategies they have acquired through their therapeutic journey at James' Place. This typically involves delivery of the "how can I get through this" set of LYCT which contains cards that encourage men to seek social support (e.g., "talk to a friend") and activities distract them from their suicidal thoughts (e.g., "go for a walk"; "listen to music"). Consistent with this, men reported in case study findings that they frequently reflected upon the coping strategies they learned through the JPM when they recognised a downward turn in their psychological wellbeing. Development of improved coping following completion of the JPM could also explain reduced total mean entrapment scores at 3- and 6-month follow-up as men perceived they are better able to control and emotionally regulate despite experiencing

high levels of psychological distress. However, this supposition is speculative and further research would be needed to examine this.

The findings also suggest further assessment of the role of self-compassion in mitigating suicidality is warranted. Follow-up data across the range of factors measured through questionnaire showed that while total mean scores of resilience, hope, GSE, loneliness and PSS fluctuated at each of the timepoint, total mean scores of self-compassion increased from baseline to 3- and 6-month follow-up. This indicates a potential adaptive role for feelings of self-kindness, self-acceptance, and mindfulness for mitigating changes in psychological distress during recovery following suicidal crisis. While research in relation to self-compassion and suicide is limited, systematic review findings show self-compassion and self-forgiveness are negatively associated with suicide ideation and suicide attempts (Cleare et al., 2019). Self-compassion extends beyond self-criticism, as a self-compassionate individual possesses self-acceptance of their own perceived failings and a mindful and non-judgmental awareness of emotionally painful experiences (Neff, 2003; 2016). Indeed, case study findings show that John perceived that sharing his suicidality with a James' Place therapist helped to destigmatise and normalise their suicidal experience (e.g., "*Well, you're not the only one. There are a lot of men out there that hold it in."*). This suggests John may have had reframed his suicidal experiences with mindful awareness by acknowledging suicidal thoughts and feelings as a common human experience rather than reflective of his own personal failure. Again, further research would be required to determine whether the JPM engenders self-compassion.

Men expressed a willingness to be involved in research after they have been discharged from James' Place which case study findings suggest may be underpinned by a sense of altruism. Yet, poor uptake and high attrition rates raises the question on how better to improve adherence to large-scale study in suicide prevention research. The brief nature of the JPM mean men are under the service for a short period of time making it harder for researchers to engage with them. Also, men leaving the service may feel less inclined to revisit their experiences of suicidality once they are discharged so as not to disrupt their recovery (Richardson et al., 2021b). While men did not criticise the questionnaire design

and administration methods used in this study, previous research has suggested inclusion of strategies including monetary incentives and ensuring accessibility of research materials could improve retention in mental health-based research (Bruton et al., 2013; Lui et al., 2018). Future research aiming to assess the long-term effectiveness of the JPM may seek to co-produce materials with key stakeholders to improve recruitment and questionnaire completion rates. Furthermore, future research should also seek to understand the mechanisms underpinning change among men who receive the JPM, with self-compassion and entrapment warranting attention, to understand how the JPM is helping men.

Strengths and Limitations

A key strength of this study is the inclusion of men experiencing suicidal crisis who are receiving a clinical intervention in a community-based suicide prevention service setting (Chopra et al., 2022; Saini et al., 2021a; 2022b). Research typically involves clinical samples in clinical settings, and there is a paucity of research examining suicide prevention within the community. Suicide related studies are often retrospective or involve psychological autopsy which can be susceptible to recall bias and/or, in the case of psychological autopsy, a limited range of prominent risk factors may be captured (Pearson et al., 2009).

This study is unlikely to have captured all risk factors associated with men's experience of suicidality given the small sample size in the present study. Further, poor uptake and high attrition rates, as well as the complex nature of suicide, limit generalisability of the results to a wider community-based population of men experiencing suicidal crisis. Several methodological limitations should also be considered when interpreting the results of this study. The present study is an observational study therefore it does not facilitate a control group comparison. It is therefore not possible to infer causality of fluctuations of suicide risk for the duration of the study follow-up period. The study results may also be subject to several types of bias including confounding bias due to additional factors exerting an effect upon CORE10 outcomes (e.g., age), recall bias due to participant recall error, and ascertainment error bias (i.e., confirmation bias) (Althubaithi, 2016; Boyko, 2013).

Participants involved in this study were self-selecting, and this may have been influenced by the degree of suicidal distress experienced by each man (Wiltsey Stirman et al., 2012). For example, men who felt more overwhelmed by their suicidality may have opted not to participate (Wiltsey Stirman et al., 2013). Further, as participants indicated their ethnicity as white British, the results may not be representative of men across a wider ethnic demographic.

While some benefits to participating in randomised controlled trials assessing suicide ideation and behaviours have previously been reported (e.g., sense of catharsis and positive feelings associated with helping others), conducting this type of study also presents several ethical challenges (Biddle et al., 2013; Peters et al., 2020). For example, ethics committee members are often apprehensive about researchers asking individuals about their suicidal thoughts, feelings and behaviours due to concern they may become worsened (Andriessen et al., 2019; Blades et al., 2018).

Nevertheless, the quantitative results do shed some light on the type and degree of precipitating and psychological factors experienced by men in suicidal crisis upon accessing a community-based suicide prevention intervention. Also, case study findings tentatively suggest that suicide prevention and safety planning strategies developed by men through their therapeutic journey at James' Place continue to be independently exercised after JPM intervention delivery. Future longitudinal research should strive to overcome the recruitment issues identified to test whether the positive effects reported to date are sustained.

Conclusion

More research is required to understand the intersection between men's suicidality, pathways to help-seeking, engagement with services and the effectiveness of services. The present study supports intervention delivery that is tailored to men's individual needs and promotes dynamic interaction with therapists. Earlier findings point to the effectiveness of

the JPM, however practical challenges of research engagement must be considered to achieve sufficient longitudinal data to test the long-term effects of the JPM.

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Appendix 1: Precipitating Factors Pre-Baseline (Upon Entry to James' Place) Attributed to Suicidal Crisis

Precipitating factor	*N* (%) Recorded by service
Relationship breakdown (n=28)	10 (35.7)
Gambling issues (n=28)	1 (3.6)
Debt (n=28)	4 (14.3)
Housing issues (n=28)	1 (3.6)
Physical health (n=28)	5 (17.9)
Mental health (n=28)	2 (7.1)
Bullying (n=28)	0
University (n=28)	1 (3.6)
Work (n=28)	8 (28.6)
Sexuality (n=28)	2 (7.1)
Victim of past abuse trauma (n=28)	3 (10.7)
Victim of crime (n=28)	0
Legal problems (n=28)	2 (7.1)
Family problems (n=28)	2 (7.1)
Bereavement (n=28)	4 (14.3)
Bereavement by suicide (n=28)	2 (7.1)
Bereavement by covid (n=28)	0
Drug misuse (n=28)	2 (7.1)
Alcohol use (n=28)	1 (3.6)
Relationship problems (n=28)	3 (10.7)
Perpetrator of crime (n=28)	1 (3.6)
Carer (n=28)	2 (7.1)
Related to asylum (n=28)	0
Health of others (n=28)	0
Covid lockdown (n=28)	4 (14.3)
Covid anxiety (n=28)	0
Covid work trauma (n=28)	0
Getting back to normal after covid (n=28)	0
Other (n=28)	0

Appendix 2: Psychological Factors Pre-Baseline (Upon Entry to James' Place) Attributed to Suicidal Crisis

Psychological variable	***N* (%) Recorded by service**	***N* (%) Missing data**
Defeat (n=26)	15 (53.6)	2 (7.1)
Humiliation (n=25)	10 (35.7)	3 (10.7)
Entrapment (n=26)	21 (75)	2 (7.1)
Social problem solving (n=26)	13 (46.4)	2 (7.1)
Coping (n=25)	7 (25)	3 (10.7)
Memory biases (n=26)	13 (46.4)	2 (7.1)
Rumination (n=26)	19 (67.9)	2 (7.1)
Thwarted belonginess (n=26)	16 (57.1)	2 (7.1)
Burdensomeness (n=25)	18 (64.3)	3 (10.7)
Absence of positive future thinking (n=26)	10 (35.7)	2 (7.1)
Unrealistic goals (n=25)	4 (14.3)	3 (10.7)
Not engaging in new goals (n=26)	13 (46.4)	2 (7.1)
Social norms (n=25)	1 (3.6)	3 (10.7)
Resilience (n=26)	9 (32.1)	2 (7.1)
Social support (n=25)	19 (67.9)	3 (10.7)
Attitudes (n=25)	3 (10.7)	3 (10.7)
Suicide plan (n=26)	9 (32.1)	2 (7.1)
Exposure to suicide (n=25)	8 (28.6)	3 (10.7)
Impulsivity (n=26)	13 (46.4)	2 (7.1)
Pain sensitivity tolerance (n=25)	7 (25)	3 (10.7)
Fearlessness of death (n=25)	5 (17.9)	3 (10.7)
Imagery of death by suicide (n=26)	12 (42.9)	2 (7.1)
Past suicide attempt or self-harm (n=26)	16 (57.1)	2 (7.1)

7. Chapter 7: A Mixed Methods Evaluation of the Acceptability and Fidelity of the James' Place Model for Men Experiencing Suicidal Crisis

The findings of chapter 6 show the JPM to be perceived as an effective suicide prevention intervention. Poor uptake and attrition prevented statistical assessment of the long-term effectiveness of the JPM. Nevertheless, the findings suggest men may continue to practice after coping strategies learned during their therapeutic journey at James' Place after they have been discharged by the service which potentially may buffer against further suicidal crisis occurring. As the James' Place service seeks to expand service provision beyond Liverpool and London, it is important to ensure delivery of JPM as planned is adhered to by therapists to maintain integrity and robustness of the effects of the James' Place model. Additionally, this has implications for confidence in future research aiming to identify which psychological mechanisms underpin reduction in suicidality among men experiencing suicidal crisis who receive the JPM. Therefore, this final study is a mixed methods study evaluating therapist perceived acceptability of JPM, and whether fidelity of delivery is maintained during clinical practice.

Note: A shortened version of this chapter has been published in the Journal of Health Psychology and Behavioural Medicine: https://doi.org/10.1080/21642850.2023.2265142

Abstract

Background: Research supports development of informal, community-based suicide prevention interventions that can be tailored to suit men's unmet needs. The James' Place model (JPM) is a community-based, therapeutic suicide prevention intervention for men experiencing suicidal crisis. Evidence supports the effectiveness of the JPM and there are plans to expand to additional sites across the UK. This study evaluates therapists perceived acceptability of the JPM, and if fidelity to the planned delivery of the model is maintained within therapeutic practice.

Method: A mixed methods design was used. Descriptive analyses of 30 completed intervention cases were examined to review fidelity of the model against the intervention delivery plan. Eight therapists took part in semi-structured interviews between November 2021 and March 2022 exploring the perceived acceptability, and barriers and facilitators to delivering the JPM.

Results: Descriptive analyses of James' Place audit notes revealed high levels of adherence to the JPM amongst therapists, but highlighted components of the model needed to be tailored according to individual men's needs. Thematic analysis led to the development of five themes. The first theme, *therapeutic environment* highlighted importance of the therapy setting. The second theme identified was *specialised suicide prevention training* in the JPM that facilitated therapists understanding and expertise. The third theme identified was *therapy engagement* which improved men's engagement in therapy. The fourth theme, *person-centred care* related to adaptation of delivery of JPM components. The final theme, *adapting the JPM to individual needs* tolerated within the structure of the JPM enables tailoring of the JPM and therapists to be responsive to men's needs.

Conclusion: The findings evidence therapist's acceptability and their moderate adherence to the JPM. Flexibility in delivery of the JPM enables adaptation of the model and co-production of therapy to meet men's needs. Implications for clinical practice are discussed.

Keywords

Men, Suicide-prevention, Fidelity, Community, Co-production, James' Place Model, Mixed-Methods

Introduction

Suicide is a global public health concern accounting for over 700,000 deaths worldwide (WHO, 2021). While suicide affects both men and women, higher rates of suicide among men are recorded worldwide (Naghavi, 2019), with men accounting for three quarters (3925 deaths) of the 5224 suicide deaths recorded in England and Wales in 2020 (ONS, 2021). Existing research evidence suggests pressure to conform to socialised traditional masculine ideals such as self-reliance, stoicism, and emotional self-control, hamper help-seeking among men experiencing psychological distress (Canetto & Sakinofsky, 1998; Seidler et al., 2016). Subsequently, men may engage in avoidant coping strategies, including substance misuse (e.g., alcohol and drugs), denial, aggressive and risky behaviour.to regain a perceived sense of control (Eggenberger et al., 2023; O'Gorman et al., 2022; Seidler et al., 2016; 2021).

Recent systematic review findings of research spanning 20 years found traditional norms of masculinity implicated in suicide risk among men in ninety-six percent of included studies (Bennett et al., 2023). Bennett et al., (2023) posit a 3 'D' Risk model to account for the relationship between traditional masculine ideals and increased suicide risk among men. Accordingly, the emergence of increasing psychological pain and suicide risk occurs from reciprocal interaction of denial, disconnection, and dysregulation within three core psychological areas of emotions (emotional suppression), self (failure to achieve standards of male success), and interpersonal connections (undermined social and relational needs); which in turn reflect individual expression of traditional masculine norms (Bennett et al., 2023). Furthermore, accumulating psychological pain may become amplified by distal and proximal risk factors an individual may be susceptible to (Bennett et al., 2023).

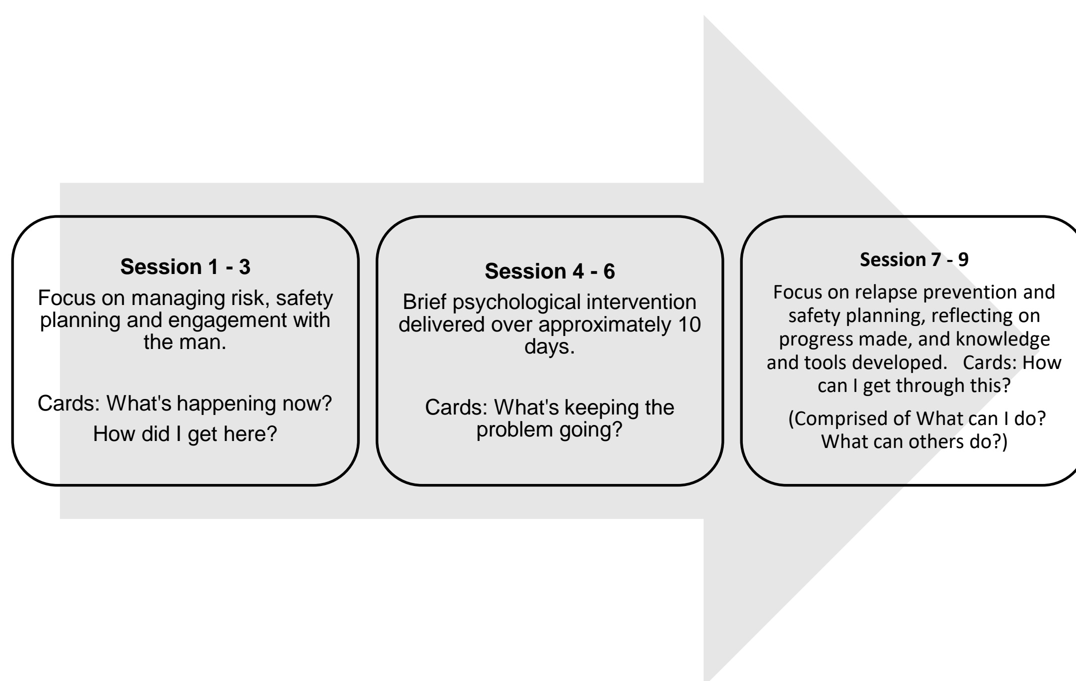
Poor help-seeking due to various barriers, including shame and fear of mental illness diagnosis, is often blamed for men's low engagement with mental health services (Cleary, 2012; Luoma et al., 2002; Rasmussen et al., 2018). Arguably, this suggests that suicide prevention support typically offered by mental health support is not meeting the needs and preferences of men experiencing suicidal crisis. This highlights an issue with the type of support suicide prevention services traditionally offer men experiencing suicidal crisis. Research has shown that men experiencing suicidal crisis can find it difficult to discuss their emotions as it conflicts with their masculine status (Cleary, 2012; River & Flood, 2021). This has led to calls for targeted suicide prevention services that are informal, community-based and "*men-friendly*" (Oliffe et al., 2020; Seidler et al., 2018; Stiawa et al., 2020; Struszczyk et al., 2019), which consider the content and structural context in which men disclose their suicidal distress (Chandler et al., 2021). Research has also advocated the need to explore men's experiences of suicide and to consult community stakeholders to understand and build capacity within the design and delivery of suicide prevention services to meet men's needs (Saini et al., 2022; Trail et al., 2021).

Established in 2018, James' Place (JP) is the UK's first community-based therapeutic suicide prevention centre for men. JP strives to redress issues of poor help-seeking and engagement among men experiencing suicidal crisis by facilitating rapid access to a brief clinical intervention called the JP Model (JPM). This is delivered within a community therapeutic setting by therapists trained to deliver the JPM and is adapted to suit individual men's needs. The JPM is underpinned by three theories of suicide each promoting safety planning and working with the individual to co-produce suicide prevention strategies; namely 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 & Kirtley, 2018). The JPM is delivered by suicide prevention therapists and involves nine sessions structured into three stages, each composed of three sessions. Figure 1 shows how the JPM is typically delivered. Sessions one to three focus upon managing risk, ensuring the man is engaged in therapy and the lay your cards on the table (LYCT) component of the intervention are

introduced to help the man to articulate their suicidal distress; sessions four to six involve delivery of brief psychological interventions; and sessions seven to nine focus on relapse prevention and creation of an individualised, detailed safety plan. Further details of the JPM can be found elsewhere (Hanlon et al., 2022; Saini et al., 2019; 2020). Several studies have shown the JPM significantly reduces distress as demonstrated by a clinically significant reduction in Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) scores (Chopra et al., 2022; Saini et al., 2020; 2021a; 2021b; 2022).

Figure 1: Specification of the James' Place Model

Figure 1 Alt text caption: Three boxes showing the structure of JPM delivery in three stages each comprised of three sessions, and descriptions of the corresponding focus of each stage and LYCT delivered.



Fidelity refers to the extent an intervention is delivered as planned (Carroll et al., 2007; Gearing et al., 2011). Assessment of fidelity determines whether intervention outcomes can be attributed to intervention content and components, rather than unaccounted factors, such as variations in implementation and/or omission of intervention components (Borrelli, 2011). Currently there are centres in Liverpool and London, with plans for future expansion of the service. Expansion of JP will inherently mean more therapists will be involved in

delivering the JPM. This, in addition to the adaptable nature of the JPM, could potentially risk deviations away from delivery of the model as planned. It is pertinent to understand the degree of fidelity adherence in JPM delivery to ensure confidence in interpretation of reported outcomes and replication of this once JP is expanded. This study aimed to understand fidelity of JPM delivery within a therapeutic setting for men experiencing suicidal crisis. The perceived context-specific facilitators and barriers of the JPM were explored to provide insights into adherence of JPM delivery in practice and its perceived acceptability.

