



**Centre for Social Work Research (CSWR),
Cass School of Education and Communities
University of East London**

**Evaluation of a non-statutory 'Place of Calm',
a service which provides support after a suicidal crisis
to inform future commissioning intentions**

Final Report, April 2016

**Stephen Briggs
Jo Finch
Rhiannon Firth**

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1. Executive Summary

1.1 Scope of the report

This is the final report of the evaluation of the Place of Calm project's pilot phase in Eastbourne. The Place of Calm takes an innovative approach to meeting the needs of people who are suicidal, offering a stay of up to 24-hours, to provide practical and emotional support, using a Peer Support approach. The report presents the findings of the evaluation, undertaken during the first quarter of 2016. The evaluation assessed the following key areas: the pattern of referrals to the Place of Calm; characteristics of people who stayed from opening in June 2015 to the end of March 2016; how the Place of Calm model operates, including its strengths and weaknesses; outcomes for guests; experiences and views of referrers and wider stakeholders working with suicidal people; cost effectiveness

1.2 Key findings

1. The Place of Calm has made a successful start as a new resource offering a different kind of support for suicidal people in East Sussex. The findings demonstrate that the project should be enabled to continue beyond the pilot phase and ultimately that it becomes established on a permanent basis
2. The Place of Calm offers a helpful and distinctive model for people in suicidal crises, which is de-stigmatising and non-medical, and which is highly valued by people who stay there.
3. Suicidal feelings and thoughts are reduced for a majority of the guests during the stay, and they also experience an improvement in their sense of well-being. In a sub-sample of guests, the improvement in mental well-being during the stay is statistically significant. The evaluation also found indicative evidence that a stay at the Place of Calm contributes to longer term improvements in mental well-being and reduction of suicidal thoughts and actions. For some of these guests the intervention of the Place of Calm is perceived to have been crucial for their recovery.
4. For some guests, primarily those with longer-term mental ill-health and extensive service use, the benefits of the Place of Calm include valuable immediate relief from crisis and suicidal feelings; it provides an additional resource that supports the work of hard-pressed mainstream services.
5. The model of care provided by the Place of Calm has robust qualities for working with suicidal people, and has the potential to be replicated elsewhere.

The key elements of the model are: practical support in the form of rest, food, shower and a comfortable room; emotional support offered by Peer Support Workers; forming a safe-plan and practical help in identifying services and supports following the stay. Some refinements based on experiences during the pilot can further improve delivery. The Place of Calm model would benefit from being articulated as a written manual or practice guide to facilitate best practice and replication.

6. Through providing service-user satisfaction, reduction of suicide feelings, improved mental well-being and de-stigmatising interventions, the Place of Calm is demonstrating potential for becoming a cost-effective service.
7. The Place of Calm is recognised by referrers from Health Services, Street Triage and AMHPS, and by the wider network of organisations involved in working locally with suicidal people, as a welcome, new resource that has an important role in the overall provision of resources to prevent suicide. Referrers have identified that the Place of Calm is helpful for individuals who do not need detention at the time under the Mental Health Act. Further work is needed to ensure that the value-added by the Place of Calm is effectively maintained and increased through becoming more widely available for people in a suicidal crisis.
8. Access to the Place of Calm is currently restricted by the referral route which requires a prior mental health assessment; there is scope for broadening access so that more individuals can have access.

1.3 Recommendations

1. The Place of Calm should be supported to continue beyond the initial pilot phase, through securing funding from appropriate sources, in order to ensure it becomes established on a long-term basis.
2. Consideration should be given to broadening the referral system to increase the availability of a stay at the Place of Calm for appropriate individuals. Key possibilities to explore are:
 - i. a self-referral pathway for individuals to access the Place of Calm;
 - ii. enabling the Place of Calm as part of the mental health act assessment process;
 - iii. offering the Place of Calm intervention model in different packages of care alongside the current offer of up to 24-hours stay
 - iv. closer working between the Place of Calm and the Survivors of suicide counselling services, including possibly working together in the same

location, to enhance cross-referral opportunities.

3. In order to prepare for widening the basis for referrals, the Place of Calm should make refinements to the model, to introduce an assessment process for guests, including enhancing links between the peer support model and professional assessment and intervention.
4. Consideration should be given to how to better integrate on-call staff into the project in order to enhance staff retention and their more active engagement, including by appropriate diversification, through developing different packages of care alongside the current offer of up to 24-hours stay (see 2, iii above).
5. The Place of Calm should consider identifying ways of marking the ending of the stay for guests, and introduce a follow-up call to guests a short time after their stay to ensure connections with follow up services and to allow guests the opportunity to talk to staff.
6. The findings and outcomes from the pilot project should be widely communicated to promote the development of the Place of Calm in other locations.
7. The findings should be communicated to referrers and their organisations and mental health commissioners to enhance understanding and confidence in the model.
8. Further research should be commissioned to undertake a rigorous assessment of the outcomes for people staying at the Place of calm, including longer term outcomes that can be used to assess how the Place of Calm benefits which individuals, and in which ways, and to assess longer-term cost effectiveness.

2. Aims and Objectives

This evaluation was commissioned by East Sussex County Council (ESCC) to assess the pilot of *The Place of Calm* in Eastbourne. It aimed to assess to what extent the *Place of Calm* pilot met its aims and objectives since opening to clients in June 2015, namely, to provide support and sanctuary for people after a suicidal crisis, and specifically:

- To provide emotional and practical support in a non-institutional community setting
- To provide the opportunity to talk to trained staff about their thoughts and feelings so as to reduce their level of distress
- To contribute to the reduction in the use of Section 136 of the Mental Health Act and to reduce time spent in inappropriate settings.

The evaluation thus aimed to capture learning from the pilot phase and to make recommendations to inform commissioning and future funding applications.

3. Background and contexts

3.1. National context

Preventing suicide is a social and health policy priority worldwide; studies show that most suicides are preventable. The National Suicide Prevention Strategy (NSPS), *Preventing suicide in England: A cross-government outcomes strategy to save lives* (HMG/DH 2012) focuses on:

- reducing the risk of suicide in high-risk groups,
- improving mental health in specific groups;
- reducing access to the means of suicide;
- providing better information and support to those bereaved or affected by suicide.