Materials and Methods

Design

A mixed methods design was used. This allowed integration of objective and subjective data, an approach needed within suicide-related research (Kral et al., 2011). Specifically, it facilitated assessment of a range of quantitative data routinely collected by JP pertaining to delivery of the JPM as planned (e.g., number of sessions men attended, frequency of delivery of LYCT) and exploration of therapists' perceptions of factors associated with the men's acceptability of, and fidelity to planned delivery of the JPM. Two facets of fidelity to the intended delivery of the JPM were assessed; 1) adherence to content of the JPM during delivery (fidelity of content); and 2) number of sessions delivered (fidelity of duration). Semi-structured interviews assessed therapists' perceived acceptability and views of fidelity to delivery of the JPM. Ethical approval was given by Liverpool John Moores University Research Ethics Committee (reference: 21/PSY/007). Written consent was gained from men using the service during their initial welcome assessment for the purpose of reviewing their records for research and/or service evaluation purposes. Welcome assessments are conducted by JP therapists who are aware of ethical issues and considerations. Written consent was also gained from JP therapists whose clinical records were audited and who participated in semi-structured interviews.

Participants

Thirty of 101 cases of men who had received and completed the JP intervention during the period from 1st December 2020 to 30th November 2021 were randomly selected for auditing. To remove bias, an administrator who was not involved in delivery of therapy, randomly selected five completed cases for each therapist for auditing. The qualitative element of this study involved semi-structured interviews with eight therapists (5 female) trained to deliver the JPM from JP Liverpool (n=4) and JP London (n=4) and were conducted between 5th November 2021 and 18th March 2022.

Quantitative Phase: Procedure and Analysis

Document analyses of internal records auditing 30 cases, representing five cases per therapist at JP Liverpool, were assessed to evaluate fidelity of adherence to the planned delivery of the JPM. The audit was conducted over two consecutive days in December 2021 by three JP staff (centre manager, clinical lead, and member of administrative staff) and a researcher. On day one, the administrator and clinical lead completed a primary audit on the 30 randomly selected cases. Simultaneously, the researcher completed a secondary audit on 15 of those cases. Once each interview session was completed, both raters reviewed their individual score sheets separately. Each item was then jointly reviewed to identify and record disagreements and a consensus reached on the final score.

Each auditor recorded JPM components delivered against JPM content specification, for example duration (i.e., number of sessions attended) and content (e.g., completion of a safety plan and sets LYCT used), using an audit tool. The audit tool was co-produced between the clinical lead and administration staff and was developed using theoretical and clinical insights from current research and clinical practice. Points were given if therapists had delivered key components of the JPM including each of the four sets of LYCT and if a safety plan was uploaded onto the clinical information system. See table 1 for the scoring scheme. Additional delivery features were assessed including the number of sessions delivered and how long men accessed the service for. Adherence was calculated by adding the points awarded and scored out of a maximum score of 10. JP deemed a score of less

than 5 (range 0-4) as an unacceptable level of adherence and a score of 5 and above as acceptable (range 5-10). Inter-rater reliability was compared against primary and secondary audits of individual cases. Disagreements between the primary and secondary audit were resolved through examination and discussion of individual case records between three auditors. Descriptive analyses of audit materials were conducted independently by the research team.

Table 1: Audit Scoring Scheme

JPM Component / Delivery Feature Assessed	**Number of Points Awarded**
Zero DNA's	1 point
Intervention duration of 6 weeks or less	1 point
8 sessions or less	1 point
Positive outcome (i.e., drop in CORE-OM score)	1 point
Safety plan documented	1 point
No. sets of Lay your Cards on the Table delivered	*Maximum no. of points available for delivery of cards = 5*
All sets of cards (i.e., 4 sets)	5 points
Three sets of cards	4 points
Two sets of cards	3 points
One set of cards	2 points
No cards delivered	0 points
Maximum score	10 points

Qualitative Phase: Procedure and Analysis

Nine therapists from James' Place were contacted via email inviting them to participate in a one-to-one semi-structured interview for a study. One therapist did not respond to either an initial email or follow-up email inviting them to participate in this study, therefore it is unknown why they did not participate – it would be deemed unethical to seek clarification on their reasons to not participate. Eight therapists did respond and agreed to take part in the study. Each participant was emailed the participant information sheet and asked to sign and return a consent form and one-to-one semi-structured interviews were subsequently arranged with each participant. Semi-structured interviews with therapists explored their views on fidelity of delivery of the JPM, including barriers and facilitators that may influence their delivery of the model. Perceived acceptability of the JPM was explored to understand

service-user related factors that may affect fidelity. Interviews were conducted either face-to-face (n=4) or online (n=4) and were audio-recorded using a Dictaphone, ranging from 42 to 66 minutes. All interviews were transcribed verbatim and analysed using reflexive thematic analysis (Braun and Clarke, 2006;2019). Trustworthiness of qualitative data was achieved as each interview was read in a process of data familiarisation, and initial codes and themes were developed through an iterative process of theme development by the primary researcher (Braun and Clarke, 2019). Three additional researchers reviewed the themes developed with the primary researcher when refining, revisiting and finalising the themes developed: thus ensuring rigour and transparency (Yardley, 2000).

Results

Quantitative Findings

Audit results are presented in table 2 and confirmed adherence scores for completed cases ranged from 2 to 9 (M=5.67, SD=2.01) indicating a medium level of adherence to planned delivery of the JPM. Fidelity delivery of the four sets of LYCT, scored out of 0 to 5, varied from no cards being delivered to all four sets of LYCT being delivered (M=2.67, SD=1.94; Range 0–5). Number of therapy sessions held with men ranged from 2 to 16 (M=8.17, SD=2.79) and duration of engagement from referral to discharge ranged from 1 to 20 weeks (M=9.00; SD=3.83). Most scheduled therapy sessions were attended by the men as indicated by the mean number of appointments recorded as did not attend M= .8; SD=1.61; Range 0-7). Safety plans were recorded in 21 of 30 cases (70%). Variability in delivery of LYCT was noted (M=2.67; SD-1.94). A maximum audit score of 5 indicated all four sets of LYCT had been delivered. Less than a quarter of cases (23.3%) of cases were found to achieve a maximum audit score of 5, with most cases recording a LYCT delivery adherence score of 0 (26.7%). Twenty-two (73%) and 27 (90%) of 30 cases reached the acceptable threshold of fidelity in delivery of the JPM as planned (i.e., a score of 5 or more) and recorded a positive outcome respectively. A reduction in CORE-OM score upon discharge from the service was recorded in every audited case, except for one case where a reduction in suicidality was reported within the clinical case notes.

Kappa measure of inter-rater agreement was calculated to determine inter-rater reliability between the primary and secondary auditors and showed there was moderate level of agreement between the auditors (κ =.521 (95% CI, .217 to .304), p <0.01. Disagreement between the primary and secondary auditors were largely due the researcher's unfamiliarity with the clinical information system and difficulty locating the required information. All disagreements were resolved by reviewing clinical case notes and discussion between the auditors.

Table 2: JP Audit Results (n = 30)

DOE*	No. Sessions	Did Not Attend	Safety Plan Completed	Positive Outcome	Cards Score	Adherence Score	Secondary Adherence Score	DAS*	Final Adherence score	CA
7	11	7	Yes	Yes	5	8	8	0	8	Yes
7	9	0	Yes	Yes	4	7			7	Yes
10	8	1	Yes	Yes	5	8			8	Yes
15	9	5	Yes	Yes	5	7	7	0	7	Yes
13	12	1	Yes	Yes	5	7	7	0	7	Yes
8	9	0	Yes	Yes	3	6	6	0	6	Yes
10	8	1	No	Yes	0	2			2	No
12	10	3	No	Yes	3	4	5 (agreed score= 4)	1	4	No
7	8	1	Yes	No	3	5			5	Yes
7	8	2	Yes	Yes	2	5	6 (agreed score=5)	1	5	Yes
10	11	0	Yes	No	5	7	8 (agreed score=8)	1	8	Yes
11	10	0	No	Yes	5	7			7	Yes
6	7	0	Yes	Yes	4	9			9	Yes
20	16	1	No	Yes	4	5	5	0	5	Yes
13	9	0	Yes	Yes	5	8	7 (agreed score=7)	1	7	Yes
11	7	0	Yes	Yes	2	6	5 (agreed score=5)	1	5	Yes
9	8	0	No	Yes	2	5			5	Yes
8	7	0	No	Yes	2	5			5	Yes
10	9	0	Yes	Yes	2	4			4	No
6	7	1	Yes	Yes	0	4	4	0	4	No

	13	6	1	No	Yes	0	2	2	0	2	No
	7	9	0	No	Yes	0	2			2	No
	5	8	0	Yes	Yes	0	5			5	Yes
	8	10	0	Yes	Yes	0	3			3	No
	1	2	0	No	Yes	0	4	4	0	4	No
	3	2	0	Yes	Yes	0	5	4 (agreed score=5)	1	5	Yes
	11	7	0	Yes	Yes	4	8			8	Yes
	11	9	0	Yes	No	4	6			6	Yes
	4	3	0	Yes	Yes	2	7			7	Yes
	6	6	0	Yes	Yes	4	9	9	0	9	Yes
Mean(SD)	8.97 (3.83)	8.17 (2.79)	N/A	N/A	N/A	2.67 (1.94)	5.67 (2.01)	5.80 (1.90)	.40 (0.51)	5.63 (2.01)	N/A
Median	8.5	8	N/A	N/A	N/A	3	5.5	6	0	5	N/A
Total (%)	N/A	N/A	9.8	70	90	N/A	N/A	N/A	N/A	N/A	73

*DOE=Duration of engagement; DAS=Difference in Adherence Score; CA=Case Acceptable

Qualitative Findings

Five themes were identified (*Therapeutic environment; Specialised suicide prevention training; Therapy engagement; Person-centred care* and *Adapting the JPM to individual needs)* and are summarised below with illustrative quotes.

Theme 1: Therapeutic Environment: The Third Therapist (N=6)

The therapeutic environment at JP is purposely non-clinical and its importance was noted by therapists.

An Environment that Speaks to Masculinity (n=4)

The physical environment at JP was perceived by therapists to speak to men's masculinity in a way that contrasts with traditional mental health services by engendering a person-focused, safe, and non-judgemental "*space*" for men to feel confident to disclose their suicidality;

> *"I must say, again, in my 20-odd years of doing therapy, it's such a unique environment. It's an environment I would not normally associate with therapeutic intervention… It's normally a cupboard underneath a staircase with no windows. So, actually being in an environment which is open, which feels like a living room, actually. And the men notice that when they come in." Therapist 6*

This facilitates engagement from men, allowing them to become visible and heard as their suicidal distress and experiences are validated without being stigmatised;

> *"The environment, and everything else like that, it's not like going somewhere where somebody is going to label you." Therapist 2*

Developing Therapeutic Alliance (n=3)

Therapists contribute to the therapeutic environment by cultivating therapeutic alliance with the men. This may involve reflecting the man's composure, or upon their own experiences to gain trust and develop rapport;

"I think personal experience is great. Because I have children myself, that is always useful. So, when men talk about their children, that's relatable… I have been divorced, so relationship breakdown, that is something that…I think it's about personal experience. What is it that can come up, that can emerge, that can connect you and this man in a way that they have never been engaged with before?" Therapist 6

Theme 2: Specialised Suicide Prevention Training (N=7)

While JP therapists are qualified, each received specialised suicide prevention training from the JP clinical lead.

Formal Training (n=7)

Training examined key areas including suicide risk factors, theoretical underpinnings of the JPM and the LYCT component. Therapists perceived training provided a framework for delivering the JPM. However, it is real-world experience of delivering the JPM that increases their confidence to foster flexibility when co-producing therapy with the men;

"Yes, I did find it useful because before I'd never worked in that way with cards. I just did literally talking therapy, person-centred talking therapy. This was new and different, but very useful. Yes, I think it gave me enough knowledge or prepared me enough to then be able to put it in practice." Therapist 1

Informal colleague support (n=3)

Therapists described benefiting from receiving additional support given from more experienced therapists during informal, incidental conversations and weekly case management meetings. This was received from colleagues separate to their clinical supervision and was viewed to offer new therapists' assurance they were delivering the JPM correctly and allowed them to envisage how they might co-produce therapy with men;

"I think at first when I first started, I was very rigid with the training that I was given, and the cards had to be done every single session and if I didn't use the cards in the session I was doing it wrong. Whereas now I think it's more organic, you bring the training that you received at the beginning as well as the cards, but it doesn't have to be in every session. One size doesn't fit all does it with our clients?" Therapist 3

Developing training (n=6)

Formal review of therapist progression shortly after assignment of their own caseload was identified by therapists as a potential improvement to training. Additionally, inclusion of case studies could enhance knowledge as to how to integrate additional therapeutic strategies within JPM delivery;

"I think doing some case studies would be really helpful. It would have been, probably, really helpful to see maybe one of the more senior therapists actually talk through, "This is how I would tend to use the cards," or, "These are the things that change between clients." Therapist 4

"Maybe like a check-in later, so you could have the initial training and then you could have a three-month check-in, so like, "How's it going?" and a refresher, "How have you actually found it in practice?" Therapist 8

Supervision: Caring for the carers (n=8)

Therapists received supervision both internally within JP and from an external provider as part of their professional registration. Both were perceived as essential for maintaining well-being. Internal supervision allowed therapists to reflect upon their clinical practice, and to seek support for more challenging cases;

"Yes, it's good to be able to offload for yourself. It's good when you feel stuck with somebody, like, "How do you do this?" Therapist 2

Conversely, therapists could confidentially explore issues relating to their clinical practice to gain an objective, non-judgemental perspective during external supervision;

“Well, I actually think it’s really useful that it is external in some ways, because some of the things that might stress me out here might be things that I don’t particularly feel comfortable talking about here. So, it’s, kind of, nice to have both of those types of supervision.” Therapist 4

Theme 3: Therapy engagement (N=8)

Face-to-face delivery, availability of rapid access to, and the brief duration of, the JPM were identified as key facilitators in promoting the acceptability of the JPM among men accessing the service. However, therapists encounter some challenges adhering to the specified number of sessions within the JPM;

Accessibility and acceptability of therapy (n=8)

Seeing men during their crisis was perceived as validating of their experience, and facilitated a safe, therapeutic space to discuss suicide whilst developing effective therapeutic strategies;

“So, for me, it is that swiftness of getting people in, and then that just being able to talk. It is just a space to say, “What’s happening for you?” and, “How are you coping with that? What can we do to keep you safe?” So, somebody is really saying to you, “Yes, what you’re feeling is worrying.” Somebody is validating, and then giving you the support of, “But we can keep you safe,” well, “We can help you to keep you safe.” Therapist 2

Reasons why men disengage were speculated and included removal of a major stressor (e.g., gaining employment), which alleviated suicidal distress. Interestingly, therapists felt some men found ending therapy difficult, speculating non-attendance to their final scheduled session may be empowering;

“Usually the guys, they've done well and everything is done, the next session is to finalise things. They decide to not attend the last session.” Therapist 1

> *"But also, if something else comes up within their lives, where they feel, "I can't make that session," or, "I think I've had enough of this now," I think it's okay to make that decision. And I think it's up to us to support that decision, because that's all part and parcel of the empowerment of those men." Therapist 6*

Keeping therapy brief (n=5)

The number of planned sessions within the JPM was perceived as acceptable and suitable. Adhering to this could be challenging and required therapists to manage their own expectations of what can be achieved within a brief intervention and to recognise a man's recovery may continue once they have completed the JPM;

> *"It's just about touching on things which can be recognised as a really important issue for somebody, without having to go into too much detail. Not getting sucked into it within the short time we have. I think it's quite useful to know it, and to notice it, and to recognise it, without having that. That's powerful." Therapist 7*

Theme 4: Person-Centred Care (N=8)

Therapists had comprehensive understanding of the JPM and its constituent elements, including the LYCT.

Normalising sharing of suicidal experiences (n=8)

LYCT were perceived by therapists to allow men to visualise and voice their suicidal distress, when previously they have felt unable to share their suicidal experiences. Self-compassion emerged as the men recognised the burden of having such a lot to contend with; thus destigmatising suicidal distress;

> *"…it's when there's that, kind of, real fear around what they're experiencing that I find it's so important to normalise it and it's so important to say, "Actually, you're not the only person to feel this way. These are some of the reasons why you may be*

feeling this way and you do have some element of control and some options available to you." Therapist 4

Delivery of the LYCT was described as a short-cut to instigating dialogue between the therapist and men, bringing focus to each session. Men's experiences informed the therapists clinical judgment and practice as they guided the men through their crisis in a person-centred, but solution focused way. Resultantly, the JPM is rapid, timely and targeted;

"I suppose what the cards do is they short-circuit all the longwinded discussions that may go on, but it brings it straight to the specific. And we also have to bear in mind that we're a time-limited service, so the earlier we can get to what the specific issues are, then it provides more time for us to really sieve that through and work that through." Therapist 6

Co-production in action (n=8)

Co-production featured in different elements of the JPM including the inclusion of therapeutic strategies and safety planning. This allows therapists to work collaboratively by standing together, shoulder-to-shoulder with men to co-produce and adapt the JPM to find solutions to their crisis. Therapists reported that they delivered the JPM in a manageable way that did not set expectations beyond the man's reach such as omitting the LYCT component if the man is too distressed to engage with them;

"*So, it's really just about making sure that it's an open conversation right from the start and that they feel that they can, you know, slow things down or change direction if they need to, so, yes." Therapist 4*

"Sometimes I think they're [lay your cards on the table] not needed and sometimes I think a client just needs to have a counselling session…" Therapist 3

In this sense, co-production facilitates a shift from "one size fits all" approaches to suicide prevention;

> *"I think in terms of co-production, I really feel that I can't work the same with every person. So, I think the treatment, or so to speak, maybe even treatment's a bit of a clinical word, but the intervention process is so tailored to each man. Like, uniquely. It's not cookie-cutter, it's not one size." Therapist 5*

Theme 5: Adapting the JPM to individual needs (N=8)

Tolerance of flexibility in the delivery of JPM components was reported, particularly with the LYCT component, to address the needs of each individual man.

Flexibility in implementation of lay your cards on the table (n=8)

Men were reported to interact with the LYCT in different ways, such as grouping relevant themes together or taking photographs of them to reflect upon their progress. Similarly, therapists described different ways of delivering the LYCT to suit each man's presentation, preserve their safety and to respond to changing needs during therapy. For example, integrating the language of the cards into their discussions rather than physically administering them, and omitting/alternating the order in which they are delivered;

> "*Sometimes when someone doesn't have any coping strategies, or think they don't have any coping strategies, then sometimes I would do the, 'How can I get through this first?' if they're very much in a distressed state.*" *Therapist 1*

> *"They've either been covered in the person saying the story, or just in the session. So, you know, I've done a few sessions where we've not used them at all, but we've done it in- If you know what I mean. So, they've not physically gone through the cards, but that's what we've been talking about." Therapist 2*

Flexibility was perceived as essential to facilitate adaptation of JPM and to ensure men's needs are met ahead of the need to rigidly administer the JPM chronologically and in its entirety;

"I think it's very useful to be flexible. Flexible, robust and adaptable, I think is the right answer to that. Because you never know what men will bring, from one week to the next... that man may be going back into a turbulent situation after leaving the session." Therapist 6

Necessity of Safety Planning (n=5)

Safety planning was viewed as an uncompromising JPM component by therapists as it documented actions men could initiate to keep themselves safe. Co-production of this occurred at different stages of the therapeutic journey;

"I mean, I think that's quite helpful. We've even had some men who, once you'd done that, they were like, "Oh, I'm okay," do you know what I mean? So, the safety plan, in itself, is a really positive thing." Therapist 2

"I always do a safety plan with men. That might be at the beginning if I think someone is a really high-risk. They also can be towards the end…" Therapist 5

Flexibility promotes use of additional therapeutic tools (n=8)

Therapist autonomy is respected within the JPM allowing them to introduce additional therapeutic techniques when tailoring its delivery. A range of additional techniques were reported to support men in developing resilience and coping skills including CBT-based approaches, self-compassion and psycho-education;

"I think there's a little bit of psychoeducation that I offer alongside what we're doing here, so things like understanding anxiety, how anxiety actually works in the body and, therefore, what we can do to try and manage it. I think that's something that I offer that doesn't necessarily come from the cards that seems to be really helpful..." Therapist 4

Discussion

Summary of Findings

This is the first study to evaluate fidelity of delivery of the JPM and was comprised of two phases: an audit of clinical cases of men accessing JP and semi-structured interviews with therapists trained to deliver the JPM exploring their perspectives of adherence and acceptability of the JPM. Descriptive analyses of JP audit notes revealed moderate levels of adherence to specification of intended delivery of the JPM amongst therapists. Audit notes and semi-structured interview findings highlighted components of JPM that required tailoring according to individual men's needs including LYCT and safety planning.