Risks for suicide vary according to **gender** (males are three times more likely to complete suicide and females are more likely to make attempts) and **age** (people aged 35-49 now have the highest suicide rate). People with **mental illness** are at elevated risks of suicide, and the **treatment and care** they receive after making a suicide attempt is an important factor in reducing repetition and completion. This recognises that a previous episode of self-harm significantly heightens the risks for ultimate completed suicide; a recent study showed that risks are 49 times greater after an episode of self-harm than for the general population (Hawton et al 2015). More than 30% of suicides take place in a public space (Owens et al 2009; PHE 2015).

Prediction of suicide depends on making holistic assessments of risk and need at the time of crisis, since risk assessments, alone are inaccurate and inadequate; there are no scales that are reliable, an individual's intention changes over time, and the

factors that precipitate suicidal behaviour are wide ranging (NICE 2011). Therefore, assessments of risk, including those made by professionals to assess whether an individual should be detained under the Mental Health Acts, always include an element of interpretation (Gould 2016)

The provision of good quality care at the time of crisis has a significant role in reducing the risk of repetition and completion (NICE 2011). As reported by NICE, service-users repeatedly comment on the need for non-stigmatising responses, and thus reducing the stigma and shame associated with suicidal behaviour is an important factor in service provision. Innovative projects, such as Maytree¹ (Briggs et al 2007) and Pieta Houses² that provide care and reduce stigma are important interventions that reduce suicidal behaviour for people, across the age range, for all sectors of society. Reducing stigma and providing good quality care means moving away from some traditional responses in criminal justice and health settings, including for those detained under the Mental Health Act. There is evidence from systematic reviews that often people who self-harm and attempt suicide are not well treated in mainstream services, and this can further traumatise and increase risks of repetition (Saunders et al 2011). An emerging evidence base shows that psychological therapies can be effective for reducing self-harm and suicidal behaviour. Interventions often involve treating other mental health conditions, including depression, and borderline or emotionally unstable personality disorder. The high rates of repetition of self-harm, especially within the twelve months after the first episode, evidence that, though short-term interventions do demonstrate effectiveness in reducing suicidal feelings and self-harming behaviour, it is only through longer-term follow up that the possibilities of repetition can be assessed.

3.2 Local Context

East Sussex has a higher than average suicide rate in England, due mainly to the impact of Beachy Head, a public place widely used for suicide attempts. For the period 2006 – 2013 there was an average 77 suicides per year, one third of which were of non-East Sussex residents. Of these deaths 32% (186 of the 584) took place at Beachy Head, accounting for 72% of all the non-resident deaths in East Sussex, an average of 23 per year (ESCC 2015).

The structures for delivering suicide prevention work in East Sussex are the East Sussex Suicide Prevention Steering Group and the Beachy Head Risk Management Group. The East Sussex Suicide Prevention Group, a multi-agency partnership chaired by public Health is responsible for co-ordinating suicide prevention work

¹ www.maytree.org.uk

² www.pieta.ie

across the county and develops an annual action plan. The Action Plan mirrors the National Suicide Prevention Strategy with focus on six key areas:

- Reduce the risk of suicide in key high-risk groups.
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide.
- Provide better information and support to those bereaved or affected by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The Beachy Head Risk Management Group is an advisory subgroup of the East Sussex Suicide Prevention Group with focus on the specific needs for suicide prevention on Beachy Head, with membership including representation from statutory and voluntary sectors (see Appendix VI for membership).

In October 2013, East Sussex Public Health were granted funding for a programme of work to reduce suicides in the county with a particular focus on Beachy Head. The five interrelated strands of work were developed through the Beachy Head Risk Management Group. One of the strands of work was to pilot a non-statutory 'place of safety' to address aftercare issues and reduce Section 136 cases. The Place of Calm was commissioned by ESCC to meet this objective and the establishment and evaluation of *The Place of Calm* was included in the Action Plan in 2014/15 and 2015/16.

3.2. Description of The Place of Calm pilot project

The Place of Calm was designed as a non-statutory resource for people in a suicidal crisis, but not needing to be detained under the Mental Health Act. The concept was to provide a comfortable, calm setting in which to recover from the suicidal crisis for a period of up to 24 hours³. Commissioned by East Sussex County Council, the contract for the 12-months pilot project was awarded in February 2015 to Sussex Oakleaf, a registered charity⁴ working in partnership with Recovery Partners⁵, a mental health recovery project working across East Sussex. Recovery Partners is a non-profit organisation that is 100% user-led and run, and project workers all have lived experience of mental health challenges and have been trained as Peer Support Specialists.

³ A stay of 24 hours and over requires that CQC regulations are followed

⁴ <http://www.sussexoakleaf.org.uk>

⁵ <http://recovery-partners.co.uk>

The *Place of Calm* is located within Sussex Oakleaf's Community Wellbeing Services house in Eastbourne. After refurbishment, the room provides facilities for an overnight stay, meals, a shower, and access to the internet. In addition to providing a setting that allows attention to physical needs of sleep, food and a shower, the Place of Calm provides care through peer support specialists, who have been trained additionally to work with people in a suicidal crisis, including safeguarding, mental capacity and Applied Suicide Intervention Skills Training (ASIST), a suicide first-aid training.⁶ The Place of Calm thus uses an intervention model which includes providing rest, food and sleep, peer support counselling, and practical support and guidance. The latter includes signposting and engaging with relevant agencies and services to address stresses and difficulties in the individual's life and which may be contributing to the suicidal crisis and related distress. Individuals staying at the Place of Calm – Guests – are required to sign a Guest Agreement and Agreed Safe Plan (see Appendix 1: Place of Calm Checklist, Guest Agreement and Agreed Safe Plan). The Safe Plan includes specific details about contacts and engagements with appropriate practical, medical and therapeutic resources and a follow up call six weeks after the stay.

A project coordinator was appointed to manage *The Place of Calm* and staff appointed to offer peer counselling and support. Access for individual users of the service was by referral initially through the Street Triage service⁷ and Approved Mental Health Practitioners (AMHPs), with a third referral route subsequently opened through Eastbourne Psychiatric Liaison in the Department of Psychiatry in Sussex Partnership NHS Foundation Trust.

3.3 **Criteria for *The Place of Calm* pilot success**

Criteria for the success of the Place of Calm include:

- success in attracting referrals of suitable individuals meeting the criteria for the use of the service through the three referral routes
- reduction of suicide risks for these individuals
- reducing the use of inappropriate custody and detention;
- supporting individuals to access appropriate services and support to thus reduce the factors leading to suicidal distress

⁶ <https://www.livingworks.net/programs/asist>

⁷ The Street Triage schemes were launched in 2013 by the Department of Health. They involve dedicated mental health professionals collaboratively working with police officers, to offer tailored interventions to ensure individuals receive the most appropriate care.

- providing a cost effective alternative service

3.4 The Evaluation Approach and Methodology

The evaluation covered the first nine months of the pilot phase of *The Place of Calm*, that is from 22nd June 2015 to 31st March 2016. The approach taken was to assess processes and outcomes, through robustly and sensitively capturing the available evidence, assessing and using this to reach informed findings and recommendations for future development. This involved establishing cooperative working relationships with the key stakeholders in ESCC and the team in the Place of Calm, and to apply both qualitative and quantitative methodologies to collecting and analysing data.

Data was gathered from a range of sources to explore and assess the experiences of guests, staff, referrers and wider networks. The core evaluation activities consisted of:

- Analysis of the Place of Calm written data for individual guests who stayed
- Interviews with Place of Calm staff
- Interviews with referrers
- Interviews and observations of meetings with representatives of organisations and services in the wider network
- Follow up interviews with guests

Methods: Interviews with all participants were semi-structured, either face-to-face or by telephone, and interview schedules are appended (Appendix II). Observations of meetings and interview data were recorded by note-taking or audio recording and interviews were analysed using thematic analysis (Guest 2012). Written data was analysed quantitatively through using simple statistics, thematic and content analysis (Krippendorff 2004).

Interviews with referrers: Services and individuals who referred to the Place of Calm were interviewed, including Street Triage, AMPHS, Department of Psychiatry at Eastbourne Hospital, Sussex Partnership NHS Foundation Trust.

Interviews and observations of meetings with representatives of organisations and services: Meetings attended included the Beachy Head Risk Management Group Meeting (25/01/16), the Place of Calm Implementation Group meeting (11/03/16). Organisations interviewed were: Sussex Partnership NHS Foundation Trust Deputy Director and Director of Nursing Standards and Safety; Head of Strategic Commissioning, Mental Health (East Sussex); Beachy Head Chaplaincy Team (BHCT); Sussex Community Counselling Partnership – Support for Survivors of

Suicide; Grassroots Suicide Prevention; Richmond Fellowship (West Sussex Alternative Place of Safety), and members of the Place of Calm Steering Group. Additional material included email correspondence with stakeholders, and minutes of meetings, including the Place of Calm Steering Group.

Analysis of Place of Calm written data: Case notes for each guest staying at the Place of Calm were read and analysed. These included:

- Place of Calm Checklist: This provides practical information; age, gender, arrival/departure times, length of stay, onward travel, mental health assessment, referrers, police involvement, services used, practical support needs identified, alternative if *The Place of Calm* were not available. The Guest Agreement and Agreed Safe Plan is part of the Checklist. This data was assessed to provide a comprehensive overview of guest characteristics, needs and risks. Additionally, the checklist provides timed accounts of actions taken by staff. These were analysed through content analysis for each case and compared across cases.
- Warwick-Edinburgh Mental Well-being Scale (WEMWBS)⁸: The 14-item WEMWBS is completed when guests arrive and leave (Appendix III). WEMWBS is used for project evaluation with some sensitivity for assessing changes at individual level. WEMWBS provides a single score ranging from 14-70. Scoring is simple using the practice-based user-guide⁹. We compared with WEMWBS data from other projects/population norms¹⁰. As WEMWBS is usually measured over a 14-day minimum the effects of reassessing within 24 hours were evaluated.
- Guest and Referrer Surveys: The Place of Calm aimed to complete surveys by guests 6 weeks after their stay, and by referrers as soon as possible after referral. Surveys use scored and free text. Scored items were analysed quantitatively. Free-text items were analysed qualitatively through content analysis. The Place of Calm experienced some difficulties in locating ex-guests to complete the surveys, and this is discussed below (section 4.5).

⁸ <http://www.healthscotland.com/documents/1467.aspx>

⁹

http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/userguide/wemwbs_practice_based_user_guide.pdf

¹⁰

http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/interpretations/wemwbs_population_norms_in_health_survey_for_england_data_2011.pdf

- Staff Interviews: We met the Project Coordinator at the beginning of the evaluation, and maintained ongoing contact, and we discussed with her the experiences of coordinating the service, development plans, staff recruitment and management. We also met and maintained contact with the director of Recovery Partners and we interviewed project support workers and bank staff to assess their experiences including how they applied the Place of Calm interventions including the ASIST model in its three phases; connecting, understanding and assisting. We assessed how staff made safe plans for guests at the end of the stay, treating this as an important aspect of the work as transitions between services are important in suicide prevention (NICE 2011). As working with suicidal people is emotionally taxing, we explored how staff managed anxieties and the role of supervision.
- Guest interviews: A purposive sample was chosen for telephone interviews to assess experiences of *The Place of Calm* and afterwards, and how this impacted on distress/suicidal feelings. There were practical and ethical difficulties in accessing former guests in this way, including their changing locations and lifestyles of these individuals, and the need to ensure individuals' safety at the time of the interviews. Thus interviews were set up and undertaken with priority given to the issue of safety. This is discussed further, below, in sections 3.6 and 4.5 of the report.