Several facilitators of acceptability of the JPM among men experiencing suicidal crisis and adherence to the specification of model delivery were encompassed within five themes. The first theme, *therapeutic environment: the third therapist* highlighted importance of the therapeutic setting for engaging suicidal men. The second theme identified *specialised suicide prevention training* in the JPM that facilitated therapists understanding and expertise. The third theme, *therapy engagement* which improved engagement in therapy among men. The fourth theme identified was *person-centred care* related to co-production and timeliness of the introduction of the LYCT or safety planning tools. The final theme *adapting the JPM to individual needs* within the parameters of the JPM structure, was identified as necessary for facilitating the adaptation of the JPM to suit men's needs.

Clinical Implications

Collectively, the factors identified were perceived by therapists to allow men to feel heard, visible, and held in a safe space while discussing their suicidal crisis. Men have historically been considered a challenging population to engage in traditional mental health support services due to poor help-seeking behaviours (Cleary 2012; 2017) associated with masculine ideals such as stoicism, self-reliance, and shame (Pirkis et al., 2017; Rasmussen et al., 2018; Seidler et al., 2021). Emerging evidence challenges the narrative around masculinity and suicidal men's help-seeking behaviours (Chandler, 2021). For example, Richardson et al., (2021b) explored suicide from attempt to recovery among men, finding

most men had recognised their need for mental health support. However, they did not know where to go or how to ask for support. This suggests that existing mental health services do not have sufficient acceptability and/or reach among men experiencing suicidal crisis. Findings elsewhere echo this point, reporting the need for informal, community-based mental health service provision for men which offers tailored, collaborative person-centred care to enhance accessibility and engagement (Player et al., 2015; Seidler et al., 2018; Struszczyk et al., 2019).

JP is embedded within the local community and offers rapid access to person-focused brief psychological support. JP has enabled establishment of close working partnerships and referral pathways with local community support services. This allows JP therapists to refer men to local services for additional psychosocial issues such as debt management, housing and alcohol and drug services. JPM principles (e.g., rapid access, referral pathways, environment) align with key priorities highlighted within health care initiatives across the UK such as the "Time, Space, Compassion" strategy in Scotland (National Suicide prevention Leadership Group, 2021) and the National Suicide Prevention Strategy (Department of Health and Social Care, 2023). The former outlines a framework advocating integration of timely access to therapeutic space offering compassionate care sensitive and empathetic towards the needs of the individual experiencing suicidal crisis (National Suicide prevention Leadership Group, 2021). While the National Suicide Prevention Strategy emphasises the role of front-line services, including those that are third sector and community-based, in providing tailored suicide crisis intervention to high-risk priority groups, including middle-aged men (Department of Health and Social Care, 2023).

Brevity of duration of the JPM was perceived as a striking intervention feature by the therapists. Research supports the effectiveness of brief psychological interventions for suicidal crisis where they deliver early intervention; the provision of targeted information about suicide (e.g., understanding and management of suicide) and safety planning is given, and sustained follow-up occurs (McCabe et al., 2018). Studies have shown that the JPM as a brief psychological intervention reduces suicide among men (Chopra et al., 2022; Saini et al., 2020; 2021a; 2021b; 2022). Although, therapists in the present study

highlighted the acceptance that some men may go on to receive further support from additional services also (e.g., for housing/unemployment issues or traumatic childhood experiences).

There is a structure and expectation that therapists will deliver each core component of the JPM including the LYCT, safety planning and the CORE evaluation questionnaires. Therapists described utilising their clinical judgment to adapt delivery of the JPM content to address the complexities of each individual man's crisis (e.g., omitting LYCT if a man seemed to not engage with this element and/or delivery of additional therapeutic strategies). This practice was also evident from audit documents. For example, although 73% of cases achieved the acceptable threshold of fidelity in delivery of the JPM as planned, closer examination of the audit results revealed delivery of the LYCT varied across cases. Audit scores for delivery of LYCT ranged from 0 to 5 corresponding from none to all four sets of LYCT being administered for the audited cases respectively. However, some the LYCT tool was not used with a quarter of men (26.7%), and thus did not achieve a maximum audit score of 5.

Ensuring fidelity to intervention delivery as planned enhances clinical and research practice. Higher levels of fidelity in intervention delivery improves intervention outcomes and replicability, and increases confidence that changes occurring in outcomes are the result of intervention effects and not because of other confounding factors such as variability in delivery of intervention components within practice; thus improving reliability and validity of the reported intervention effects (An et al., 2020; Bellg et al., 2004; Borelli, 2011; Durlak et al., 2008). Arguably, inconsistent application of LYCT within delivery of the JPM brings into question observed intervention effects associated with JPM. However, lower suicidal distress scores and positive outcomes reported within the present study and elsewhere support the JPM as an effective suicide prevention intervention (e.g., Saini et al., 2020; 2021; 2022). Furthermore, while there is no agreed acceptable threshold of what constitutes high versus low fidelity within implementation science, it has been suggested that 80–100% corresponds with high fidelity and 50% with low fidelity (Borelli et al., 2011; Holcombe et al., 1994; Noell et al., 2002). Audit findings reported within the present study

showed 73% (27 of 30) of cases were delivered as planned indicating moderate level of adherence and good translation of JPM specification into clinical practice.

Several reasons could account for variability in LYCT delivery within practice. JP therapists each received specialised suicide prevention training which included training in the theoretical underpinnings of the IMV model (O'Connor 2011; O'Connor and Kirtley, 2018). In keeping with the theme of co-production within the present study, it is feasible that JP therapists applied knowledge of the evidence based which has informed to the utilisation of the LYCT tool to meet the needs of each individual man. For example, in striving to achieve balance of fidelity and flexibility of the JPM, therapists may verbally describe and discuss individual themes relating to cards within the LYCT component identified during therapy that are clinically relevant to the individual man's experiences of suicidal crisis.

Therapists described utilising their clinical judgment to adapt delivery of the JPM content to address the complexities of each individual man's crisis (e.g., omitting LYCT and/or delivery of additional therapeutic strategies). The decision to omit LYCT may be a clinical decision made by therapists to sustain the safety of men beyond the therapy room which is informed by the level of suicidal distress an individual man is experiencing. Therapists reflected during interviews that LYCT delivery was not always appropriate for every man and perceived that flexibility and co-production facilitated within the parameters of the JPM was a pre-requisite for shifting away from universal approaches to suicide prevention. However, as the LYCT tool is a core component of the JPM, this poses a significant challenge to ensuring adequate fidelity of delivery of the JPM within clinical practice. Forty-five individual cards comprise the what's happening cards which are the initial set of LYCT typically delivered within the JPM. Although many men were positive about this component of the model some did want to engage with cards and just wanted to speak about their suicidal crisis and precipitating factors that may have led up to it. In a practical sense, this poses a dilemma within the field of suicide prevention in trying to achieve fidelity in delivery of a suicide prevention as planned to ensure the evidence base supporting an intervention is adhered to while also balancing flexibility to deliver tailored suicide prevention in a move away from one-size fits all approaches called (e.g., Player et al., 2015; Seidler et al., 2018;

Struszczyk et al., 2019). Specifically in relation to JP, balancing fidelity of delivery with the adaptation of the JPM for individual men without diminishing mechanisms of change poses a significant challenge to therapists delivering the model and researchers evaluating its effectiveness.

While this highlights a significant challenge in ensuring accurate translation of the theory underpinning the evidence base of the JPM, it should be be highlighted that most cases achieved a moderate level of fidelity. Although a small sample of 30 cases were selected for inclusion within the audit which may not be representative of the entire service, it captures elements of the JPM delivered within the limits of time and resource constraints imposed. Furthermore, transparency in reporting of fidelity of intervention delivery is limited and often under-reported and fidelity assessment by individuals not involved within the development of an intervention (Borelli et al., 2011; Krishnamoorthy et al., 2023). While the latter point does not preclude reasons to neglect examination of fidelity of intervention delivery as planned, it does add a dimension of transparency to the fidelity assessment made and further illustrates how JP aims to learn reflect and learn the lessons to improve service delivery.

Safety planning was perceived by therapists as an essential component of the JPM. However, audit findings revealed that 70% of cases had safety plans documented onto the clinical information system. Several reasons may account for safety plans not being documented. For example, some men prefer a digital safety plan accessible via their mobile phone app's (e.g., the Stay Alive app) meaning it is not possible to upload this to the clinical recording system. The clinical information system in use at the time of the audit did not have a facility for therapists to upload copies of safety plans developed this way. Therefore, a safety plan may have completed but not uploaded onto the clinical information system.

Audit results have been used to guide development of a newly introduced clinical information system and to further improve clinical practice and training. For example, audit results indicated inconsistent use of the LYCT component of the JPM. An audit score of 5 out of 10 is considered acceptable, however if no sets of cards of the LYCT component is

used, then intervention delivery is considered non-adherent. Measures have now been put in place such that a case review is triggered if the "*What's happening now*" cards have not been introduced by session three.

Strengths and Limitations

This study challenges the perception that men do not seek help for suicidal crisis, adding to literature highlighting the need for informal, community-based mental health service provision for men experiencing suicidal crisis. However, generalisability of the audit findings is limited as they only reflect the data of men accessing JP and it is not possible to establish how delivery of the JPM may be required to change to engage men not accessing the service to be effective in reducing suicidal distress. As with any suicide prevention intervention study, suicidal distress may reduce without psychological intervention (Chopra et al., 2022). Therefore, it is feasible reduction in suicidal distress observed within the sample was not attributable to the JPM (Chopra et al., 2022). However, research evidence suggests the JPM significantly reduces suicidal distress among men (Chopra et al., 2022; Saini et al., 2020; 2021a; 2021b; 2022).

The study also provided valuable insights into fidelity of delivery and identification of the facilitators and barriers that may influence acceptability and implementation of the JPM but neglects the views of men who engaged with JP. Involving JP staff provided invaluable expertise when navigating the clinical recording system and extracting data during the audit process. Additionally, the audit tool which assessed adherence of delivery fidelity while clinically informed, was developed internally by JP. This could have introduced bias into the audit procedure such as observer bias whereby JP staff unconsciously recorded fidelity of intervention components more favourably (e.g., presence of a safety plan when it was not recorded on the system). Steps were taken to ensure random selection of completed cases for therapists, and the first and second coder maintained independence in assessing adherence of therapist delivery of the JPM. However, a range of fidelity assessment methods are recommended (Bellg et al., 2004).

Future Research

Future research should seek to explore the views of men accessing JP to gain further understanding of factors that may influence implementation of the JPM. Also, the types and frequency of additional therapeutic approaches used by therapists should be assessed and linked to behaviour change techniques to further understanding of JPM components attributable to suicidality reduction. Lastly, additional methods to assess fidelity of the JPM should be deployed in future evaluations. Gold standard approaches include using observation methods (e.g., video- or audio-recorded sessions) and/or self-report methods (Bellg et al., 2004). However, it is important to note this study evaluated delivery fidelity and does not provide an assessment of the quality of delivery such as therapeutic competence.

Conclusion

Findings support the need for clinical pathways and mental health service provision that holistically considers the complexities of suicide among men, such as that offered by JP. Seeking to standardise every aspect of the JPM is not feasible given the individual nature of suicidal crisis. Rather, moderate delivery fidelity to core components of the JPM is achievable when tailoring the model to address men's individual needs.

Ethical Declaration: Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and was approved by an Institutional Review Board/Ethics committee. See details under Methods.

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Chapter 8: Discussion

This final chapter discusses the findings of this thesis in the broader context of community-based suicide prevention research for men by summarising the key findings of each study, highlighting the implications of these in relation to community-based suicide prevention for men, and summarises the broader strengths and limitations of the thesis as a collective piece of work. Possible future areas of research are also outlined.

8.1. Discussion

8.1.1. Chapter Introduction

In this final chapter, the findings of each study (chapters 3 to 7) are summarised, and the evidence generated by each study is considered within the context of the thesis research aims. I interpret and discuss how the findings interlink and feature alongside existing suicide prevention literature, highlighting how they extend current thinking around suicide prevention among men experiencing suicidal crisis and address gaps within the existing literature within this field. The strengths and limitations of the thesis findings, the wider clinical implications of the research and directions for future research are discussed and recommendations for suicide prevention among men experiencing suicidal crisis are outlined.

8.2. Summary of Thesis Findings

The overall aim of this mixed methods thesis was to evaluate the feasibility and effectiveness of the JPM.

Five studies comprise this thesis (Figure 1). The first, "*The role and effectiveness of co-produced community-based mental health interventions that aim to reduce suicide among adults: A systematic review*" (published; chapter 3) reports on how co-production is utilised within community-based suicide prevention interventions. In doing so, this study highlights how the James' Place service sits within the broader field of community-based suicide prevention provision. The key findings and implications of this study are summarised below in Box 1.

Box 1: Overview of Study 1

What does this study add? Findings are consistent with previous findings that found co-production facilitates collaborative working and the generation and mobilisation of new knowledge, which allows the development of person-centric approaches and tailoring of suicide prevention interventions to suit the targeted audience. However, this study identified a lack of definition in operationalisation of co-production used and evaluation of impacts of outcomes, particularly in relation to the effectiveness of the suicide prevention intervention. *Implications*: Researchers and stakeholder partnerships should be transparent about how they operationalise co-production within the context of the suicide prevention intervention developed and use theories of suicide to be able to ascertain measurable outcomes to assess mechanisms of suicide intervention. *Future research*: Should seek to assess the short- and long-term clinical and wider outcomes of co-produced suicide prevention interventions. To do this, researchers must be mindful to clearly define co-production as applied within the context of specific individual interventions.

Systematic review findings from study 1 found that co-production enabled the tailoring of intervention content and its mode of delivery to suit the targeted audience preferences and needs, and stakeholders derived some positive experiences from their involvement. Findings showed a dominance of co-productive methodologies included within the design and development of community-based suicide prevention interventions, with most studies lacking inclusion of co-production beyond this. Relatedly, clear definition of the nature of co-production used within the intervention, theory underpinning it and evaluation of suicide-related outcomes were often lacking.

The second study, a public health case study as described within the remit of the publishing journal rather than a public health case study framework, ("*James' Place Model: Application of a novel clinical, community-based intervention for the prevention of suicide among men*" (published; chapter 4) leads on from the systematic review findings of chapter 3. Specifically, in identifying a lack of evaluation of the impacts and outcomes associated with community-based suicide prevention interventions in study 1 (chapter 3), study 2 (chapter 4) examined and described the model of practice of James' Place and the implementation framework of delivering of a brief psychological intervention for the prevention of men experiencing suicidal crisis within which it is applied using a public health case study approach. Box 2 summarises the key findings and wider implications of this study.

Box 2: Overview of Study 2

What does this study add? Delivery of JPM supports the use of co-production in the design and delivery of a community-based suicide prevention intervention for men experiencing suicidal distress from service. Evidence from case studies show the JPM to be an acceptable model of suicide prevention by men experiencing suicidal crisis, with rapid access to a co-produced, interactive, and dynamic therapeutic intervention, tailored to suit individual needs delivered within a non-clinical setting promoting its acceptability. Of note, was the novel lay your cards on the table component of the JPM for engaging men in therapy and facilitating adaptation of the JPM to address individual needs.

Implications: In challenging perceptions of conventional help-seeking for suicidal crisis by men experiencing suicidal crisis, the findings support the delivery of co-produced suicide prevention interventions for men experiencing suicidal crisis within a non-clinical, community-based setting to promote engagement and reach among men.

Future research: Should garner further evidence of the short- and long-term effectiveness of the JPM and the clinical utility of constituent components of the JPM such as the lay your cards on the table.

James' Place has successfully integrated co-production into its values and working practice from service inception, development through to delivery and this is described and reflected within study 2. Subsequently, co-production is a fundamental feature of the JPM that affords therapists delivering the model flexibility to adapt intervention delivery to suit the individual needs of each man. This finding is reflected within the case studies, with the dynamic nature of lay your cards on the table (LYCT) highlighted as being particularly useful in supporting men when articulating the diverse nature and intricacies of their individual suicidal crisis. Additionally, rapid access and the non-clinical environment of the James' Place service is recognised for supporting men when discussing their suicidal crisis. Collectively, these factors (non-clinical therapeutic environment, lay your cards on the table, and rapid access) are perceived to support the acceptability of the JPM in normalising the sharing suicidal distress to support their suicidal disclosure to specialised suicide prevention therapists at James' Place.

The third and fourth studies each highlight different aspects relating to the effectiveness of the JPM in practice. The third study examined the role of the LYCT component of the JPM in predicting suicidal distress indicated by CORE clinical outcome scores showing the predictive utility of the cards in clinical practice. This extends understanding of the role of the LYCT component of the JPM, reflected in study 2 as an important feature of the JPM in engaging men and facilitating the co-production and tailoring of therapeutic approaches to address individual needs and priorities. Box 3 provides an overview of the main findings of this study.

Box 3: Overview of Study 3

What does this study add? Findings are consistent with previous research highlighting the diversity and complexity of biopsychosocial risk factors contributing to men's suicidal crisis. Several card variables were found to significantly predict CORE-OM scores including the role of lack of social support and inability to sleep. Significant psychological factors found to be predictive of suicidal distress CORE-OM scores identified through delivery of the LYCT (e.g., *"my friends don't talk to me anymore"*) correspond with components of established theories of suicide such as the Integrated motivational theory of suicide (O'Connor, 2011; O'Connor & Kirtley, 2018). This further supports the use of LYCT in appraising suicidal risk and adapting suicide prevention delivery to suit individual needs and priorities.

Implications: The LYCT component of the JPM facilitates interactive appraisal of psychological risk factors driving men's suicidal crisis, allowing monitoring of how these may fluctuate during the delivery of the JPM from beginning through to its end. This informs tailoring of the JPM in response to individual needs, and to changes in psychological risk factors throughout the clinical journey. Beyond James' Place, the findings support the use of theory-driven informed approaches in the assessment of suicide and in suicide prevention.

Future research: Should seek to understand the short- and long-term effectiveness of the JPM, and mechanisms underpinning changes in suicidal distress. Also, as some inconsistencies in delivery of the LYCT among men receiving the JPM were noted, further research should seek to understand the acceptability and fidelity of delivery of the LYCT. More widely, the findings highlight the social nature of male suicide, highlighting the important role of social support in the prevention of suicide among men.

The LYCT component of the JPM is a novel, interactive component of the JPM that facilitates exploration of the individual expression of extensive biopsychosocial factors that may influence men's suicidal crisis. In assessing the ability of the LYCT to predict suicidal

distress outcomes evaluated using the CORE-OM, it was found that the WHN card "*I think about killing myself all of the time*" made a unique, significant contribution to variance in CORE34 outcome scores. The HDIGH card, "*My friends don't talk to me anymore",* significantly predicted CORE34 scores, while "*I have lived through terrible experiences" significantly* predicted CORE10 scores. Of the KPG cards, *"I can't sleep"* and *"I can't relax"* predicted the CORE34 and CORE10 scores respectively. Lastly, "*use of relaxation/mindfulness techniques"* significantly predicted CORE10 outcomes. Overall, the findings support the use of LYCT in assessing and tailoring the JPM to address risk factors underpinning men's suicidal crisis and underscore the importance of social support in the prevention of suicide among men. The findings also more widely support integration of theory informed approaches in the assessment of biopsychosocial factors underpinning men's suicide risk and in suicide prevention.

However, while study 3 findings showed a relationship between use of the LCYT component of the JPM in predicting suicide distress outcomes, uncertainty remained over the short- and long-term effectiveness of the JPM. Moreover, questions remained over the mechanisms of change engendering a reduction in suicidal distress and entrapment for men in receipt of the JPM. Therefore, the fourth study aimed to determine the effectiveness of the JPM and examined several factors including the potential mechanisms of change (hope, self-compassion, resilience, generalised self-efficacy, social isolation, and perceived social support) educed by the JPM through descriptive statistics and case studies. Also, in this study the feasibility of conducting long-term research among men who have received the JPM for suicidal crisis was explored. To achieve the aims of this study mixed methods longitudinal case study approach was used. Box 4 provides an overview of the findings of study 4.

Box 4: Overview of Study 4

What does this study add? Service data showed *relationship breakdown* and *work* ,and *entrapment* as the most frequent precipitating and psychological factors contributing to men's suicidal crisis upon their acceptance to the James' Place service. This finding aligns with conceptualisation of men's suicidal experiences within dominant masculine ideals and norms (e.g., stoicism). However, contrary to the portrayal of men as poor help-seekers, this study highlights that men do seek help and engage with psychological support for suicide crisis when the service provision is sensitive towards men's needs and preferences. Descriptive case study findings further support this supposition as the JPM was reported by as an acceptable and efficacious suicide prevention intervention both in the short- and long-term for men experiencing suicidal crisis. Men perceived a reduction in suicidality in the short-term and described sustained use of coping strategies long-term (e.g., implementing individual safety plan interventions). However, poor uptake and high attrition rates prevented statistical analyses to support this assertion.

Implications: Findings emphasise the social nature of men's experiences of suicide and their help-seeking and engagement with suicide prevention services. Community-based suicide prevention services embracing an inclusive approach to masculine norms and delivering tailored suicide prevention to men in providing accessible and acceptable services for men experiencing suicidal crisis could potentially improve engagement and reduce suicide among this high-risk population.

Future research: Should seek to understand sustainability of reduced suicidality engendered by services such as the James' Place long-term. Efforts to understand the long-term effectiveness of community-based suicide prevention interventions may require researchers to utilise multiple innovative research methodologies to capture robust data in determining long-term effects.

Poor uptake and high attrition prevented multivariate analyses of quantitative data. While bivariate tests indicate significance within the results, multivariate analyses would have provided a more robust test of significance. Nevertheless, descriptive analyses of service data revealed relationship status and work, and entrapment were the most frequently cited precipitating and psychological factors respectively cited by men. Mean reductions of key risk factors associated with suicide including psychological distress, entrapment and loneliness and potentially protective factors of resilience, hope, generalised self-efficacy, perceived social support and self-compassion at baseline and 3-month follow up periods were also found. This suggests a sustained reduction in suicidality among men who have received the JPM. While multivariate analyses are required to establish whether this change is statistically significant, the quantitative results support a pattern of precipitating and psychological factors consistent with the social construction of male suicide.

Qualitative descriptive case studies further illustrate men's experiences of JPM and post-intervention, and their perceived acceptability and feasibility of conducting long-term research who have received the JPM. The JPM was perceived to rapidly reduce suicidality among men in the short-term. Specifically, the opportunity to discuss their suicidal thoughts and feelings using the LYCT, and being supported by specialised suicide prevention therapists in the delivery of a tailored intervention that helped the men to develop coping strategies was perceived to directly reduce suicidality. Sustained use of strategies developed during their clinical journey at James' Place to prevent relapse was perceived by the men as a long-term effect of the JPM. This included engaging with the LYCT to identify feelings, recording thoughts and feelings in a diary to "off-load", and referring to safety planning techniques to ward off low mood and/or triggers that may contribute to suicide ideation.

The results collectively suggest the JPM may have some positive short- and long-term effects in reducing suicidality among men. However, further research is needed to understand whether these effects are sustained and generalise to a wider cohort of men who has accessed JPM. Reluctance to engage in the research was demonstrable by poor uptake of the questionnaire among men accessing James' Place for the duration of this

study despite case study findings suggesting men were motivated to engage with research to support service development. Going forward, researchers will have to consider innovative ways to overcome poor uptake to engage men in suicide related research. This re-think may require researchers to abandon stringent methodologies (e.g., randomised controlled trials) traditionally considered as gold standard when capturing data from men actively experiencing suicidal crisis. Rather, researchers may consider using alternative approaches that build up a picture of short- and long-term intervention effects analogous to a mosaic in creating an understanding how and why community-based suicide prevention services such as James' Place are effective in the short- and long-term.

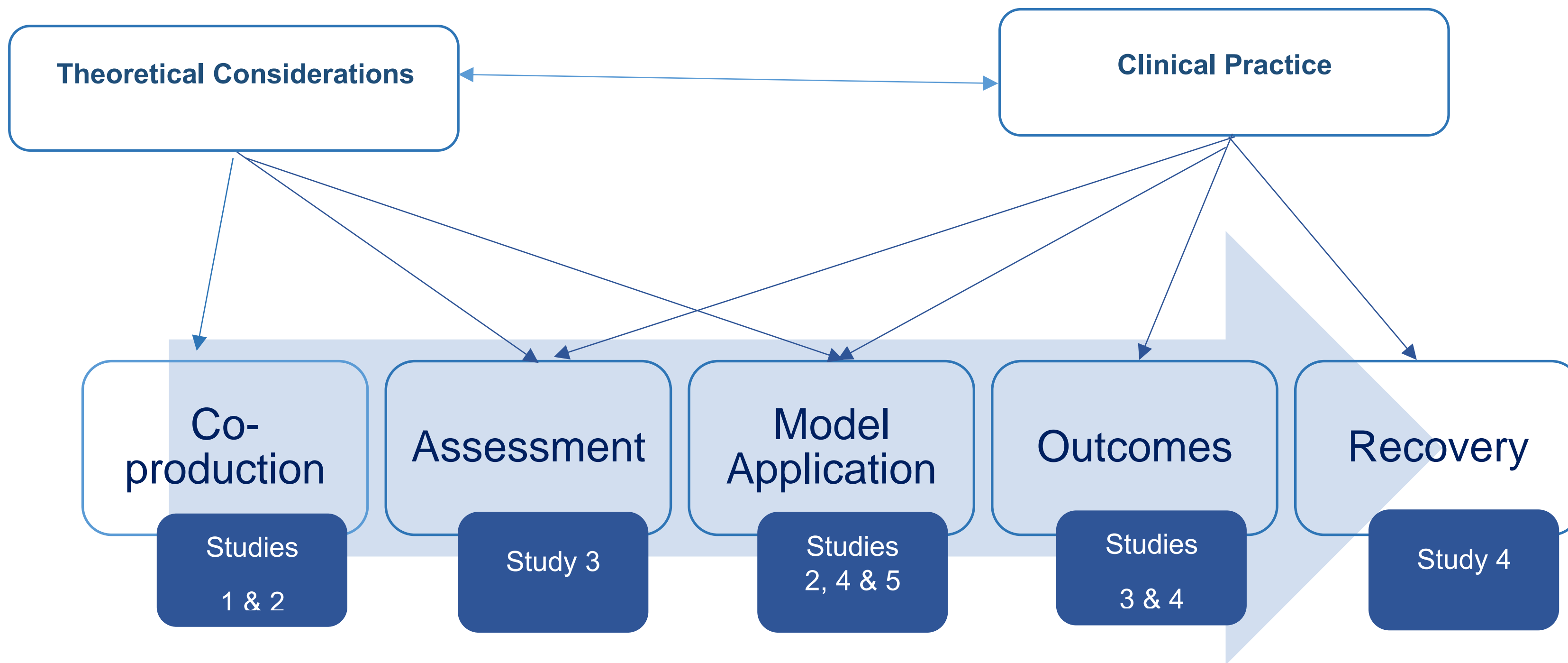
Findings suggest the JPM is an acceptable community-based suicide prevention service for men experiencing suicidal crisis, which appears to support men in overcoming suicidal crisis to establish effective coping strategies to prevent future relapse. However, less was known about the perceived acceptability and fidelity of delivery of the JPM by therapists trained to deliver the JPM. Using a mixed methods approach, the final study of this thesis aimed to explore fidelity of delivery of the JPM and the perceived service-related and service-user related barriers and facilitators underpinning the feasibility and acceptability of the JPM in real-world practice. Internal audit documents were reviewed to determine fidelity of delivery of a sample of James' Place cases. Semi-structured interviews with suicide prevention therapists explored their views and perceptions relating to perceived factors influencing delivery and acceptability of the JPM. Findings from this study highlight important considerations for maintaining fidelity of planned intervention delivery as the James' Place service executes its service expansion to a further three sites over the next two years. Box 5 summaries study 5.

Box 5: Overview of Study 5

What does this study add? Tailoring of suicide prevention interventions to meet individual needs are widely promoted. The findings highlight the need for practitioners delivering community-based suicide prevention interventions to balance delivery of specified components of the intervention as planned to preserve the integrity of the intervention while on the other hand ensuring individual needs are met. *Implications:* Rapid access to a tailored community-based suicide prevention intervention delivered within a non-clinical, community-based setting is perceived as acceptable by specialised suicide prevention therapists to men experiencing suicidal crisis. However, tolerance of flexibility within co-produced, community-based suicide prevention interventions such as the JPM is required to balance adaptation of intervention delivery while also ensuring delivery of specified components of the intervention as planned to preserve the integrity of the intervention. *Future Research:* Incorporating additional methods of evaluating fidelity (e.g., session recordings) would uncover circumstances that command therapists to adapt delivery of the JPM to meet individual needs.

Analysis of audit documents revealed moderate adherence to planned delivery of the JPM. Inconsistency in the delivery of the LYCT was noted with some sets of cards being delivered and others not. Alternatively, no LYCT sets were delivered at all. In accounting for this, tolerance of flexibility within delivery of the JPM was perceived by therapists as necessary to enable co-production of therapy to meet each man's individual needs and preferences. It could be argued this raises questions over the acceptability and fidelity of delivery of the JPM by men experiencing suicidal crisis. Nevertheless, therapists perceived the JPM to be acceptable for men experiencing of suicidal crisis with rapid access, to a face-to-face tailored brief psychological intervention delivered by specialised suicide prevention therapists within in an informal, non-clinical setting underpinning its acceptability.

Figure 1: Relationship Between Thesis Studies and the JPM Therapeutic Pathway of Care



8.3. Interpretation of Findings

This next section will synthesise the results of each study within the context of previous research, James' Place, and implications for future directions within the service and the wider field of community-based suicide prevention services for men.

8.3.1. The Role of Co-production in Community-Based Suicide Prevention Interventions for Men

Co-production is becoming more commonly implemented to shape mental health service provision and delivery to suit the needs and priorities of individual service users (e.g., National Collaboration Centre for Mental Health, 2021a and b). This is important in healthcare interventions, including suicide prevention, as co-production can contribute to development of person-centric interventions that are more acceptable and engaging for whom they are intended (Thabrew et al., 2018). Arguably, this increasing emphasis highlights the need for robust evaluative systems within co-produced interventions to determine the effectiveness and cost-effectiveness of the intervention upon service users (Clarke et al., 2017). However, as found in study one, a universal definition of co-production is lacking with diverse definitions being used within studies (Brandsten & Houghin, 2015; Filipe et al., 2017; Masterson et al., 2021). Few studies incorporated formal evaluation of suicide-related outcome, which is consistent with previous research showing a dearth of evaluation of impacts and clinical outcomes on patients/service user-related outcomes, including clinical outcomes (Clarke et al., 2017; Sharma et al., 2017; Slattery et al., 2020). This may have implications in real world practice in the delivery of suicide prevention interventions, especially as the newly published suicide prevention strategy has emphasised the need for tailored and person-centred approaches to suicide prevention (DHSC, 2023). For example, while co-production may allow for tailoring of interventions to suit individual needs, without a clear remit of what this looks like and how it is applied within the means there is a risk that co-production may be applied in a tokenistic way (Smith et al., 2022; van de Graff et al., 2023). Some have argued the nature of co-production means we should avoid universal or gold standard approaches to its implementation (Smith et al.,

2023; van der Graaf et al., 2023). Consistent with this view it is asserted pursuit of consensus in a definition of co-production as pointless endeavour due to the range of different conceptualizations and approaches used in the application of co-production (Masterson et al., 2021; Smith et al., 2023; Williams et al., 2020). It has also been purported that measuring the impact of co-produced interventions could undermine the democratic principles of co-production such as power sharing and giving voice to patients/service-users (Slattery et al., 2020; Williams et al., 2020). Rather, a flexible approach to co-production should be embraced where it is viewed as a "*social space*" in which ideas and knowledge are generated with less emphasis placed upon impacts and outcomes (Filipe et al., 2017).

Debate within this arena shows no sign of abating any time soon. Irrespective of position and thoughts on a universal definition of co-production and measuring impacts and outcomes, suicide prevention interventions rely upon effective outcomes for the recipient as a matter of life and death. In this vein, knowledge of short- and long-term effects are required to prevent relapse and promote continued recovery. Using theoretical approaches in the design and development of suicide prevention interventions, such as ideation-to action Models (e.g., IMV; O'Connor, 2011; O'Connor & Kirtley, 2018) and offers a behaviour change framework to understand the mechanisms that may engender change within an intervention (Skivington et al., 2021). For example, ideation to action models such as the Integrated motivational volitional model (O'Connor, 2011; O'Connor & Kirtley, 2018) which attempt to explain the interplay of factors underpinning suicide ideation and suicide attempt or death by suicide respectively (Bennett et al., 2023). Furthermore, this understanding is required if acceptable and effective community-based suicide prevention interventions are to be accessible and funded.

In the current climate of co-production research within suicide prevention where lack of definition, theory and evaluation pervades this arena (Hanlon et al., 2022), it is imperative that researchers and practitioners are clear and transparent in their objectives when integrating co-production to understand how best to support adults experiencing suicidal crisis in the delivery of community-based suicide prevention interventions (Smith et al., 2022).

A pragmatic approach going forward would be for researchers and involved stakeholders to be self-critical of their own research and clinical practice endeavours. This could be achieved by clear operationalisation of co-production specific to their context (research and/or clinical practice), being coherent and transparent of their inclusion of co-production, acknowledging how and why deviations away from gold standard co-productive methodologies have occurred (Smith et al., 2022). Whilst arguably this may rebuke the democratic foundations of co-production, this approach does embrace the wide range of diverse approaches and activities applied within the field of suicide prevention, and facilitates adaptation of co-production (Smith et al., 2022) such as in suicide prevention interventions, including its context and content of delivery, to suit targeted populations such as men (Chandler, 2022).

The James' Place service was identified within the systematic review (chapter 3) as using co-production to tailor intervention delivery within clinical practice in the delivery of a suicide prevention intervention and evaluating related outcomes was shown by included studies related to James' Place. The next section discusses principal components of the James' Place service and their therapeutic model (JPM) that contribute its feasibility and effectiveness in practice.

8.3.2. Undoing Medicalised Approaches to Suicide Prevention to Promote Help-Seeking Among Men Experiencing Suicidal Crisis

The studies comprising this thesis, yearly evaluations conducted by the James' Place service (Saini et al., 2020; 2021; 2022) and peer reviewed journals (Chopra et al., 2022; Hanlon et al., 2022; 2023; 2024 Saini et al., 2021; 2023) culminate as evidence which speaks to the effectiveness of the JPM. In terms of feasibility, unpicking key factors identified by the studies of this thesis builds a picture of what contributes to the JPM being an accessible, acceptable, and effective suicide prevention intervention for men experiencing suicidal crisis.

Adherence to dominant masculine norms (e.g., self-reliance, stoicism) are widely considered to hamper men's help-seeking for mental health difficulties (Seidler et al., 2016). Rather, men externalise their depressive symptoms characterised by behaviours that impose men at increased risk of suicide, such as alcohol and substance misuse to preserve masculine norms (Armstrong et al., 2020; Richardson et al., 2021). Together, this perpetuates an oversimplified narrative that men do not engage in emotional talk. However, disclosure of suicidal thoughts and feelings have been described by men who have experienced suicidality to occur when their limit of self-reliance becomes exhausted prompting them to uptake help (Seidler et al., 2021) and when the content and context of disclosure are suitable (Chandler, 2021). Yet, it is reported men can often be deterred from engaging with traditional mental health support due to negative experiences including challenges to accessing appropriate accessing appropriate referral pathways, discomfort discussing emotional distress with their service provider, and mislabelling and/or underestimating the severity of their distress (Strike et al., 2006).

In promoting accessibility, James' Place co-produced the service from inception and design to delivery with diverse stakeholders including men with lived experience of suicidality to create a service with reach which speaks to men's needs and preferences (Saini et al., 2019). Incorporating co-production to inform service design and delivery, including the environment (context) in which men discuss their content of their suicidality, maximises accessibility and engagement of suicide prevention services for men experiencing mental health difficulties such as suicidality (Oliffe et al., 2020). James' Place is a community-based service which men can access via various referral pathways including self-referral (Saini et al., 2020; 2021; 2022). Having a wide-range of referral pathways and being community-based breaks down traditional barriers to accessible suicide prevention for men such as negative experiences encountered while help-seeking such as long-waiting list and medicalised focussed approaches (River 2018; Tryggvadottir et al., 2019; Bennett et al., 2023). In contrast, James' Place carefully anticipates the needs of men experiencing suicidal crisis to offer an evidence informed suicide prevention service that considers the wider social and structural issues (e.g., financial difficulties, unemployment, relationship

breakdown) relating to a man's suicidality. While in keeping with key theory informing JPM (e.g., IMV model's consideration of social context contexts), suicide prevention delivery without consideration of the intersectionality of structural factors with the wider psychosocial issues of suicide has been criticised for having limited therapeutic effect (Chandler et al., 2021; O'Connor, 2011; O'Connor et al., 2018). Further, therapeutic approaches are brief and solution-focussed, targeted towards individual drivers of each individual man's suicidal crisis. Taking this bespoke, solution therapeutic approach has been found to be preferred by men experiencing suicidal crisis (Lindon et al., 2018; Seidler et al., 2021).

Rapid access to psychological support is facilitated as men typically receive a welcome assessment within 48 hours of referral to James' Place (Hanlon et al., 2022). Rapid access to brief psychological intervention is imperative to ensure timely delivery of mental health support to individuals while they are experiencing suicidal crisis and in the prevention of suicide (Chopra et al., 2022; McCabe et al., 2018; National Institute for Healthcare Excellence, 2019; Saini et al., 2020; 2021b) and forms a key component of the JPM (Hanlon et al., 2022). Embedding James' Place within the local community ensures sociocultural and contextual relevance to the community which it serves (Sharp et al., 2022). While the co-produced informal, non-clinical therapeutic environment design of therapy rooms at James' Place in resembling neutrally toned a living room accommodates a plurality of masculinities (Galdas et al., 2023). This creates an accessible male-sensitive space which allows men to prioritise their mental health needs and reframe their notion of masculinity as valuing emotional-orientated disclosure when engaging in therapy (Johnson et al., 2012; Seidler et al., 2016; Vickery, 2021).

8.3.3. Allowing Men to be *Seen* and *Unsilenced*: Delivery of a Bespoke Evidence-Based Model

Tailoring of suicide prevention interventions are widely promoted to address the diverse, complex, and individual nature of suicidal crisis, particularly for men (Seidler et al., 2016; 2018;b Struszczyk et al., 2019). It is widely espoused that co-production can contribute to

development of person-centric interventions that are more acceptable and engaging for whom they are intended (Thabrew et al., 2018). Co-production facilitates adaptation of the JPM to suit individual men's needs and preferences. Specialist suicide prevention therapists trained to deliver the JPM implement a blended approach to build therapeutic alliance with men by talking (e.g., avoiding the use of jargon/using direct, frank language to name suicide), allowing men time to reflect in silence and the LYCT, which are a novel, interactive component of the JPM.