3.6 Ethical issues

An application was made to the University Research Ethics Committee (UREC) and was approved on 15th December 2015 (UREC 1516 34). Ethical issues included obtaining informed consent, and a participant information sheet and written consent form were prepared (Appendix III), the importance of sensitivity to potential individual distress experienced by former guests, maintaining confidentiality of all data, safe data storage, and risk-assessment. A particular requirement was that interviews with guests and ex-guests required informed consent, and that interviewers had to be sure of the safety of guests before undertaking interviews. Prior to all interviews, Place of Calm staff were required to contact ex-guests, clarify that they were willing to partake in the research and that they were in a safe place to do so. Research team members then explained the reasons for the study, what it would involve and explained the informed consent procedures, for which participants were invited to provide written agreement.

4. Findings

4.1 Characteristics of Guests staying at the Place of Calm

There have been 30 referrals leading to a stay at the Place of Calm, up to 31/03/16. Referrals occurred from soon after the opening in June 2015. There were 6 referrals in the first quarter (July – September 2015), 9 in the second quarter (October – December 2015), and 15 referrals in the third quarter (January –March 2016).

The total number of referrals includes three guests who were re-referred, 2 of these staying twice and one staying three times, leaving a total of 26 individuals, of which 14 were female and 12 were male.

Table 1: Place of Calm guests by gender

Gender	Number
Female	14
Male	12
Total	26

The 26 guests were aged between 18 and 61, with an even spread across each age group (decade).

Table 2: Place of Calm guests by age

Age	Gender	Number	Both male and female
18-29	Female	5	8
	Male	3	
30-39	Female	1	5
	Male	4	
40-49	Female	2	6
	Male	4	
50-59	Female	3	5
	Male	2	
60 +	Female	1	2
	Male	1	
Total		26	26

Detailed ethnicity data has not been recorded; the majority of the guests are White British. The limited ethnic range of guests requires further exploration.

With the importance of Beachy Head for attracting suicide attempts from a wide geographical location, it is of interest that more than half the referrals to the Place of

Calm have been local, with 8 from Eastbourne, and a further 7 from other Sussex locations. Out of area referrals were for people who live in London, Oxford, Berkshire, Norwich, Southend-on-Sea, Bishop Stortford, Leicester, Hampshire and Glastonbury. Visits to Beachy Head accounted for 14 referrals, of 12 people (2 people made repeated visits to Beachy Head and were re-referred). Of these 12, 9 were male and 3 were female.

Table 3: Location of Place of Calm guests

Location	Number of referrals	Number of guests
Eastbourne	11	9
Sussex (outside Eastbourne)	7	5
Beyond Sussex	12	12
Total	30	26

Suicidal histories and episodes: Place of Calm guests arrived, on admission after a suicidal episode, which involved suicidal ideation or self-harm, coming to the attention of the referring organisations in public spaces (PHE 2015), or attending A&E. Prior to admission to the Place of Calm, a mental health assessment was required to be undertaken by hospital staff, AMPHS or Street Triage. Suitability for a stay at the Place of Calm required the assessment to conclude that a suicide attempt was not imminent, that the risks were not sufficient to necessitate detention under the Mental Health Act and that there were no physical injuries requiring hospital attendance.

Guest's had varied suicidal histories, which can be organised into three distinct groups. Whilst some guests had long standing relationships with suicidal behaviour, involving repeated suicide attempts and ideation (15 guests), for another group of 11 guests the events that led to the stay at the Place of Calm was the first time they that they had openly entertained suicidal solutions for current problems. For the group of guests who repeated suicidal ideas and actions a distinction could be made between those who appeared to be in a continuous relationship with suicide, and those for whom it was intermittent. For the more continuous group of 9 guests, suicidal thoughts and actions occurred regularly and frequently over time, whereas for the intermittent group of 6 guests, though there were repeated suicidal thoughts and actions these occurred at different points of time in their lives, sometimes with long gaps between episodes. For example, one guest, now in his 50's, recalled one previous suicide attempt as a student, many years before. The three groups can be called Continuous, Intermittent and Recent.

Table 4: Guests' suicidal histories

Suicidal history	Number
Long standing: continuous	9
Long standing: intermittent	6
Recent only	11
Total	26

Mental health and psychosocial factors

The differences between the three categories of guest's varied histories of suicidal thoughts and actions related closely to their mental health histories. In the Continuous group most had experienced enduring mental health difficulties; all but two of the guests who had long-term or repeated suicidal experiences also had enduring mental health difficulties, and all those guests, apart from one, who had enduring mental health difficulties experienced repeated suicidal or self-harm behaviour. Long-term or enduring mental health difficulties, often referred to as emotionally unstable personality disorder (EUPD) included in these individuals, unstable relationships, dysregulation of emotions, substance misuse, and offending behaviour. Guests gave the sense of needing to manage these issues over the long-term, and being short of internal and social resources to do so, relying extensively on health and social care services, and frequently becoming suicidal or self-harming when overwhelmed by these difficulties. Psychosocial difficulties also included backgrounds of abuse in childhood, including sexual abuse, and recurrent practical difficulties including homelessness, and unemployment and financial difficulties.

In contrast, the Intermittent and Recent groups were less beset by long-term mental health difficulties than by periodic or recent crises, which were influenced by relationship difficulties, including break-ups, with significant others; partners, parents, children and grandchildren. In terms of mental health, depression, influenced by the impact of loss, and anxieties are prominent. Other difficulties faced included work-related and financial worries including debt, which at the time of the crisis were felt to be overwhelming. In both the Intermittent and Recent categories, underlying loneliness or social isolation, and managing through not expressing difficulties, or emotions, or not being able to access resources led to being in what guests described as a 'bad place', a lack of self-esteem and feelings of worthlessness, intermingled with shame and distress at not being able to manage without help. The suicidal crisis served to make contact with others and gain knowledge of how to seek help, and put feelings into perspective. This contrasted with the Continuous group's reliance on and continual searching for help from mental health and social care services. Thus in all categories, the intervention needs included both practical and

emotional issues.

Formulating these three categories of guests accessing the Place of Calm provides important distinctions in terms of needs during the stay, the responses to the intervention, the requirements from services and the likely outcomes. Thus the three groups can be expected to respond differently to the stay at the Place of Calm.