The JPM is an evidence-based model of suicide prevention. For example, lived experience experts consulting on the design of the James' Place service highlighted difficulties men experiencing suicidal crisis often encounter when trying to find the words to articulate their suicidal distress. Taking this learning on board in the development of the JPM, James' Place co-produced LYCT in consultation with men with lived experience of suicidal crisis by drawing upon the IMV model of suicide. Specifically, card variable names relate to the precipitating, motivational and volitional factors of the model (e.g., I feel trapped, I don't belong) (O'Connor, 2011; O'Connor & Kirtley, 2018).

Delivery of the LYCT facilitates shoulder-to-shoulder work between the therapist and man and can support men in identifying and articulating the risk factors and drivers of their suicidal crisis during a time when their cognitive ability (e.g., problem solving/attentional and emotional biases) may be impaired by their suicidality (da Silva et al., 2018). This informs adaptation and co-production of the JPM to redress these factors. Indeed, talking, use of silence and activity are purported as key characteristics of intervention content that promote intervention engagement among men which may facilitate understanding of the intersectionality of masculinity with interpersonal, social, and cultural systems (Oliffe et al., 2020; Seidler et al., 2018b).

Further, the flexible nature of the LYCT allows for therapists to deliver this component in a manner suited to the individual man (see chapter 7). This may involve delivery each of all four sets of cards, just those sets that most resonate with the individual man (e.g., just the what's happening now cards) or none at all. Alternatively, some men may opt for the

therapist to discuss key themes covered within the cards that are pertinent to their suicidal crisis. Alternatively, men may use LYCT and add to the card variables by writing pertinent issues relating to their suicidal crisis on blank cards. Varying patterns of use of cards were highlighted within frequency tables of chapter 5 and audit findings reported of chapter 7. While variability in application of LYCT presents challenges to fidelity of delivery of the JPM as planned, flexibility is important for ensuring men have capacity to be heard when discussing the nuanced and individual aspects of their suicidality. Specifically, this is important in shifting away from blanket application of universal suicide prevention interventions which are much needed particularly for high-risk groups including men (Bennett et al., 2023; DHSC, 2023; Seidler et al., 2018).

To summarise, the findings of this thesis support the role of co-production in the development and delivery of community-based suicide prevention services for men experiencing suicidal crisis. The findings offer insight into how integration of co-production in practice can be harnessed to optimise accessibility, acceptability. and delivery of adapted of a community-based suicide prevention service for men experiencing suicidal crisis. In doing so, this opens a needed, arguably overdue, platform for men to become visible and unsilenced in discussing their suicidal distress. Stepping back to the original foundations of the James' Place service which has guided its inception, design, delivery, and expansion reveals the pillars of the JPM that provide an implementation framework for wider development of community-based suicide prevention services for men as discussed below.

8.4. Recommendations for Practice

8.4.1. Transforming Suicide Prevention for Men

The evidence generated from the studies of this thesis supports a call for affirmative action in the provision of suicide prevention services that address men's needs. Drawing upon the findings of this thesis, this next section discusses the wider implications for transforming community-based suicide prevention service provision for men to optimise reach, acceptability, and effectiveness.

8.4.2. Rapid Access

Therapists identified rapid access to a bespoke therapy as being a potential mechanism of change for reducing suicidality receiving the JPM. Seeing men while they are in crisis rather than weeks later allows issues underpinning the crisis to be directly addressed. The effect of this four-fold; one, it allows men to recognise the drivers of their suicidality in a safe, therapeutic space suicide; two, to develop appropriate strategies to keep them safe in the present and future to prevent reoccurrence of crisis; three, it prevents escalation underlying issues of suicidality, allowing men to be signposted to additional services for further support (e.g., debt management, alcohol services); and lastly and most significantly, it saves lives.

James' Place has established robust links with referrers within the local community which facilitates rapid access into James' Place. Referral pathways enable men to be referred to James' Place from multiple sites (e.g., GP's and A&E departments). Men can also self-refer into by contacting James' Place via telephone and/or by completing an online form accessible on the James' Place website. Rapid access in conjunction with this no-nonsense approach breaks down known barriers that deter men from seeking help for mental health such as their reticence to seek help and long waiting lists (Galdas et al., 2005; Vickery et al., 2021). Men are more likely to die upon suicide attempt than women due to the violent nature of methods used and rapid progression from suicide ideation to fatal suicide attempt (Jordan and McNeil, 2020; Richardson et al., 2021; Schrijvers et al., 2012; Tsirigotis et al., 2011). It is therefore intuitive that early intervention at the point of suicidal crisis is likely to be efficacious in averting suicide death and further suicide attempts. Also, it improves accuracy and relevance of the therapeutic intervention to prevent suicide. Community-based suicide prevention services seeking to develop local referral pathways into their service should seek to engage with local stakeholders from inception through to design to learn and understand community needs and priorities when developing acceptance criteria to the service. This ensure service provision is aligned with the sociocultural context in which masculinities are expressed relevant to the community to service serves (Dworkin et al., 2015) and may potentially overcome issues of distrust of conventional mental health service provision often experienced by men (Oliffe et al., 2020). Being clear in who the

service is targeted towards should help improve the quality of referrals and ensure the service is right for each man's needs.

8.4.3. Therapeutic Environment

Related to the issues of accessibility of suicide prevention services as discussed above is the therapeutic environment. A key constituent of the JPM is the therapeutic environment. James' Place centres are situated within the local community in such a way that they are visible to men within the places where they live, work, and socialise which contextualises the service in a familiar environment making easy for men to connect with (Gladas et al., 2023; Robertson et al., 2018; Sharp et al., 2021). The therapeutic environment inside James' Place is deliberately informal and non-clinical and has been informed by various stakeholders and experts including men with lived experience of suicide (described in chapter 4). Tonal neutral décor cautions against inadvertently reinforcing dominant masculine stereotypes (e.g., sporting teams such as football clubs) that may exclude underserved and marginalised men (Galdas et al., 2023). Specialised suicide prevention therapists contribute to the therapeutic environment by co-producing therapeutic approaches with men, which ensures delivery of JPM corresponds to men's health literacy using frank, relatable language and avoiding the use of jargon (Oliffe et al., 2020; Seidler et al., 2018). Therapists noted in chapter 7 the importance of the therapeutic environment in allowing men to feel comfortable to disclose their suicidality, promoting discussions with men about their suicidal crisis.

It is important to note that the therapeutic environment of community-based suicide prevention services will likely change dependent upon the locality of the service and its sociocultural context. However, adopting the principles highlighted to cultivate the therapeutic environment will promote accessibility and reach of community-based suicide prevention services targeting men.

8.4.4. Person-Centred Approach

A constant theme throughout this thesis is that there is a need for brief, person-centred, tailored approaches that are dynamic, goal-orientated and suited to the sociocultural context of men accessing suicide prevention interventions who are experiencing suicidal crisis. This finding is neither novel nor surprising since it is consistently reported within the literature (e.g., Galdas et al., 2023; Oliffe et al., 2020; Seidler et al., 2016). Emphasis of the JPM during the clinical journey is upon co-production of therapy with a specialised suicide prevention therapist that is solution-focussed in redressing the drivers of a man's suicidal crisis. Stepping back with the man through a process of co-production while they are held in a safe, therapeutic space facilitates knowledge exchange which then informs development of suicide prevention intervention content within the structure of the JPM that considers the needs of their targeted audience. Also, the theory-driven nature of JPM and LYCT enable therapists to identify risk factors driving men's suicidality and appropriate coping strategies (e.g., safety planning). Contrastingly, LYCT in conjunction with the therapeutic rapport built through open, direct, jargon-free communication by therapists, equip men to articulate their suicidality. Content of community-based suicide prevention interventions targeting men experiencing suicidal crisis should implement the core content components of the JPM to engage men specifically: be co-produced to facilitate an individualised approach; utilise novel techniques to promote communication (e.g., visual, dynamic techniques that promote shoulder-to-shoulder work); be theory-driven to inform assessment and delivery of therapeutic approaches; and promote solution- and goal-orientated techniques.

8.4.5. Routine Service Data Collection and Evaluation

Routine data collection and evaluative systems embedded into James' Place practice facilitates continual monitoring of individual men as they progress through the therapeutic journey at JPM. This allows men to reflect upon their progress within a supported, therapeutic environment and provides an indicator of the individual and wider benefits and impacts of the service in reducing suicide distress and entrapment for men while receiving

the JPM and before discharge. While implementing evaluation of impacts and outcomes within a co-productive approach is not without controversy, it is an intuitive requisite that will enable community-based services to be responsive to men's needs as a service evolves and informs delivery of a targeted intervention in the prevention of suicide.

8.5. Strengths and Limitations

Strengths and limitations of individual studies are addressed within each chapter. Therefore, this section recognises the broader strengths and limitations of this thesis as a collective body of work.

A key strength of this thesis is that it has involved data from men during the time they were experiencing suicidal crisis and underwent support from a community-based suicide prevention service and therapists who have supported them to understand the feasibility and effectiveness of the JPM. Typically research within this area has involved clinical cohorts within psychiatric settings and/or findings from psychological autopsies. However, confidence can be gleaned from the present findings since they represent real-world data captured while men were experiencing suicidal crisis.

Second, the mixed-methods approach used within this thesis allowed for data collection to reflect the views and perspectives, and experiences of both men experiencing suicidal crisis and specialised suicide prevention therapists delivering the JPM in seeking to understand the feasibility and effectiveness of the JPM. This blended approach provided unique insight into real-world delivery of a community-based suicide prevention intervention for men. Richness of data obtained through thematic analyses of data provided a valuable understanding of approaches that both enhance and deter uptake and engagement of men experiencing suicidal crisis. This is important to consider given the unrelenting high rates of suicide among men. Taking this information forward allows James' Place to be responsive were necessary to be responsive to men's needs. Additionally, it allows the service to care for the carer in ensuring that therapist needs are also met in delivering the JPM. Extending beyond James' Place, the principles of findings reported are generalisable

to the wider community and could guide development of acceptable community-based suicide prevention interventions targeting men in suicidal crisis.

Focus of this thesis being upon the James' Place service inherently limited the pool of potential participants to engage within research studies. This had the benefit of allowing a personalised approach to data collection (e.g., the researcher directly contacting each man and therapist involved in the study) and an optimum sample size is not specified to achieve generalisability of qualitative findings that are thematically analysed. However, it remains important to acknowledge that the sample of participants interviewed is small. Likewise, the sample size of men who participated in this study is also small. Men have described themselves as feeling *"fragile"* following a suicide attempt and expressed a reluctance to revisit their emotional state prior to their suicide attempt (Richardson et al., 2021b). This may in part explain the poor uptake within study 3 as men may have felt reticent to reflect upon their suicidal experiences during this vulnerable period of their recovery (chapter 5). Nevertheless, the sample does reflect that the James' Place service is a new service and is currently undergoing a period of growth as awareness of the service grows and as it expands to additional centres across England.

While quantitative analyses used within this thesis are statistically robust, the quantitative results are limited by the restrictive nature of the data. Poor uptake and follow-up completion rates restricted statistical analyses in study 4 and undermined attempts to explain the mechanisms underpinning the effectiveness of the JPM. This poses a significant consideration for researchers within the field as how to engage men who have previously experienced suicidal crisis at a time when they may wish to move on without revisiting a painful experience. Nevertheless, much of this work is exploratory.

8.6. Future Research

Suicide prevention for men is a significant public health priority with its reduction featuring as a key priority within the most recent suicide prevention strategy (DHSC, 2023). Research in the field provides a valuable resource for guiding targeted research efforts towards

suicide prevention, especially since mental health attracts limited funding (Saini et al., 2020). With this in mind, the wider implications of this thesis findings for future research was considered.

Future research should aim to build upon the findings of this thesis to further develop the James' Place service and to mobilise the evidence-based knowledge generated to inform community-based suicide prevention services targeting men experiencing suicidal crisis. The need for community-based tailored suicide prevention for men was consistently noted throughout this PhD, and this is widely echoed within the wider literature (Player et al., 2015; Seidler et al., 2018; Struszczyk et al., 2019). Research examining intervention effectiveness for men experiencing suicidal crisis (Blisker & White, 2011; Bennett et al., 2023). While studies within this thesis provide some evidence of how the principles informing JPM can be implemented, the paucity of research surrounding suicide prevention interventions for men suggests a gap in translation of research evidence into clinical practice at sufficient scale and pace. Closing this gap is imperative if we are to address the well-documented needs of men experiencing suicidal crisis in a meaningful way and to achieve the priorities featured within the suicide prevention strategy (DHSC, 2023). Chapter 7 findings highlighted the importance of tolerance of flexibility in delivery of the JPM in addressing men's needs and maintaining adherence to delivery of JPM as planned (Hanlon et al., 2023). Therapists reported a perceived need for flexibility in delivery of JPM, however this does raise questions over the integrity of recorded changes in suicidality among men receiving the JPM if it is being implemented in different ways (Hanlon et al., 2023). These challenges are not unique to delivery of suicide prevention. Indeed, similar challenges have been reported from research examining fidelity-related issues in other healthcare domains such as that examining delivery of the NHS Diabetes Prevention Programme (e.g., Bower et al., 2023).

Future research should take a two-fold approach to redress this challenge (i.e., need for flexibility vs. fidelity). First, as James' Place is expanded, future research should seek to embed monitoring of fidelity into the working practices of the service. This will allow the service to be responsive to make the required changes to any fluctuations of delivery of the

JPM as planned beyond the tolerance which can be accommodated within the model itself without risking outcomes. Second, future research should aim to explore the optimum point at which accommodation of flexible delivery and tailoring of the JPM does not lessen intervention effectiveness. Understanding this could shed some light on the necessary steps required to scale up community-based suicide prevention interventions delivering a bespoke suicide prevent intervention for men experiencing suicidal crisis whilst sustaining intervention outcomes and saving lives.

Knowledge around risk factors for suicide of men attending James' Place are generally well-understood as shown within chapter 5. However, less is known about how these risk factors are therapeutically redressed by the JPM. Findings from chapter 5 and 6 support the therapeutic benefits of the JPM in mitigating the negative effects of several factors associated with suicide including entrapment, interpersonal relationship issues and structural issues which is consistent with previous research (e.g., Farr et al., 2024; O'Connor & Portzky, 2018; Scourfield et al., 2015). Findings from this thesis (e.g., chapter 6) and elsewhere pertaining to the JPM suggest a role for the development of improved coping which mitigates suicidality. However, the precise mechanism(s) underpinning the therapeutic benefits of JPM are unknown and warrant further investigation. Conducting randomised controlled trials are particularly challenging among a population experiencing suicidality. One approach future research could seek to overcome this methodological challenge could be to map the therapeutic approaches used by James' Place therapists using the theoretical domains framework (TDF) to identify behaviour change techniques taxonomy (BCTT) utilised by therapists (Atkins et al., 2017; Michie et al., 2013). Using the TDF and BCT taxonomy would facilitate a theoretical examination of the cognitive, affective, social and environmental influences of behaviour change in relation to the JPM (Atkins et al., 2017; Michie et al., 2013). This could potentially enable identification of the mechanisms of change underpinning the JPM and enhance the understanding of the sustained effects of the intervention.

Less remains known about the impact of the JPM on underserved populations such as neurodivergent groups. For example, while JPM is an inclusive service, at present it has

no understanding of how many men engaging with the service have neurodivergent needs as this is not recorded on their clinical system unless the therapist notes this in their consultation notes. Research evidence is burgeoning that highlights the increased risk of suicide among neurodivergent individuals, such as who are autistic (Cassidy et al., 2022). Understanding of how neurodivergent men engage with the JPM could inform development of a pathway of care and what adaptations may be required to tailor delivery of the JPM that meets their needs. This direction for future research also aligns with key priorities of the national suicide prevention strategy (DHSC, 2023).

8.7. Conclusion

The narrative that men do not talk pervades the literature, and while men do face challenges when seeking help, it is important that researchers, health care professionals and policy makers acknowledge that men do uptake mental health support when service provision conditions are suitable. This thesis presents evidence, alongside peer-reviewed publications published in academic journals, that men do seek help for suicidal crisis evidenced by engagement among men at James' Place and the programme of planned expansion to address continued demand for the service. Current mental health service provision for men experiencing suicidal crisis is inadequate, and continues to fail men, attested by continued high rates of suicide among men. This thesis represents a call to action to stop facing this global health crisis with the perplexing approach of continuing to do what we always have done in the hope that something changes. Rather, it is imperative that this knowledge is mobilised to reshape community-based suicide prevention for men to suit men's needs and priorities. The JPM is a blueprint for accessible, acceptable, and effective community-based suicide prevention intervention provision. In shifting away from universal suicide prevention approaches towards person-focussed approaches, rapid access to co-produced therapy within a therapeutic environment sensitive to men's sociocultural experiences can enable frank discourse and exchange about suicide and its prevention, to reduce suicide among men and its associated psychological burden to the individual and significant others.

9. References (Introduction, Methodology and Discussion)

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Appendix 1: Study 3: Example of Search Terms

	Search Term	Search Field
1.	co-product*	Title search
2.	collaborat*	Title search
3.	“collaborative approach”	Title search
4.	co-design*	Title search
5.	co-creat*	Title search
6.	co-develop*	Title search
7.	co-evaluat*	Title search
8.	“action research”	Title search
9.	“lived experience”	Title search
10.	“user experience”	Title search
11.	“user involvement”	Title search
12.	“patient involvement”	Title search
13.	“patient participation”	Title search
14.	“patient engagement”	Title search
15.	“patient cent* care”	Title search
16.	“person cent* care”	Title search
17.	“shared decision making”	Title search
18.	MH suicide [MESH]	Title search
19.	suicid*	Title search
20.	Suicide [keyword]	Title search
21.	MH “community mental health services” [MESH]	
22.	“community mental health services” [keyword]	Title search
22.	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17	
23.	18 OR 19 OR 20 OR 21 OR 22	
24.	23 AND 24	

Appendix 2: Study 4: UREC Ethical Approval Document

Dear Claire

UREC opinion: Favourable ethical opinion with provisos

UREC reference: 20/NSP/043

Research Governance Assessment: Approved – the study may commence.

The University Research Ethics Committee (UREC) has considered the above application. On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above study on the basis described in the application form, protocol, supporting documentation and any clarifications received, subject to the provisos and conditions specified below. You are required to email the final version of the ethics application with the provisos addressed to FullReviewUREC@ljmu.ac.uk. Please note, UREC will not check that the provisos have been applied in the final version of the ethics application and will not email any further notifications to the applicant once the final version of the ethics application has been forwarded to UREC. If the applicant does not want to apply the provisos as stated below, the applicant must notify UREC and resubmit the ethics application for further review.

Minute No:	**20.13.02**
Project:	**Hanlon, Claire (PGR NSP)** **An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis. (David McIlroy, Pooja Saini and Helen Poole)**
Decision:	**Favourable ethical opinion with provisos**
Notes to applicant:	**Comments** UREC considers the participants to be vulnerable – which is why it is important that the gatekeeper is involved in recruiting and safeguarding the participants and the participants are fully informed about the content of the questionnaire participant information sheet, how the questionnaire will be administered and when/how the participant should seek help. **Provisos**: E1 - Researcher stated no participants will be left distressed. The researcher will not know given that the research is on line – please rephrase this sentence. Please fully inform the participants on the PIS and questionnaire that the questionnaire is long and their answers could be depressing – inform the participants how they might recognise that they might benefit from further support and how to go about this. Please also make it clear to the participants that the questionnaire must not be used as a call for help –

	because the questionnaire will be made anonymous when submitted, the researchers will not be able to respond to the answers provided.

Conditions of the favourable opinion

Prior to the start of the study.

COVID-19. Studies that involve face-to-face activity – you must ensure participant facing documents explain the potential risks of participating in the study which are associated with COVID-19, how the risks will be mitigated and managed.

After ethical review.

You must ensure the information included in the participant facing documents are always current and informed by ongoing risk assessments and any changes to current practices.

Where any substantive amendments are proposed to the protocol or study procedures further ethical opinion must be sought (https://www.ljmu.ac.uk/ris/research-ethics-and-governance/research-ethics/university-research-ethics-committee-urec/amendments)

Any adverse reactions/events which take place during the course of the project are reported to the Committee immediately by emailing FullReviewUREC@ljmu.ac.uk

Any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately emailing FullReviewUREC@ljmu.ac.uk

Please note that favourable ethics opinion is given for a period of five years. An application for extension of the ethical opinion must be submitted if the project continues after this date.

Research Governance Approval.

This email also constitutes LJMU Research Governance Approval of the above referenced study on the basis described in the ethics application form, protocol, supporting documentation and any clarifications received, subject to the conditions specified below.

Conditions of Approval

Compliance with LJMU Health and Safety Codes of practice and risk assessment policy and procedures and LJMU Code of Practice for Research

Ensure the study is covered by UMAL

COVID-19. Compliance with LJMU's travel restrictions

COVID-19. Studies that involve any face-to-face research activity have the appropriate risk assessment in place – the risk assessment is signed by the school Director or nominated other, revised, resigned and reissued when required and sent to the Safety, Health and Environment Department by email to SHE@ljmu.ac.uk

COVID-19. Studies that involve any face-to-face research activity meet COVID-19 practices which are current at the time the research activity takes place.

Where relevant, appropriate gatekeeper / management permission is obtained at the study site concerned and any other approvals that are required are obtained.

The LJMU logo is used for all documentation relating to participant recruitment and participation e.g. poster, information sheets, consent forms, questionnaires.

The study consent forms, study data/information, all documents related to the study etc. will be accessible on request to a student's supervisory team and/or to responsible members of Liverpool John Moores University for monitoring, auditing and data authenticity purposes.

Yours sincerely

Mandy Williams, Research Support Officer

(Research Ethics and Governance)
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LIVERPOOL JOHN MOORES UNIVERSITY

Appendix 3: Study 4: Participant Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

Participant Information Sheet for James' Place Service User

LJMU's Research Ethics Committee Approval Reference:

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis

You are being invited to take part in a study. Before you decide it is important for you to understand why the study us being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the study?

Study Team

Principal Investigator: Claire Hanlon, PhD student

Co-investigator: Dr David McIlroy, Dr Pooja Saini & Dr Helen Poole

School/Faculty within LJMU: School of Psychology / Faculty of Science

What is the purpose of the study?

The purpose of the study is to find out whether the way in which the service provided by James' Place helps to reduce thoughts about suicide and improve mental wellbeing in both the short- and long-term for men who are experiencing or have recently recovered from suicidal crisis. To do this, we are asking you to complete a questionnaire shortly after coming to James' Place for the first time. If you agree, we contact you again in 3-, 6- and 12-months and ask you to complete the questionnaire again.

The findings form part of a PhD and will help us to evaluate whether the way in which help is provided by James' Place service to men who are experiencing or recently recovered from suicidal crisis helps them to feel better, and also help us to identify areas that are both successful and those that may require further development. This may contribute to improving the James' Place service for future service users.

This study hopes to answer the following questions:

1. Does the way in which help provided by James' Place for men who are experiencing suicidal crisis to feel better in the short- and long-term?

2. Does the way in which help provided by James' Place for men who are experiencing suicidal crisis help to reduce suicidal thoughts and feelings associated with entrapment and social isolation among adult men at suicidal risk?

3. Does the way in which help provided by James' Place for men who are experiencing suicidal crisis help improve positive thoughts and feelings of self-efficacy, self-compassion, resilience, hope and perceived social support?

4. Do positive thoughts and feelings associated with self-efficacy, self-compassion, resilience, hope and social support influence the suicidal thoughts, feelings and behaviours of men post- suicide crisis?

Why have I been invited to participate?

You have been invited to participate because you have been referred or self-referred to James' Place for support as you have been experiencing suicidal thoughts and feelings. It may be that the therapist asked whether you would like to take part and that you contacted the researcher or that the researcher contacted you directly.

To take part in the study you must have had direct experience of James' Place therapy as a service user. In addition, you must be 18 years or older to take part.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and provided with an online link to a questionnaire. You can withdraw at any time by informing the investigators without giving a reason and without it affecting your any future treatment you receive from James' Place.

What will happen to me if I take part?

We will talk you through the study procedures and give you the chance to ask any questions. If you decide to take part, a researcher will ask you to complete an online questionnaire. There is the option to complete a paper version of the questionnaire if you prefer or do not have access to a mobile phone, laptop/computer or tablet (e.g. ipad). The questionnaire will take no longer than 20 minutes to complete.

The questionnaire will ask questions relating to general information such as age, as well as questions about your beliefs and thoughts around mental health, including questions about suicide and self-harm, and positive psychological factors, such as resilience and social support. We will also ask for your contact details including your mobile number and email. This is because for the study to be a success we would like you to repeat the questionnaire again in 3- , 6- , and 12-months. Again, this will take no longer than 20 minutes. This will allow us to compare your answers from the previous questionnaire and to evaluate the effectiveness of the support you received from James' Place. Also, information collected by James Place will be linked with the questionnaire data Liverpool John Moores collects.

What should I consider?

- Questions will focus on your thoughts and feelings about different psychological factors you may be experiencing, including thoughts and feelings on suicide, self-harm, wellbeing, problems/symptoms, life functioning, risk/harm and additional psychological factors including coping, social support and hope.

Information collected by James Place will be linked with the questionnaire data LJMU collect.

You are free to stop at any time, to take a break, skip any question you do not wish to answer or to withdraw from the study at any time, without affecting your treatment and care from James' Place.

Are there any possible disadvantages or risks from taking part?

You will be asked to give up some of your time to complete the questionnaire a total of 4 times over a 12-month period. Also, as the questionnaire asks questions about your thoughts and feelings about different psychological factors including suicide and self-harm, this may affect your mood and how you are feeling. You are free to not answer any question you don't wish to answer and you are free to withdraw your participation at any time without giving a reason. This will not affect the standard of care you receive from James' Place.

If you feel distressed at any point or are personally affected by participation in this study you may wish to seek support/advice from James' Place via telephone (on 0151 303 5757), email (info@jamesplace.org.uk) or text JP on 85258 for James' Place 24 / 7 helpline. Alternatively, you can contact the Samaritans (116 123).

What are the possible benefits of taking part?

Whilst there will be no direct benefits to you for taking part in the study, but it is hoped that this work will help us to understand the short- and long-terms effects of the James' Place service. This may help inform the development of the service for future service users who are experiencing suicidal thoughts.

What will happen to the data provided and how will my taking part in this project be kept confidential?

The information you provide as part of the study is the **study data**. Any study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.), is known as **personal data**. This includes more sensitive categories of personal data (**sensitive data**) such as your race; ethnic origin; politics; religion; trade union membership; genetics; biometrics (where used for ID purposes); health; sex life; or sexual orientation. Personal data collected from you will be recorded using a linked code and stored securely and separately from the coded data. However, your responses to the questionnaires will be kept confidential and anonymous to others.

When you agree to take part in a study, we will use your personal data in the ways needed to conduct and analyse the study and if necessary, to verify and defend, when required, the process and outcomes of the study. For example, all questionnaire responses will be pooled together during analysis.

Personal data will be accessible to the study team only. In addition, responsible members of Liverpool John Moores University may be given access to personal data for monitoring and/or audit of the study to ensure that the study is complying with applicable regulations.

When we do not need to use personal data, it will be deleted or identifiers will be removed. Personal data does not include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). However, your consent form, contact details, and questionnaire responses will be retained for 5 years.

Limits to confidentiality

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to James' Place or an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

The investigator believes you are at serious risk of harm, either from yourself or others

The investigator believes you may be at risk of suicide

The investigator suspects a child may be at risk of harm

You pose a serious risk of harm to, or threaten or abuse others

As a statutory requirement e.g. reporting certain infectious diseases

Under a court order requiring the University to divulge information

We are passed information relating to an act of terrorism

What will happen to the results of the study?

The investigator intends to publish the results in a PhD thesis, journal article and to talk about the study findings at academic conferences.

Who is organising and funding/commissioning the study?

This study is organised by Liverpool John Moores University and funded/commissioned by Liverpool John Moores University, and has no conflict of interest.

Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: xxx).

What if something goes wrong?

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The investigator should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

Data Protection Notice

Liverpool John Moores University is the sponsor for this study based in the United Kingdom. We will be using information from you and/or your records from James' Place in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Liverpool John Moores University will process your personal data for the purpose of research. Research is a task that we perform in the public interest. Liverpool John Moores University will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the study to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Contact for further information about the study

Claire Hanlon

Liverpool John Moores University

Room 3.13 Tom Reilly Building

Byrom Street

Liverpool

L3 3 AF

C.A.Hanlon@ljmu.ac.uk

Contact for questions regarding support

James' Place

50 Catherine Street

Liverpool

L8 7NG

0151 303 5757

info@jamesplace.org.uk

24/7 Crisis Text line: text JP to 85258

Website: https://www.jamesplace.org.uk/

Thank you for reading this information sheet and for considering to take part in this study.

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.

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LIVERPOOL JOHN MOORES UNIVERSITY

Appendix 4: Study 4: Participant Consent form

LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM

An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis

Claire Hanlon, School of Psychology / Faculty of Science

I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. ☐

I understand that any personal information collected during the study will be anonymised and remain confidential ☐

I understand that information collected by James' Place will be linked with the questionnaire data LJMU collect ☐

5. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature
Name of Person taking consent *(if different from researcher)*	Date	Signature

Note: When completed 1 copy for participant and 1 copy for researcher

Appendix 5: Study 4: Gatekeeper Participant Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

GATEKEEPER INFORMATION SHEET

Title of Project: An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis

Name of Researcher and School/Faculty: Claire Hanlon, School of Psychology / Faculty of Science

What is the reason for this letter?

You are being invited to take part in a study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. As us if there is anything that is not clear or if you would like more information. Take the time to decide whether or not you wish to take part. Thank you for taking the time to read this.

What is the purpose of the study/rationale for the project?

The purpose of this study is to evaluate the immediate and long-term effectiveness of the James' Place therapeutic model for men experiencing suicidal crisis over 12-months. In order to do this we will be distributing a questionnaire among men who have direct experience of your service. The findings of the study will help us to evaluate the James' Place therapeutic model in promoting psychological wellbeing among men who have experienced suicidal crisis. This may contribute to improving the service for future service users.

What we are asking you to do?

We are asking for your service's involvement in the study and participant identification. Specifically, we are asking you and your therapists to ask service-users who they assess are psychologically fit to do so, if they would be interested and willing to participate in our study. If your service-user agrees and states that they wish to take part in the study, we are asking for you and your therapists to provide them with the researchers contact details to enable them to contact the researcher directly to discuss taking part. If the service-user prefers and asks you to do so, you may provide the researcher with the service-users contact details, but only if they say that they are happy for this to happen.

Why do we need access to your facilities?

Only the James' Place service can inform and share information on those who have direct involvement with the service, such as the individuals you support and who refers to your service.

If you are willing to assist in the study what happens next?

We will arrange a convenient time for you to meet with the researcher and to discuss the study in further detail. We will then give you information and questionnaires to share with potential participants James' Place service users and whom therapists identify as it being appropriate to ask if they would like to take part in the study. They will then be directed to contact the researcher directly, either in person if they are available to attend the centre or via email, if they have any questions.

How we will use the Information/questionnaire?

The participant will be asked to complete and return completed questionnaires to James' Place (a designated box will be provided to store them) or posted back to the researcher using a prepaid envelope. The information provided will be pooled with the responses of other participants and be analysed collectively.

Will the name of my organisation taking part in the study be kept confidential?

No, this will not be necessary as James' Place therapists will identify and invite potential participants to take part in the study and the study is an evaluation is about the service James' Place offer to men experiencing suicidal crisis. However, all participant data will be anonymised prior to analyses.

What will taking part involve? What should I do now?

Taking part will involve the therapists providing participants with an information sheet to inform them about the study. A questionnaire will be provided by the researcher. Potential participants will have the opportunity to speak to the researcher further about the study either face-to-face or via email or telephone. Participants will also be asked to return the completed questionnaire to the researcher via a secure designated box which the researcher will provide or via post in a prepaid envelope. Any audit data requested as part of this evaluation study will be sent directly to the researcher.

Sign and return the Gatekeeper Consent Form provided

For participants who are aged under 16 only, please make sure Signed Parental Consent Forms are collected back BEFORE distributing the questionnaire.

Should you have any comments or questions regarding this research, you may contact the researchers: Claire Hanlon via telephone (Tel: XXX) or email (email: C.A.Hanlon@ljmu.ac.uk).

This study has received ethical approval from LJMU's Research Ethics Committee *(REC reference number and date of approval)*

Contact Details of Researcher

Claire Hanlon; tel: XXXX; email: C.A.Hanlon@ljmu.ac.uk

Contact Details of Academic Supervisor

Dr David McIlroy; tel: 0151 904 6303; email: D.McIlroy@ljmu.ac.uk

Dr Pooja Saini; tel: 0151 231 8121; email: P.Saini@ljmu.ac.uk

If you have any concerns regarding your involvement in this research, please discuss these with the researcher in the first instance. If you wish to make a complaint, please contact researchethics@ljmu.ac.uk and your communication will be re-directed to an independent person as appropriate.

Appendix 6: Study 4: Gatekeeper Consent Form

LIVERPOOL JOHN MOORES UNIVERSITY

GATEKEEPER CONSENT FORM

Title of Project: An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis

Name of Researchers: Claire Hanlon, School of Psychology / Faculty of Science

Please tick to confirm your understanding of the study and that you are happy for your organisation to take part and your facilities to be used to host parts of the project.

Please note your participation will involve identifying potential participants, providing them with information about the study and a questionnaire (once only) and sharing audit data / reports.

I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that participation of our organisation and students/members in the research is voluntary and that they are free to withdraw at any time, without giving a reason and that this will not affect legal rights. ☐

I understand that any personal information collected during the study will be anonymised and remain confidential. ☐

I agree for our organisation and students/members to take part in the above study. ☐

5. I agree to conform to the data protection act ☐

Name of Gatekeeper:	Date:	Signature:
Name of Researcher:	Date:	Signature:
Name of Person taking consent:	Date:	Signature:
(if different from researcher)		

Appendix 7: Study 4: Debrief Details

Debrief Sheet

If you feel distressed at any point or are personally affected by participation in this study you may wish to seek support/advice from James' Place via telephone (on 0151 303 5757), email (info@jamesplace.org.uk) or text JP on 85258 for James' Place 24 / 7 helpline.

Alternatively, you can contact the Samaritans (116 123).

Appendix 8: Study 4: Questionnaire

Contact Details

This questionnaire is entirely confidential. We are only interested in the answers of a large group of people, and not the answers of individuals. This questionnaire has been designed for men attending, or who have previously attended, James' Place who are aged 18 years or older. Only complete this questionnaire if you are aged 18 years or older.

Your participation is voluntary and you may withdraw at any time without giving reason. If you do not feel comfortable answering a question, just skip it and move onto the next question.

We would like to contact you again to ask you to complete an identical questionnaire in 3-, 6- and 12-months' time.

Study Identification Code: ______________________________

General Information

Please tick the box that best represents your answers:

1. *Your age (in years)*: 18 – 24 ☐ 25 – 29 ☐ 30 – 34 ☐

35 – 39 ☐ 40 – 44 ☐ 45 – 49 ☐ 50 – 54 ☐

55 – 59 ☐ 60 – 64 ☐ 65 – 69 ☐ 69 – 70 ☐

75 or older ☐

2. *Where would you have sought help from had you not come to James' Place*?

A&E ☐ GP ☐ Friends ☐ Family ☐

Other (please specify): ______________________________

3. *Your relationship status:* Single ☐ In a relationship ☐

Living with partner ☐ Married ☐ Separated ☐ Divorced ☐

4. *How was the support you received from James' Place given*?

Face-to-face ☐ Online ☐ Telephone ☐

5. *If you received online or telephone support from James' Place, would you have preferred to receive support face-to-face*?

Yes ☐ No ☐ Not bothered ☐

6. *If you had the option to choose, how would you prefer to receive support from James' Place*?

Telephone ☐ Online video call ☐ Face-to-face ☐

7. *In a few words, can you tell us the reason why you would prefer face-to-face or telephone / online support from James' Place*:

____
_

CORE-34

Over the last week

0 = Not at all

1 = Only occasionally

2 = Sometimes

3 = Often

4 = Most of the time

1. I have felt terribly alone and isolated.	0	1	2	3	4
2. I have felt tense, anxious or nervous	0	1	2	3	4
3. I have felt I have someone to turn to for support when needed.	0	1	2	3	4
4. I have felt OK about myself.	0	1	2	3	4
5. I have felt totally lacking in energy and enthusiasm.	0	1	2	3	4
6. I have been physically violent to others.	0	1	2	3	4
7. I have felt able to cope when things go wrong.	0	1	2	3	4
8. I have been troubled by aches, pains or other physical problems.	0	1	2	3	4
9. I have thought of hurting myself.	0	1	2	3	4
10. Talking to people has felt too much for me.	0	1	2	3	4
11. Tension and anxiety have prevented me doing important things.	0	1	2	3	4
12. I have been happy with the things I have done.	0	1	2	3	4

13. I have been disturbed by unwanted thoughts and feelings.	0	1	2	3	4
14. I have felt like crying.	0	1	2	3	4
15. I have panic or terror.	0	1	2	3	4
16. I have made plans to end my life.	0	1	2	3	4
17. I have felt overwhelmed by my problems.	0	1	2	3	4
18. I have difficulty getting to sleep or staying asleep.	0	1	2	3	4
19.I have felt warmth or affection for someone.	0	1	2	3	4
20. My problems have been impossible to put to one side.	0	1	2	3	4
21. I have been able to do most things I needed to.	0	1	2	3	4
22. I have threatened or intimidated another person	0	1	2	3	4
23. I have felt despairing or hopeless	0	1	2	3	4
24. I have thought it would be better if I were dead.	0	1	2	3	4
25. I have felt criticised by other people.	0	1	2	3	4
26. I have thought I have no friends	0	1	2	3	4
27. I have felt unhappy	0	1	2	3	4
28. Unwanted thoughts or memories have been distressing me	0	1	2	3	4
29. I have been irritable when with other people	0	1	2	3	4
30. I have thought I am to blame for my problems and difficulties	0	1	2	3	4
31. I have felt optimistic about my future	0	1	2	3	4
32. I have achieved the things I wanted to	0	1	2	3	4
33. I have felt humiliated or shamed by other people	0	1	2	3	4
34. I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4

Entrapment-SF

1 = Not at all like me

2 = A little bit like me

3 = Moderately like me

4 = Quite a bit like me

5 = Extremely like me

1. I often have the feeling that I would just like to run away.

1 2 3 4 5

2. I feel powerless to change things.

1 2 3 4 5

3. I feel trapped inside myself.

1 2 3 4 5

4. I feel I’m in a deep hole I can’t get out of.

1 2 3 4 5

Social Isolation

1. I lack companionship.

Hardly ever or never Some of the time Often

2. There is no one I can turn to

Hardly ever or never Some of the time Often

3. I am an outgoing person

Hardly ever or never Some of the time Often

4. I feel left out

Hardly ever or never Some of the time Often

5. I feel isolated from others

Hardly ever or never Some of the time Often

6. I can find companionship when I want it

Hardly ever or never Some of the time Often

7. I am unhappy being so withdrawn

Hardly ever or never Some of the time Often

8. People are around me but not with me

Hardly ever or never Some of the time Often

Generalised Self Efficacy Questionnaire (Jerusalem and Scharwer, 1995)

	Not at all true	Hardly true	Moderately true	Exactly true
1. I can always manage to solve difficult problems if I try hard enough.				
2. If someone opposes me, I can find the means and ways to get what I want.				
3. It is easy for me to stick to my and aims and accomplish my goals.				
4. I am confident that I could deal efficiently with unexpected events.				
5. Thanks to my resourcefulness, I know how to handle unforeseen circumstances.				
6. I can solve most problems if I invest the necessary effort.				
7. I can remain calm when facing difficulties because I can rely on my coping abilities.				
8. When I am confronted with a problem, I can usually find several solutions.				
9. If I am in trouble, I can usually think of a solution.				
10. I can usually handle whatever comes my way.				