4.2 Interventions provided by the Place of Calm

The Place of Calm pilot used a distinctive intervention approach to offering support for guests over the 24-hour period of the stay. The elements of the approach, described above at 3.3, combined to provide a place of calm, for reflection and recovery. The provision of a comfortable and welcoming space met immediate physical needs for rest, food, a shower and shelter. Guests were allowed to be on their own with the knowledge that a staff member was available, within earshot, if needed. The welcoming, warm and affirming presence of staff was accompanied by 1-1 discussions with staff who offered support for practical and emotional needs. All guests were:

- welcomed and offered peer support;
- provided with space, and attention to physical needs: shower, sleep, food;
- put in contact with resources for follow-up after leaving the Place of Calm;
- provided with a safe plan for leaving.

Case notes (the Place of Calm checklist) show that Place of Calm staff work hard to establish rapport, using the peer support model, and that they make considerable efforts to identify appropriate resources to meet the various needs of guests after they leave. These include practical resources, for debt management and housing needs, for example, and therapeutic and mental health needs. Staff draw up extensive lists of appropriate resources, make phone calls and accompany guests when they are visiting local services. For those who have travelled from out of area, extensive phone calls are made to services local to the guest. Staff facilitate guests contacting family members and friends to elicit support as part of the safe plan for after the stay and to explore how more positive relationships can be built.

Staff and guest perceptions of the interventions are discussed in the following two sections of the report.

4.3 Staff views, experiences and staff training

Interviews with Place of Calm staff explored their experiences of working in the Place of Calm, in their respective roles, how they work with individual guests and how they experienced the various stresses of working with suicidal people. Alongside the

interviews, the research team attended a monthly training session and engaged in on-going informal discussions. Analysis of the data from the interviews identified the following themes: relating to guests; peer support; rewards and challenges of the role; training; guests' leaving the Place of Calm and management perspectives.

Relating to guests: Staff emphasised the importance of providing a calm environment, as a basic requirement, and felt that this was the case except when the Day Centre is busy during the day, so when someone is anxious it's not a good environment, "with that door banging" (03). The person-centred approach, meaning following closely the needs and feelings of the individual guest was frequently mentioned as an important aspect of the work:

"I don't have a set plan for every guest, it's person-centred so it's about what each individual guest needs" (03)

and listening:

"I am surprised because they have often been part of the MH system and surprised they have not been listened to or allowed to tell their stories. I just listen. This is the model and it became obvious" (01)

"it's humbling to hear the stories, it can be upsetting, but I can empathise, it's rewarding. I might be the first person they have told" (02)

and:

"I convey a calm, steady, with love, might sound weird but I surround them with love, short bursts of time, they can talk and be listened to; over and over guests express gratitude" (01)

Guest's needs may be practical, observing the impact of attending to physical needs and being flexible with the approach:

"Food or a shower is important, it's funny the amount of people who come out of the shower and say they feel better. We make it person centred. The amount of time differs, some people like to come in and watch TV to distract themselves, some may sleep but some struggle to sleep" (05)

However, staff were also able to challenge guests to make use of the time and resources in the Place of Calm; for example, one staff member gave the example of introducing the idea of focussing on what needs to change:

"Some guests are avoidant, some just want to watch TV. With two guests, I did make a comment about that, i.e. I am just wondering what you could change when you leave, where they have come from and what they would like

to be doing. Those direct interventions (based on my observations and reflections) really helped changed the situation” (03)

Peer-support: Place of Calm staff feel the peer-support model gives them an edge in understanding the mental health and suicidal issues in the guests:

“People have their own stories and these stories have aspects that can be upsetting. Being a peer, we can empathise with people’s situations or events. When people realise we are peers, they often tell you more” (05)

Therefore, the capacity for empathy and disclosure are seen as the key benefits of peer-support. Staff gave examples of disclosure which they felt made a difference in relating to guests. One example, was supporting a guest who was becoming increasingly agitated:

“I then had an intense feeling, a gut instinct, that she was feeling ashamed. I said, “I have been where you have been”. The guest said “really”. The guest asked me what had helped me get through, so I said, building up a support network, finding friends and people I could be honest with, working with health care professionals. I felt the shame lifting and a change in the balance of power between us (03)

This also demonstrates the staff member reflectively using the emotional experience at the time. The impact of timely disclosure, and the sharing of having – or having had – issues too, impacted beneficially on guests (see section 4.5 below). Awareness of power relations is an additional aspect of peer support, also mentioned by other staff, alongside an awareness of the shame or potential humiliation of exposing personal difficulties to others:

“Some people feel shameful, are homeless, or in a place that is not good for their mental health” (02)

Rewards and challenges: The rewarding aspects of the work were described as making good emotional contact with guests, feeling privileged to hear their stories (see above) and the outcomes of the work during a guest’s stay. Staff felt a sense of purpose, for example, expressed as “filling a gap in the market” (02) when someone might have been sent home without further support:

“The rewards are when you think, this person could have been sent home and would not have been able to manage.” (04)

Others commented on the magnitude of saving the lives of people who were suicidal. Limitations were seen to include “the time limit? Is 24-hour enough?” (05):

“You don’t really have time to get to know people in 24 hours – and you can’t save everyone. There is more focus here on being empowered as we all have natural empathy” (03)

Staff mentioned frequently the advantages and disadvantages of the 24-hour time limit, which limits how much a guest can be helped:

“I struggle with knowing that not everyone will walk out the door feeling better. But how much can we do in 24 hours but I know I can do enough or between us we can do enough.” (03)

Challenges included predicaments posed by individual guests, for example:

“I found a situation challenging, when a guest started getting panicky, it was my lack of experience so I phoned up for some support. In hindsight and with more experience I would handle it differently. Another challenge are substance users. If a guest has been drinking heavily then when they are not drinking when here, it may be volatile. It could be stressful if you didn’t know how to handle it. In 6 months the panicky person was the only really stressful situation”. (02)

Other challenges included in the working schedule, particularly being on call:

“It’s challenging, if I am on call I can’t go that far. Waiting around can be stressful because you are anticipating something may happen. It’s the uncertainty. Last week we had three people in a row and no one since. No consistency with it. (02)

A further area of challenge was working with other organisations and their limitations. For example:

“Over 24 hours what can be stressful is dealing with the different agencies. For example, someone came in with the referrer and said they will be going in a psychiatric ward the following day. Heard nothing so next day I chased up with the crisis team and the ward. A nurse said there was a bed available from 3 pm. The ward manager then rang back and said it’s not true, we don’t have a bed.” (03)

Training: Staff felt positively about the training they received at the Place of Calm, including the ASIST training and the monthly staff training sessions:

“I have done the ASIST training – it useful, helping people move forward, thinking about the challenges, reflecting and exploring this with guests, e.g. medication, support networks, where they could get more support”. (02)

Some staff expressed enthusiasm for the training, whilst others preferred to be more practical and action oriented. In the former category:

“I feel well trained, the grass roots training (ASIST) is fantastic. The peer support training is helpful and we have team training every 4 weeks. You can never have too much training.” (05)

On the other hand, staff expressed a view in favour of learning and identifying training needs through practice:

“I like being put in at the deep end, being proactive. It’s the right way for me……. I think as I get more experience in the job I will have a better idea of what training needs are”. (02)

A member of the research team observed one of the monthly training sessions. One aspect of this is to provide a reflective space to think about the work and issues that had arisen. There is a purposeful articulation of the model, or approach, and the peer recovery aspect is a strong part of this; for example, one worker spoke about having felt suicidal previously in her life. The peer aspect was purposefully discussed with regard to how to effectively help people. Staff are thoughtful about their role; there is a sense of wanting to really engage with guests in a helpful, empowering, different way, including using own experience as one of a number of tools.

Guests’ leaving the Place of Calm: The importance of the process of leaving was emphasised in interviews with staff. Whilst some felt positive about the process of ending, there was also recognition of the anxiety for both guests and staff members:

“It’s always difficult when you say goodbye to someone, you can see their nervousness about going. We try not to get too emotionally attached and try and prepare people as best as possible to exit. ……I try to make sure guests can be prepared as well as possible”. (05)

The uncertainty of what will happen for a guest after leaving and the relationship between worrying about this but also trusting the work was expressed:

“Endings can be quite hard, if the guest doesn’t have somewhere to go or has limited friends and family support. You have to live with the not knowing but to do the work to help the person keep themselves safe. You need to trust the guest that they have the tools in them and they will be ok. I need to believe that. It’s valid to worry but you have to trust they will be ok” (04).

A key component of ending consists of drawing up safe plans. These are undertaken in detail throughout the stay, as assessments of needs:

“I do safe plans, have it written down and (for) each guest on a half hour by half hour basis, I am sort of assessing, what is it they need. I have a self-awareness of what each guest might need, interventions do need to be offered and guests have a chance to be listened to, their story heard and practice advice given” (03)

Management perspectives: Interviews with the Project Coordinator and Director of Recovery Partners provided perspectives about issues arising in managing the Place of Calm. Challenges included retaining staff, and the problem of becoming disconnected from the working team through the on-call system. On the other hand,

there was a sense that staff could work too hard, including having to work through the night. There was a preference for staff showing compassion:

“All the staff are on the warm side, they are positive, but warm is not enough and they have found some guests have been demanding. But the staff are more on the compassionate side and I would rather this than cold and clinical. We are peer workers but we are good on boundaries” (04).

Other concerns included uncertainty about the future of the project, and the problem of attracting referrals to a new project, though this is felt to have eased recently with the widening of the referral network (see section 4.6 below). Developing the skills of peer support workers was also a preoccupation: sometimes it was felt the peer support workers did not ask ‘the right question’, and introducing some professional input was felt to be important. A psychologist is now also offering training sessions, alongside those delivered monthly by the Director of Recovery Partners, who is a social worker and an AMHP. Training and supervision contribute significantly to the rigour of the approach, described by the psychologist as effective working in a small team that works well together.

4.4 Outcomes for those who stayed at the Place of Calm

Outcomes for guests who stayed at the Place of Calm have been assessed through qualitative assessments of guests’ and referrers’ perceptions, and the quantitative results of the surveys of guests and referrers and WEMWBS scores. The key outcome is reduction of suicide risks, and this implies assessing changes in the psychosocial factors that led to suicidal crises. Differences in outcomes between the three groups - Continuous, Intermittent and Recent – were expected, owing to the different factors in these groups. The data for assessing outcomes is limited as a controlled study was not in the scope of the evaluation, and there are many variables that affect outcomes. Guests access a range of services that contribute to outcomes alongside input from the Place of Calm. In other words, for these guests, multiple services input into the response to the suicidal crisis and the role of the Place of Calm cannot be isolated from the sum total of these inputs. To assess outcomes, we will draw therefore, on the various levels of data available and exercise appropriate caution in drawing conclusions. The perceptions of referrers and a sample of guests will be discussed below (4.5 and 4.6) and here we will focus on the outcomes from the WEMWBS.

Warwick-Edinburgh Mental Well-being Scale (WEMWBS): A member of the Place of Calm staff completed the WEMWBS scale on admission and at the end of stay. The scale (see Appendix IV) has 14 items with a five-point rating scale, from ‘none of the time’ to ‘all of the time’. Guests are asked to choose a rating that best describes their experience over the past two weeks for each item. The scale has been devised therefore to allow for repeated ratings after a minimum of 14 days, and the use of the scale in the Place of Calm diverges from this by re-administering the scale within 24

hours. Interpretation of the data needs to take this divergence into account.

All but one guest completed the forms on admission, and this guest along with one other did not complete on leaving. Scores on the WEMWBS can range from the minimum of 14 to the maximum of 70. The average scores for guests on admission was 22.84 (median 22) and on leaving the average rose to 34.29 (median 38). Scores thus increased from admission to leaving. This may mean that guests felt their mental well-being had improved during the 24 hours (or less) of their stay.

Table 5: WEMWBS Means and Medians

	On admission (n=25)	Leaving (n =24)
Mean	22.45	35.36
Median	22	40

Benchmarked against national data for England¹¹, the WEMWBS scores for Place of Calm guests are, not surprisingly, low. The national mean is 51.6071 and the median is 53. The mean for the Place of Calm cohort on leaving (35.36) is below the 25th percentile mean of 47, and further below this on admission.

For the sample of guests as a whole the change in WEMWBS scores from admission to leaving is not statistically significant (two-tailed t-test: $p = 1.64$). However, for the Recent group of guests only the difference is significant (two-tailed t-test, $p < 0.001$). This would suggest that the Recent group experience a significant increase in their sense of well-being during the stay. However, it should be stressed that this does not mean that guests in other groups do not benefit from the stay, as there are a range of factors that can influence the recording of higher or lower scores in the WEMWBS, which, as has been noted earlier, is validated for a minimum of 14 days between tests.

4.5 Experiences of individuals who stayed at the Place of Calm

Guests were followed up by survey and by research interview. The Place of Calm aimed to undertake a survey with each guest at 6 weeks after the stay. In practice this proved difficult to achieve, largely due to the somewhat chaotic lived experiences of some guests, primarily in the Continuous group, and through the fact that a substantial number of guests returned to their home areas at distances away from the Place of Calm. Phone contacts can be unreliable.

The Place of Calm Survey: The survey contained 30 items requiring responses,

11

http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/interpretations/wemwbs_population_norms_in_health_survey_for_england_data_2011.pdf

mainly on a five-point scale (strongly agree, agree, neutral, disagree, strongly disagree) with a free text option, and 22 items that gathered background and demographic data. The survey is appended to this report (Appendix V). 11 guests have completed the survey at the time of writing the report. These guests record very positive scores for the items requiring comment on perceptions of their stay, To select some key items:

Q1: Being a guest at the Place of Calm improved my mental health and well-being while I was there? (e.g. symptoms such as anxiety and depression)

5/11 guest strongly agreed; 4/11 guests agreed; 1 disagreed; 1 deemed the question not applicable

Q5: Being at the Place of Calm made me feel less suicidal at the time

6/11 guests strongly agreed; 5/11 guests agreed

Q6. I believe being at the Place of Calm saved my life, that day

5/11 strongly agreed; 5/11 agreed; 1 disagreed

Q7: Since being at the Place of Calm the frequency of my self-harm has

Increased: 2/11; Decreased: 5/11; Stayed the same 1/11; Not applicable: 3/11

Q8: Regarding the support you received at the time, how would you rate the following?

These responses are shown in Table 6 below:

Table 6: Guests rating of support types

Support Type	Categories	Guests rating somewhat + very important
Peer support	Very Important (8) + Somewhat Important (1)	9
Safety or wellbeing plan	Very Important (5) + Somewhat Important (4)	9
Practical Support: signposting/contact with services	Very Important (5) + Somewhat Important (5)	10
Practical support/ shower, time to rest	Very Important (8) + Somewhat Important (3)	11
N		11

Q9. Since being at the Place of Calm my mental health and wellbeing has improved
Strongly agree: 2/11; Agree: 4/11; Disagree: 2/11; Strongly disagree: 2/11;
N/A: 1/11

Guests also reported that since being at the Place of Calm,

- suicide attempts were reduced (8/11 guests)
- access to appropriate services increases (7/11)
- visits to A&E reduced (7/11)
- times felt to be in crisis reduced (7/11)

These results indicate that for some guests the stay led to perceived beneficial changes in key areas. Guests commented very positively on their experience of the Place of Calm:

“I cannot speak highly enough of my stay at the Place of Calm. I felt that I was given the space when I needed it and completely supported when I needed it too. I really appreciated not being judged by anyone and all my needs were met during my stay. Thank you!”

“The place is an amazing place with such warmth and love went out of their way for me. (Staff 1) was lovely and (Staff 2) looked after me at night. I was listened to and mattered. the hardest is leaving after 24hrs, not sure 24hrs is just enough”

Though most guests completing the survey experienced the stay itself as positive, views about subsequent effects were more divided. Some guests’ free text comments reflected a difference between the positive feelings at the time and afterwards:

“I felt very supported at the place of calm and received high quality of care and support, but when I left it made me feel worse as I had hope, then realised I had no support from anywhere after leaving”.

‘At the time yes [Place of Calm reduced needs for other treatments] but I came crashing down afterwards when I left’

These comments, alongside the scores in the survey, are important for differentiating the perceived impact of the Place of Calm for different guests. Cross referencing the scores by individual guests show that the more negative or equivocal responses came from individuals in the Continuous group of guests, and reflected, not dissatisfaction with the Place of Calm during the stay, but rather that this did not lead to longer term changes. Other comments indicated on-going struggles, but also

attempts to take steps to clarify or improve matters, for example:

'I still feel very up and down and I am trying to get an accurate diagnosis and sort out my medication'.

"Really appreciated the kindness and the listening at PoC. The time at PoC made me realise I really wanted to get some counselling. I am just getting by day by day and feel low at the moment"

The survey is not of a representative sample of guests and was not independent, being administered by Place of Calm staff and, therefore, findings from the survey are limited in these respects. However, it is important, firstly, that some guests do experience the Place of Calm as very positive during the stay and that it is perceived by some as making a difference after the stay. For some guests the impact of the stay was very powerfully expressed:

'a life saver"

"being in Place of Calm is the only time I have felt supported in the last two years"

Research follow-up interview: As with the survey, the research follow-up interview was affected by access factors, and, in addition, the need to ensure safety, as discussed above (section 3.5), added a further limitation. Research interviews were set up as described above (Ethics, section 3.6). The intention was to select a purposive sample to include local and out of area guests, and to reflect diverse background and mental health histories. Obtaining access to guests in the Continuous Group were most difficult. However, a sample of ten guests agreed to undertake these interviews, and these included both local and out of area guests, and guests from the three categories: recent, continuous and intermittent (See Table 7 below).