Resilience: Brief Resilience Scale

Please respond to each item by marking one box per row

	Please respond to each item by marking one box per row	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
1	I tend to bounce back after hard times.	1	2	3	4	5
2	I have had a hard time making it through stressful events.	5	4	3	2	1
3	It does not take me long to recover from a stressful event.	1	2	3	4	5

4	It is hard for me to snap back when something bad happens.	5	4	3	2	1
5	I usually come through difficult times with little trouble.	1	2	3	4	5
6	I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

Hope Trait Scale (Snyder 1994)

Directions: Read each item carefully. Using the scale shown below, please select the number that best describesYOU and put that number in the blank provided.

1. = Definitely False

2. = Mostly False

3. = Somewhat False

4. = Slightly False

5. = Slightly True

6. = Somewhat True

7. = Mostly True

8. = Definitely True

___ 1. I can think of many ways to get out of a jam.

___ 2. I energetically pursue my goals.

___ 3. I feel tired most of the time.

___ 4. There are lots of ways around any problem.

___ 5. I am easily downed in an argument.

___ 6. I can think of many ways to get the things in life that are important to me.

___ 7. I worry about my health.

___ 8. Even when others get discouraged, I know I can find a way to solve the problem

___ 9. My past experiences have prepared me well for my future.

___10. I've been pretty successful in life.

___11. I usually find myself worrying about something.

___12. I meet the goals that I set for myself

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you Very Strongly Disagree

Circle the “2” if you Strongly Disagree

Circle the “3” if you Mildly Disagree

Circle the “4” if you are Neutral

Circle the “5” if you Mildly Agree

Circle the “6” if you Strongly Agree

Circle the “7” if you Very Strongly Agree

1. There is a special person who is around when I am in need.

1 2 3 4 5 6 7

2. There is a special person with whom I can share my joys and sorrows.

1 2 3 4 5 6 7

3. My family really tries to help me.

1 2 3 4 5 6 7

4. I get the emotional help and support I need from my family.

1 2 3 4 5 6 7

5. I have a special person who is a real source of comfort to me.

1 2 3 4 5 6 7

6. My friends really try to help me.

1 2 3 4 5 6 7

7. I can count on my friends when things go wrong.

1 2 3 4 5 6 7

8. I can talk about my problems with my family.

1 2 3 4 5 6 7

9. I have friends with whom I can share my joys and sorrows.

1 2 3 4 5 6 7

10. There is a special person in my life who cares about my feelings.

1 2 3 4 5 6 7

11. My family is willing to help me make decisions.

1 2 3 4 5 6 7

12. I can talk about my problems with my friends.

1 2 3 4 5 6 7

Self-Compassion Scale (Neff, 2003)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never Almost always

1 2 3 4 5

1. I'm disapproving and judgmental about my own flaws and inadequacies.

1 2 3 4 5

2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

1 2 3 4 5

3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

1 2 3 4 5

4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

1 2 3 4 5

5. I try to be loving towards myself when I'm feeling emotional pain.

1 2 3 4 5

6. When I fail at something important to me I become consumed by feelings of inadequacy.

1 2 3 4 5

7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

1 2 3 4 5

8. When times are really difficult, I tend to be tough on myself.

1 2 3 4 5

9. When something upsets me I try to keep my emotions in balance.

1 2 3 4 5

10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

1 2 3 4 5

11. I'm intolerant and impatient towards those aspects of my personality I don't like.

1 2 3 4 5

12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

1 2 3 4 5

13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

1 2 3 4 5

14. When something painful happens I try to take a balanced view of the situation.

1 2 3 4 5

15. I try to see my failings as part of the human condition.

1 2 3 4 5

16. When I see aspects of myself that I don't like, I get down on myself.

1 2 3 4 5

17. When I fail at something important to me I try to keep things in perspective.

1 2 3 4 5

18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

1 2 3 4 5

19. I’m kind to myself when I’m experiencing suffering.

1 2 3 4 5

20. When something upsets me I get carried away with my feelings.

1 2 3 4 5

21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

1 2 3 4 5

22. When I'm feeling down I try to approach my feelings with curiosity and openness.

1 2 3 4 5

23. I’m tolerant of my own flaws and inadequacies.

1 2 3 4 5

24. When something painful happens I tend to blow the incident out of proportion.

1 2 3 4 5

25. When I fail at something that's important to me, I tend to feel alone in my failure.

1 2 3 4 5

26. I try to be understanding and patient towards those aspects of my personality I don't like.

1 2 3 4 5

Appendix 9: Study 4: Case Study Participant Information Sheet

Participant Information Sheet [Service User]

Research Ethics Committee Reference Number: 19/NSP/057

Title of Study: An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis

You are being invited to take part in a research study. You do not have to take part if you do not want to. Please read this information, which will help you decide.

1. What is the purpose of the study?

This study hopes to understand the short- and long-term effects of having therapy at James' Place, and to find out if and how therapy at James' Place has helped men once they have left the service.

This study hopes to answer the following questions:

1. Does the way in which help is provided by James' Place for men who are experiencing suicidal crisis to feel better in the short- and long-term?

2. What part of the help provided by James' Place for men who are experiencing suicidal crisis helped and did not help?

3. What motivated men who had previously received therapy at James' Place to complete follow-on questionnaires about the short- and long-term effects of the James' Place Model?

4. What can be done to improve response rates to questionnaires sent to men who have previously received therapy at James' Place which ask questions about their experiences during and after suicidal crisis?

5.Why have I been invited to participate?

You have been invited because you previously received therapy at James' Place for suicidal thoughts and feelings and you completed a questionnaire aiming to understand the short-and long-term efficacy of the James' Place Model   Please note, a long time may have passed since you last accessed James' Place.

6. Do I have to take part?

No. You can ask questions about the research before deciding whether to take part. If you do not want to take part that is OK. We will ask you to sign a consent form and will give you a copy for you to keep.

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. You may withdraw from the study by contacting Claire Hanlon [email: C.A.Hanlon@2019.ljmu.ac.uk].

7. What will happen to me if I take part?

We would like you to attend a focus group which will take place in person at James' Place Liverpool on Wednesday 21st December 2022 at 10am. It should last approximately 40 minutes. You will be asked approximately 10 questions relating to what you feel has

helped you both when you came to James' Place for therapy and after you were discharged from James' Place. Also, you will be asked questions about how you feel study questionnaires designed for James' Place could be improved to increase uptake from men who have accessed James' Place. Open and honest answers will be encouraged.

8.Will I be photographed or video/audio recorded and how will the recorded media be used?

The recording is essential to your participation, but you should be comfortable with the audio recording process. You are free to stop the recording at any time and therefore withdraw your participation.

The audio recordings of your activities made during this study will be used only for analysis in reports and publications and for illustration in conference presentations. No other use will be made of them without your written permission, and no one outside the research team will be allowed to access the original recording accept for a transcription service (UK – Transcription Limited http://www.uktranscription.com/. Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device.

9. Are there any potential risks in taking part?

Questions included in this study require participants to reflect on their wellbeing. If you feel worried or in low mood we would like to point out that there are several sources of advice or help which are free and readily available to you and which may provide useful. Specifically, these include:

James' Place via telephone (on 0151 303 5757), email (info@jamesplace.org.uk) or text JP on 85258 for James' Place 24 / 7 helpline.

Alternatively, you can contact the Samaritans (116 123).

10. Are there any benefits in taking part?

There will be no personal benefit to you from taking part in this study. The potential or hoped for benefits of the study for the wider society are that this work will help us to understand the short- and long-term effects of the James' Place service. This may help inform the development of the service for future service users who are experiencing suicidal thoughts.

11. Payments, reimbursements of expenses or any other benefit or incentive for taking part

You will receive an Amazon voucher for participation.

12. What will happen to information/data provided?

The information you provide as part of the study is the study data. Any study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.), is known as personal data. Your participation in this study will not involve the collection/use of personal data by the investigator.

We will keep personal data safe and secure. People who do not need to know who you are will not be able to see your name. The personal data collected will include:

A record of consent (which will include your name)

Study data. We will use a code/pseudonym so that you cannot be directly identified from the data. Study data will include Audio recording[s] (which include your voice). Focus group recordings will be deleted once the Focus group transcript has been verified as accurate and an evaluation has determined that it has no further research value.

Study data / records of consent will be kept for five years after the study has finished. Once we have finished the study, we will keep some of the data so we can check the results. LJMU approved transcription services which adhere to data protection and GDPR will process data in accordance with data protection legislation and the LJMU privacy notice.

We will not tell anyone that you have taken part in the focus group, although there is of course a possibility that another member of the group might recognise you. All members of the focus group will be asked to respect the confidentiality of their fellow participants.

We will write our reports in a way that no-one can work out that you took part in the study.

We would like your permission to use direct quotations but without identifying you in any research outputs.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

The investigator believes you are at serious risk of harm, either from yourself or others

The investigator suspects a child may be at risk of harm

You pose a serious risk of harm to, or threaten or abuse others

As a statutory requirement e.g. reporting certain infectious diseases

Under a court order requiring the University to divulge information

We are passed information relating to an act of terrorism

13. Who is organising the study?

This study is organised by Liverpool John Moores University.

14. Whom do I contact if I have a concern about the study or I wish to complain?

If you have a concern about any aspect of this study, please contact Claire Hanlon or Dr Pooja Saini, and we will do our best to answer your query. You should expect a reply within 10 working days. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at Liverpool John Moores University who will seek to resolve the matter as soon as possible:

Chair, Liverpool John Moores University Research Ethics Committee; Email: FullReviewUREC@ljmu.ac.uk; Tel: 0151 231 2121; Research Innovation Services, Liverpool John Moores University, Exchange Station, Liverpool L2 2QP

15. Data Protection

Liverpool John Moores University is the data controller with respect to your personal data. Information about your rights with respect to your personal data is available from:

https://www.ljmu.ac.uk/legal/privacy-and-cookies/external-stakeholders-privacy-policy/research-participants-privacy-notice

UK Transcription services is a data processor in this study and will process data in accordance with data protection legislation and the LJMU privacy notice

16. Contact details

Principal Investigator: Claire Hanlon

LJMU postgraduate research student

LJMU Email address: C.A.Hanlon@2019.ljmu.ac.uk

LJMU School/faculty: Psychology/Faculty of Health

LJMU Central telephone number: 0151 231 2121

Supervisor Name: Dr Pooja Saini

LJMU Email address: P.Saini@ljmu.ac.uk

Note: Unless there is good reason not to do so, and if this reason has been explained in the ethics application that received a favourable ethical opinion, a copy of the participant information sheet should be retained by the participant.

Appendix 10: Study 4: Case Study Consent Form

Participant Consent Form [Focus Group]

Study title: An evaluation of the effectiveness of a community-based suicide prevention service delivering a clinical therapeutic model for men experiencing suicidal crisis

Research Ethics Committee Reference Number: **19/NSP/057**

Principal Investigator: Claire Hanlon

Principal Investigator: Claire Hanlon

LJMU postgraduate research student

LJMU Email address: C.A.Hanlon@2019.ljmu.ac.uk

LJMU School/faculty: Psychology/Faculty of Health

LJMU Central telephone number: 0151 231 2121

Supervisor Name: Dr Pooja Saini

LJMU Email address: P.Saini@ljmu.ac.uk

If you are happy to participate, please complete and sign the consent form below

		Please initial
	I confirm that I have read the information sheet dated 23/11/2022 (version 1) for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
	I understand what taking part in the study involves.	
	I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions I can withdraw from the study at any time, without giving a reason and without penalty or my legal rights being affected.	
	I understand that the study involves taking audio recordings of me and I am happy to proceed. I understand that I will not be able to participate in the study if I later decide not to be audio recorded.	
	I understand who will have access to personal data provided, how the data will be stored and what will happen to the data at the end of the project.	
	I understand that my information may be subject to review by responsible individuals from Liverpool John Moores University for monitoring and audit purposes.	
	I understand that personal data will remain confidential and that all efforts will be made to ensure I cannot be identified in reports or any further outputs.	
	I understand that parts of our conversation will be used verbatim in future publications or presentations and that all efforts will be made to ensure I cannot be identified in reports or any further outputs.	

	I understand that there may be instances where information is revealed which means that the investigators will be obliged to break confidentiality and this has been explained in more detail in the information sheet.	
	I agree to take part in this study.	

Name of Participant Date Signature

For participants unable to sign their name, mark the box instead of signing

I have witnessed the accurate reading of the consent form with the potential p and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely

Name of Investigator Date Signature

Name of Person taking consent Date Signature

(if different from investigator)

The investigator AND the participant should each retain a copy of the signed participant consent form

Appendix 11: Study 4: Case Study Semi-Structured Interview Schedule

Thank you for coming along today. We're interested learning about your experiences of completing the questionnaires you completed for the short- and long-term evaluation of the James' Place therapy. Also, we are interested to understand the effects having therapy at James' Place had and if the therapy helped.

1. To begin with, could you each introduce yourselves

2. Can you tell me what motivated you to complete the questionnaires?

3. Did anything help you to complete the questionnaire?

Prompt: For example, having it online / accessible via mobile phone; receiving a text message before receiving the questionnaire?

4. Who do you think it would it be better to receive the questionnaire from?

Prompt: For example, from James' Place? An independent researcher?

5. How do you think it would be best to receive questionnaires in the future?

Prompt: For example, via a text message/online or in person?

6. We asked men to complete questionnaires at specific timepoints. Shortly after beginning therapy at James' Place and then at 3-, 6- and 12-month follow-up's. What are your thoughts on the time frames we followed men up for?

7. How would you improve the questionnaire to get a better response rate in the future?

Next, I'm going to ask some questions to explore how you feel James' Place may have helped you.

8. How did having therapy at James' Place help you?

Prompt: What was the impact on your work life? And your home life?

9. Did you revisit any of the learning you gained from James' Place such as the safety planning or the lay your cards on the table?

10. That's all my questions, is there anything else you'd like to add or anything I've missed that you think might be important for understanding how James' Place therapy helped? And how to improve the uptake of questionnaires?

Appendix 12: Study 5: Ethical Approval Document

Dear Claire

Thank you for registering your study as minimal risk.

An evaluation of acceptability and fidelity of the James' Place therapeutic Model

UREC opinion: Favourable ethical opinion

UREC reference: 21/PSY/007

Research Governance Assessment: Approved – the study may commence.

Conditions of the favourable opinion

Prior to the start of the study.

COVID-19. Studies that involve face-to-face activity – you must ensure participant facing documents explain the potential risks of participating in the study which are associated with COVID-19, how the risks will be mitigated and managed.

After ethical review.

The study is conducted in accordance with the Minimal Ethical Risk Guiding Principles

You must ensure the information included in the participant facing documents are always current and informed by ongoing risk assessments and any changes to current practices.

Where any substantive amendments are proposed to the protocol or study procedures further ethical opinion must be sought (https://www.ljmu.ac.uk/ris/research-ethics-and-governance/research-ethics/university-research-ethics-committee-urec/amendments)

Any adverse reactions/events which take place during the course of the project are reported to the Committee immediately by emailing FullReviewUREC@ljmu.ac.uk

Any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately emailing FullReviewUREC@ljmu.ac.uk

Please note that favourable ethics opinion is given for a period of five years. An application for extension of the ethical opinion must be submitted if the project continues after this date.

Research Governance Approval.

This email also constitutes LJMU Research Governance Approval of the above referenced study on the basis described in the minimal risk registration form, supporting documentation and any clarifications received, subject to the conditions specified below.

Conditions of Approval

Compliance with LJMU Health and Safety Codes of practice and risk assessment policy and procedures and LJMU Code of Practice for Research

Ensure the study is covered by UMAL

COVID-19. Compliance with LJMU's travel restrictions

COVID-19. Studies that involve any face-to-face research activity have the appropriate risk assessment in place – the risk assessment is signed by the school Director or nominated other, revised, resigned and reissued when required and sent to the Safety, Health and Environment Department by email to SHE@ljmu.ac.uk

COVID-19. Studies that involve any face-to-face research activity meet COVID-19 practices which are current at the time the research activity takes place.

Where relevant, appropriate gatekeeper / management permission is obtained at the study site concerned.

The LJMU logo is used for all documentation relating to participant recruitment and participation e.g. poster, information sheets, consent forms, questionnaires.

The study consent forms, study data/information, all documents related to the study etc. will be accessible on request to a student's supervisory team and/or to responsible members of Liverpool John Moores University for monitoring, auditing and data authenticity purposes.

Yours sincerely

Mandy Williams, Research Support Officer

(Research Ethics and Governance)
Research and Innovation Services
Exchange Station, Tithebarn Street, L2 2QP
t: 01519046467 e: a.f.williams@ljmu.ac.uk

https://www2.ljmu.ac.uk/RGSO/93042.htm

https://twitter.com/LJMUEthics

Appendix 13: Study 5: Audit Tool

JP Identifier: JP0000	**Primary Auditor ☐ Secondary Auditor ☒**	
No. of weeks (*from referral to discharge)*		
No. of sessions attended		
No. of DNA's		
Was a safety plan completed?		
Positive outcome? *(Drop in core score)*	N (12-23)	
Sets of cards used *(score out of 5):* *All sets of cards used = 5* *Three sets of cards used = 4* *Two sets of cards used = 3* *One set of cards used = 2*		
Compliance score *(score out of 10 – see below for score breakdown*)*		

***How to find compliance score**

A maximum score of 10 made up of:

Zero DNA's = 1 point

Duration of 6 weeks or less = 1 point

Total of 8 sessions or less = 1 point

Positive outcome (drop in core score) = 1 point

Safety Plan completed = 1 point

All sets of cards used = 5 points

Or

Three sets of cards used = 4 points

Or

Two sets of cards used = 3 points

Or

One set of cards used = 2 points

Or

No sets of cards used = 0 points

Appendix 14: Study 5: Participant Invite Email

Dear

We would like to invite you to be part of an interview study where we will be asking therapists at James Place about their perceived acceptability and the fidelity of delivering the James' Place Model to men experiencing suicidal crisis. Participation will take place during working hours and the study has been approved by James' Place. You do not have to take part in the study. We have attached a Participant Information Sheet about the study and if you would like to ask any further questions please do not hesitate to me.

I will be conducting the interviews and once you have let us know whether you would like to take we can arrange a time and date suitable to us both to complete the interview. Interviews take place either face to face at James' Place or remotely using zoom, at a time that is convenient to you.

Best wishes

Claire

Appendix 15: Study 5: Participant Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

Title: An evaluation of acceptability and fidelity of the James' Place therapeutic Model

LJMU's Research Ethics Committee Approval Reference: **21/PSY/007**

School/Faculty: **School of Psychology, LJMU**

Researcher Name and Contact Details: Claire Hanlon, Postgraduate researcher, School of Psychology, Tom Reilly Building, Byrom Street, Liverpool, L3 3AF, email: C.A.Hanlon@2019.ljmu.ac.uk

Name and Contact Details and status of Supervisor: **Dr Pooja Saini, Lead Researcher, School of Psychology, Tom Reilly Building, Byrom Street, Liverpool, L3 3AF, email:** P.Saini@ljmu.ac.uk

Name and Contact Details and status of Director of Studies: **Dr David McIlroy, School of Psychology, Tom Reilly Building, Byrom Street, Liverpool, L3 3AF, email:** D.McIlroy@ljmu.ac.uk

You are being invited to take part in a research study. Before you decide if you want to take part, it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not. Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to understand the perceived acceptability and fidelity of delivery of the James' Place therapeutic model within a therapeutic setting for men experiencing suicidal crisis. We are interested in understanding your experiences of delivering the James' Place model to men experiencing suicidal crisis. The study is mixed-methods and will involve semi-structured qualitative interviews with James' Place therapists trained to deliver the James' Place model, as well as quantitative assessment of adherence checklist, supervision and meeting notes.

This study hopes to answer the following;

What are the elements of the James' Place therapeutic model therapists routinely deliver in their practice when supporting men experiencing suicidal crisis?

To what extent do therapists practice as an autonomous practitioner when delivering the James' Place model?

What is the perceived acceptability of the James' Place therapeutic model, including barriers and facilitators, by James' Place therapists?

Why have I been invited to participate?

You have been invited to take part because you are a therapist trained to deliver the James' Place therapeutic model. The exclusion is that no one under 18 years old can

participate and those who have not been trained in the delivery of the James' Place brief therapeutic model.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw at any time by informing the investigators without giving a reason and without it affecting your rights in any way.

What will happen to me if I take part?

We would like to invite you to attend a one-to-one interview which will last about one 30-40 minutes and will take place face-to-face or remotely via zoom during your working hours. You will asked to read a participant information sheet and, if you are happy to take part in this study, you will be asked to sign a consent form. During the interviewer a researcher will ask you questions about your experiences of delivering the James' Place model, such as the perceived acceptability of the James' Place model and therapeutic strategies you may use when delivering the mode. Open and honest answers will be encouraged.

Will I be recorded and how will the recorded media be used?

The audio recordings of the interview made during this study will be used only for analysis in reports and publications and for illustration in conference presentations. No other use will be made of them without your written permission, and no one outside the research team will be allowed access to the original recordings accept for the transcription service – UK Transcription Limited http://www.uktranscription.com/. Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device.

What are the possible disadvantages and risks of taking part?

The interview will take time to conduct (typically about 30 to 40 minutes) and could involve conversation that may cause you to become upset. However, as noted at any point you may leave the study, without detriment to yourself. Moreover, you do not need to respond to any questions you do not wish to. The topic may be sensitive or upsetting for some participants and in this case we can signpost you to support services if required such as Samaritans or Listening Ear.

What are the possible benefits of taking part?

It is hoped that this study will help provide useful guidance for all those involved with the implementation and delivery of James' Place Brief Psychological Therapeutic Intervention. We also hope the study will prompt further debate about future research or project priorities within the centre. By taking part you have the opportunity to receive and reflect upon your own feedback and those of the wider group within the write up in the report (all anonymised), which may be of interest to you.

What will happen to the data provided and how will my taking part in this project be kept confidential?

The information will be audio recorded, anonymised and treated confidentially. The interviews will be transcribed and the researchers will undertake a themed analysis of the data. Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device. The interview recordings will be sent to an independent company who will produce a transcript and anonymise any identifiable information, such as names of people or places. You will not be directly identifiable in any ensuing reports or

publications. We will use pseudonyms in transcripts and reports to help protect the identity of individuals and organisations unless you tell us that you would like to be attributed to information/direct quotes etc. Anonymised data might be used for additional or subsequent research studies. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public. If necessary, personal data will be stored confidentially for as long as it is necessary to verify and defend, when required, the process and outcomes of research. The time period may be a number of years. Personal data will be accessible to *the research team only.* Personal data collected from you will be recorded using a linked code – the link from the code to your identity will be stored securely and separately from the coded data.

Limits to confidentiality

Please note that confidentiality may not be guaranteed; for example, due to the limited size of the participant sample, the position of the participant or information included in reports, participants might be indirectly identifiable in transcripts and reports. The investigator will work with the participant in an attempt to minimise and manage the potential for indirect identification of participants.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

The investigator believes you are at serious risk of harm, either from yourself or others

What will happen to the results of the research project?

The investigator intends to write up the results for publication within a peer reviewed journal. A summary of findings will also be made available to individuals with an interest in this area. If you wish to receive a summary of the findings upon completion of the study please let the researcher know after the interview.

Who is organising and funding/commissioning the study?

This study is organised by Liverpool John Moores University and part of a wider PhD research project evaluating the efficacy and acceptability of the James' Place model for men experiencing suicidal crisis.

Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: **21PSY/007**).

What if something goes wrong?

If you have a concern about any aspect of this study please contact Claire Hanlon (XXXX or C.A.Hanlon@2019.ljmu.ac.uk) or Dr Pooja Saini (07946169335 or P.Saini@ljmu.ac.uk) who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

Data Protection Notice

The data controller for this study will be Liverpool John Moores University (LJMU). The LJMU Data Protection Office provides oversight of LJMU activities involving the

processing of personal data, and can be contacted at secretariat@ljmu.ac.uk. This means that we are responsible for looking after your information and using it properly. LJMU's Data Protection Officer can also be contacted at secretariat@ljmu.ac.uk*.* The University will process your personal data for the purpose of research. Research is a task that we perform in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

You can find out more about how we use your information by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Contact for further information

Claire Hanlon, PhD Researcher, School of Psychology, Tom Reilly Building, Byrom Street, Liverpool, L3 3AF. t: XXXX e: C.A.Hanlon@2019.ac.uk

Dr Pooja Saini, Lead Researcher, School of Psychology, Tom Reilly Building, Byrom Street, Liverpool, L3 3AF. t: 07946169335 e: P.Saini@ljmu.ac.uk

Thank you for reading this information sheet and for considering taking part in this study.

Appendix 16: Study 5: Participant Consent Form

LIVERPOOL JOHN MOORES UNIVERSITY

LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM

Title: An evaluation of acceptability and fidelity of the James' Place therapeutic Model

Name of Researcher:	**Claire Hanlon, School of Psychology – LJMU**
Superviors:	**Pooja Saini, School of Psychology - LJMU**
	Jen Chopra, School of Psychology – LJMU
	Helen Poole, School of Psychology - LJMU
	David McIlroy (DoS), School of Psychology - LJMU

1. I confirm that I have read and understand the information provided for the above evaluation study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.

3. I understand that any personal information collected during the study will be anonymised and remain confidential.

4. I agree to take part in the interview study.

5. I understand that the interview will be audio recorded and I am happy to proceed.

6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

Note: When completed 1 copy for participant and 1 copy for researcher

Appendix 17: Study 5: Semi-structured Interview Schedule

What is your role at James' Place?

Training

What training on the James' Place model did you receive?

How useful did you find the training?

PROMPT: Do you feel you understand the James' Place model / intervention to be able to deliver it?

How would you improve the training?

The Model

In this next section, I'll be asking you about the James' Place model and how it's used in therapy, for example how you combine co-production within the therapy with the individual needs and priorities.

What aspects of the model would be expected to be delivered during the intervention and how often?

How do you co-produce therapy with the men?

PROMPT: What aspects of the model do you co-produce and how often?

How do you find the model works with men?

PROMPT: Can you tell me about a time when you were flexible in the delivery of the James' Place model? What aspects of the model did you use and not use?

Are there aspects of the model you do not routinely deliver? If yes, what are these? Can you tell me a bit about why you would not deliver that aspect of the model?

How do you use the 'Lay your Cards on the Table' intervention as part of the therapy you offer?

How you find the process? What were the pros and cons? What would you change, if anything to improve the intervention?

Are there times when you wouldn't use the cards? If yes, can you tell me about the decision-making processes about why you wouldn't use the cards?

What additional therapeutic strategies or techniques, different to those included within the James' Place model, may you deliver within the intervention?

If yes: Have you used those methods before in a therapeutic setting? What would prompt you to use those methods?

11. Thinking of the James' Place model / intervention, what do you think works well with the men? What do you think does not work so well with the men?

PROMPT: How would you improve the James' Place model? How would you adapt the model to suit the individuals priorities and needs?

Supervision

12. What supervision do you receive and by whom?

13. How useful do you find supervision?

14. If you could change anything about the James' Place model / intervention, what would that be and why?

Appendix 18: Frequency Tables of LYCT Sets

Table 1: What's Happening Now Card Variable Frequencies

WHN Card Variable	Selected (Yes/No)	Frequency	Frequency Percentage (%)
WHN1	*Yes*	179	35
	No	332	65
WHN2	*Yes*	139	27.2
	No	372	72.8
WHN3	*Yes*	75	14.7
	No	436	85.3
WHN4	*Yes*	20	3.9
	No	491	96.1
WHN5	*Yes*	117	22.9
	No	394	77.1
WHN6	*Yes*	35	6.8
	No	476	93.2
WHN7	*Yes*	133	26
	No	378	74
WHN8	*Yes*	122	23.9
	No	389	76.1
WHN9	*Yes*	31	6.1
	No	480	93.9
WHN10	*Yes*	129	25.2
	No	382	74.8
WHN11	*Yes*	170	33.3
	No	341	66.7
WHN12	*Yes*	103	20.2
	No	408	79.8
WHN13	*Yes*	105	20.5
	No	406	79.5
WHN14	*Yes*	69	13.5
	No	442	86.5
WHN15	*Yes*	116	22.7
	No	395	77.3

WHN16	*Yes*	117	22.9
	No	394	77.1
WHN17	*Yes*	126	24.7
	No	385	75.3
WHN18	*Yes*	157	30.7
	No	354	69.3
WHN19	*Yes*	67	13.1
	No	444	86.9
WHN20	*Yes*	75	14.7
	No	436	85.3
WHN21	*Yes*	131	25.6
	No	380	74.4
WHN22	*Yes*	104	20.4
	No	407	79.6
WHN23	*Yes*	93	18.2
	No	418	81.8
WHN24	*Yes*	162	31.7
	No	349	68.3
WHN25	*Yes*	141	27.6
	No	370	72.4
WHN26	*Yes*	130	25.4
	No	381	74.6
WHN27	*Yes*	126	24.7
	No	385	75.3
WHN28	*Yes*	89	17.4
	No	422	82.6
WHN29	*Yes*	125	24.5
	No	386	75.5
WHN30	*Yes*	100	19.6
	No	411	80.4
WHN31	*Yes*	149	29.2
	No	362	70.8
WHN32	*Yes*	97	19
	No	414	81

WHN33	*Yes*	134	26.2
	No	377	73.8
WHN34	*Yes*	55	10.8
	No	456	89.2
WHN35	*Yes*	138	27
	No	373	73
WHN36	*Yes*	51	10
	No	460	90
WHN37	*Yes*	153	29.9
	No	358	70.1
WHN38	*Yes*	73	14.3
	No	438	85.7
WHN39	*Yes*	91	17.8
	No	420	82.2
WHN40	*Yes*	77	15.1
	No	434	84.9
WHN41	*Yes*	173	33.9
	No	338	66.1
WHN42	*Yes*	88	17.2
	No	423	82.8
WHN43	*Yes*	141	27.6
	No	370	72.4
WHN44	*Yes*	128	25
	No	383	75
WHN45	*Yes*	114	22.3
	No	397	77.7
	Total	270	58.2

Table 2: How Did I Get Here Card Variable Frequencies

HDIGH Card Variable	**Selected (Yes/No)**	**Frequency**	**Frequency Percentage (%)**
HDIGH1	*Yes*	102	20
	No	409	80
HDIGH2	*Yes*	44	8.6
	No	467	91.4
HDIGH3	*Yes*	85	16.6
	No	426	83.4
HDIGH4	*Yes*	146	28.6
	No	365	71.4
HDIGH5	*Yes*	34	6.7
	No	477	93.3
HDIGH6	*Yes*	80	15.7
	No	431	84.3
HDIGH7	*Yes*	96	18.8
	No	415	81.2
HDIGH8	*Yes*	36	7
	No	475	93
HDIGH9	*Yes*	36	7
	No	475	93
HDIGH10	*Yes*	57	11.2
	No	454	88.8
HDIGH11	*Yes*	63	12.3
	No	448	87.7
HDIGH12	*Yes*	26	5.1
	No	485	94.9
HDIGH13	*Yes*	34	6.7
	No	477	93.3
HDIGH14	*Yes*	55	10.8
	No	456	89.2
HDIGH15	*Yes*	43	8.4
	No	468	91.6

HDIGH16	*Yes*	110	21.5
	No	401	78.5
HDIGH17	*Yes*	93	18.2
	No	418	81.8
HDIGH18	*Yes*	44	8.6
	No	467	91.4
HDIGH19	*Yes*	32	6.3
	No	479	93.7
HDIGH20	*Yes*	49	9.6
	No	462	90.4
	Total	158	30.9

Table 3: Keeping the Problem Going Card Variable Frequencies

KPG Card Variable	Selected (Yes/No)	Frequency	Frequency Percentage (%)
KPG1	*Yes*	87	17
	No	424	83
KPG2	*Yes*	31	6.1
	No	480	93.9
KPG3	*Yes*	104	20.4
	No	407	79.6
KPG4	*Yes*	23	4.5
	No	488	95.5
KPG5	*Yes*	82	16
	No	429	84
KPG6	*Yes*	26	5.1
	No	485	94.9
KPG7	*Yes*	99	19.4
	No	412	80.6
KPG8	*Yes*	22	4.3
	No	489	95.7
KPG9	*Yes*	105	20.5
	No	406	79.5
KPG10	*Yes*	79	15.5
	No	432	84.5
KPG11	*Yes*	83	16.2
	No	428	83.8
KPG12	*Yes*	43	8.4
	No	468	91.6
KPG13	*Yes*	40	7.8
	No	471	92.2
KPG14	*Yes*	58	11.4
	No	453	88.6
KPG15	*Yes*	39	7.6
	No	472	92.4
KPG16	*Yes*	64	12.5

	No	447	87.5
KPG17	*Yes*	23	4.5
	No	488	95.5
KPG18	*Yes*	19	3.7
	No	492	96.3
KPG19	*Yes*	27	5.3
	No	484	94.7
	Total	156	30.5

Table 4: How Can I Get Through This Card Variable Frequencies

HCIGTT Card Variable	**Selected (Yes/No)**	**Frequency**	**Frequency Percentage (%)**
HCIGTT1	*Yes*	97	19
	No	414	81
HCIGTT2	*Yes*	83	16.2
	No	428	83.8
HCIGTT3	*Yes*		
	No	60	11.7
		451	88.3
HCIGTT4	*Yes*		
	No		
		107	20.9
HCIGTT5	*Yes*	404	79.1
	No		
		102	20
HCIGTT6	*Yes*	409	80
	No		
		64	12.5
HCIGTT7	*Yes*	447	87.5
	No		
HCIGTT8	*Yes*	71	13.9
	No	440	86.1
HCIGTT9	*Yes*	48	9.4
	No	463	90.6
HCIGTT10	*Yes*	70	13.7
	No	441	86.3
HCIGTT11	*Yes*	70	13.7
	No	441	86.3
HCIGTT12	*Yes*	84	16.4
	No	427	83.6
HCIGTT13	*Yes*	76	14.9
	No	435	85.1
HCIGTT14	*Yes*	79	15.5
	No	432	84.5
HCIGTT15	*Yes*	78	15.3
	No	433	84.7

HCIGTT16	*Yes*	79	15.5
	No	432	84.5
HCIGTT17	*Yes*	90	17.6
	No	421	82.4
HCIGTT18	*Yes*	110	21.5
	No	401	78.5
HCIGTT19	*Yes*	69	13.5
	No	442	86.5
HCIGTT20	*Yes*	80	15.7
	No	431	84.3
HCIGTT21	*Yes*	91	17.8
	No	420	82.2
HCIGTT22	*Yes*	39	7.6
	No	472	92.4
HCIGTT23	*Yes*	56	11
	No	455	89
HCIGTT24	*Yes*	76	14.9
	No	435	85.1
HCIGTT25	*Yes*	41	8
	No	470	92
HCIGTT26	*Yes*	46	9
	No	465	91
	Total	131	25.6

Appendix 19: Precipitating Factors Pre-Baseline (Upon Entry to James' Place) Attributed to Suicidal Crisis

Precipitating factor	N (%) Recorded by service
Relationship breakdown (n=28)	10 (35.7)
Gambling issues (n=28)	1 (3.6)
Debt (n=28)	4 (14.3)
Housing issues (n=28)	1 (3.6)
Physical health (n=28)	5 (17.9)
Mental health (n=28)	2 (7.1)
Bullying (n=28)	0
University (n=28)	1 (3.6)
Work (n=28)	8 (28.6)
Sexuality (n=28)	2 (7.1)
Victim of past abuse trauma (n=28)	3 (10.7)
Victim of crime (n=28)	0
Legal problems (n=28)	2 (7.1)
Family problems (n=28)	2 (7.1)
Bereavement (n=28)	4 (14.3)
Bereavement by suicide (n=28)	2 (7.1)
Bereavement by covid (n=28)	0
Drug misuse (n=28)	2 (7.1)
Alcohol use (n=28)	1 (3.6)
Relationship problems (n=28)	3 (10.7)
Perpetrator of crime (n=28)	1 (3.6)
Carer (n=28)	2 (7.1)
Related to asylum (n=28)	0
Health of others (n=28)	0
Covid lockdown (n=28)	4 (14.3)
Covid anxiety (n=28)	0
Covid work trauma (n=28)	0
Getting back to normal after covid (n=28)	0
Other (n=28)	0

Appendix 20: Psychological Factors Pre-Baseline (Upon Entry to James' Place) Attributed to Suicidal Crisis

Psychological variable	N (%) Recorded by service	N (%) Missing data
Defeat (n=26)	15 (53.6)	2 (7.1)
Humiliation (n=25)	10 (35.7)	3 (10.7)
Entrapment (n=26)	21 (75)	2 (7.1)
Social problem solving (n=26)	13 (46.4)	2 (7.1)
Coping (n=25)	7 (25)	3 (10.7)
Memory biases (n=26)	13 (46.4)	2 (7.1)
Rumination (n=26)	19 (67.9)	2 (7.1)
Thwarted belonginess (n=26)	16 (57.1)	2 (7.1)
Burdensomeness (n=25)	18 (64.3)	3 (10.7)
Absence of positive future thinking (n=26)	10 (35.7)	2 (7.1)
Unrealistic goals (n=25)	4 (14.3)	3 (10.7)
Not engaging in new goals (n=26)	13 (46.4)	2 (7.1)
Social norms (n=25)	1 (3.6)	3 (10.7)
Resilience (n=26)	9 (32.1)	2 (7.1)
Social support (n=25)	19 (67.9)	3 (10.7)
Attitudes (n=25)	3 (10.7)	3 (10.7)
Suicide plan (n=26)	9 (32.1)	2 (7.1)
Exposure to suicide (n=25)	8 (28.6)	3 (10.7)
Impulsivity (n=26)	13 (46.4)	2 (7.1)
Pain sensitivity tolerance (n=25)	7 (25)	3 (10.7)
Fearlessness of death (n=25)	5 (17.9)	3 (10.7)
Imagery of death by suicide (n=26)	12 (42.9)	2 (7.1)
Past suicide attempt or self-harm (n=26)	16 (57.1)	2 (7.1)