Table 7: Sample of guests giving follow up interviews

Guest identifier	Guest category	Location	Gender	Age
A	recent	local	M	40's
B	recent	local	F	40's
C	recent	out of area	M	30's
D	continuous	local	F	60's
E	continuous	local	F	40's
F	intermittent	out of area	M	50's
G	recent	out of area	M	40's
H	intermittent	out of area	F	50's
J	recent	local	M	20's
K	recent	out of area	M	40's

The research interview enabled a deeper exploration of the experiences of the Place of Calm. In the sample were six guests who were in the 'Recent' category, meaning they had encountered suicidal experiences for the first time in the events leading up to their stay at the Place of Calm. All these guests insisted that the Place of Calm had made a huge impact on them, not only at the time but in the longer-term. Three of these guests, Guests C, G, K, all male, from out of the area had gone to Beachy Head. They described being in 'a bad way' before going to Beachy Head and all had been socially withdrawn whilst in this state not feeling able to talk to anyone. Their initial reception by the Place of Calm was powerful: Guest C felt comfortable with the staff and the setting immediately, Guest K was immensely relieved by the caring reception, and Guest G said he "felt straight away he was with someone who understood". Guest G appreciated the opportunity to shower and was particularly grateful that a Place of Calm staff member helped by getting his clothes washed; he said "I was hungry, I was cold and I was smelly". He felt about the staff that he "had never met people like that" and that he could easily open up in talking with them, adding that he "opened up more with them than he could with friends".

All these guests identified the quality of one-to-one conversations with peer support workers as having a crucial and lasting benefit for them. Guest C said his despair that his current predicament was not reparable was overturned by the warmth of the staff who "made him feel it could be put right" and that he had a future: "I told them things that had been bothering me for years" and which he had not been able to talk about before. Guest G. said that the Place of Calm staff had helped him feel he was not worthless, which was his state of mind at the time. Guest K felt gratitude and

relief. Guests C and G expressly valued the disclosures of the peer support workers. Guest G. thought this helped “without a doubt” as the peer support worker disclosed having similar problems in the past that had been resolved by taking small steps. Guest C. said that the peer support worker’s disclosure in his case had helped by addressing the shame he felt “after really making a fool of myself by what I did”.

All three guests felt the stay at the Place of Calm was long enough, and both referred to the confidence the staff placed in them. Guest C said that “he was quite surprised they let him go home after what he did” and found the trust placed in him empowering. Guest G spoke of how his departure was timed for when he felt confident enough to leave. Guest C said that “if they [the staff] had not been so nice he would have gone back there [Beachy Head]” and that the intervention was at least partly responsible for where he is today, a few months after the stay, which he described as being “in a very different place”. Guest K wished to have an opportunity to thank the staff in person. The services set up by the Place of Calm once they returned home were also helpful in maintaining their change: Guest C would like to see a Place of Calm in every town.

Guests A, B, and J, local people, also in the Recent category of guests, and experiencing mental health services and suicidal behaviour for the first time, found the approach taken by peer support workers was crucial. Guest A found it “humbling” the attention he received from staff and some of the “positive thinking” has been important since his stay. He referred to some thoughts the worker wrote on post-its which he keeps with him and reads if he is in difficulties. Guest B contrasted the experience of the Place of Calm with being in hospital. The latter she felt was impersonal, “like a conveyor belt” whilst the Place of Calm:

“It was like being looked after by your family. In hospital nobody talked to you and I was left on my own. At the Place of Calm, it was like being wrapped in cotton wool in your home, not pestered, and if you are on your own you know someone is there”.

They found it helpful that the peer support workers had mental health issues themselves. Guest A was impressed how the workers “really put themselves out” and the practical help was really useful. Guest J felt really understood, and all three felt that the Place of Calm had lasting benefits for them. Guest A said he was “in a different place now” and that “it came at the right time: another couple of days and I wouldn’t be speaking to you now”. Guest J felt if he did “get into that state again” he would want to go the Place of Calm. Guest B. said she has not had thoughts of suicide since and like Guest C, she felt that the Place of Calm should be replicated: “They should be pushed out all over the country”.

Four guests who were interviewed in the continuous and intermittent categories provided contrasting feedback on their experiences. Guest F had made one previous suicide attempt some years previously and had not had a recurrence of suicidal feelings until the current episode. He was extremely anxious in the Place of Calm and did not wish to be left alone. He felt helped to think about going to his doctors for some medication to help with the stress and anxiety he felt and also to thinking about a talking therapy. His suicidal feelings have not returned and he felt very positively about the Place of Calm as having helped him significantly.

Guest H was forthright, from her intermittent suicidal experiences including being detained under the Mental Health Act that the recovery approach was vital for her, and that though Place of Calm staff let her know they too had experienced mental health difficulties, their focus was on her needs rather than their own; they “didn’t cross that boundary”. She felt empowered by the Place of Calm’s approach which she characterised as supporting her to take decisions rather than “doing it for her”. She felt “treated like a human being in distress should be treated”, empathically, and she contrasted this with her experiences of hospital admissions. She felt the Place of Calm was “instrumental in starting a process rolling in my life, for me getting my life better”.

Guest E has frequent hospital admissions for her mental health difficulties, suicidal feelings and self-harm. She stayed briefly at the Place of Calm but did not feel safe and left to go to A&E. She explained this sense of not feeling safe was something that happened to her in new places and she felt something very similar when she first went to stay at a hospital she has now stayed in a few times. She said that the hospital had suggested the Place of Calm and she found the staff “amazing, but she didn’t feel safe”, A peer support worker sat with her and she felt he did his best but she felt suicidal and frightened, especially as it wasn’t secure and she could just leave. She said once she had got out of her frightened state she could see that the Place of Calm was “a good sanctuary” and if she was offered a stay again she might accept.

Guest B questioned whether a 24 hours stay was long enough in her situation:

“I felt good when I came out. I was apprehensive about leaving though and I could have stayed longer to get my strength up – maybe I could have stayed 2-3 days.”

Similarly, Guest D felt that 24 hours was simply not long enough for her and that because her stay was too short, in her view, it did not help her “start the ball rolling to get out of the mess”. She thought that staying for a week would have been necessary as she said she felt so mentally and physically weak and it would have taken so long

to gather her thoughts. Guest D has continuous mental health issues, and has repeatedly gone to Beachy Head. In her interview she was at pains to distinguish between what she felt were the strengths of the Place of Calm and her situation and needs. She commented that the Place of Calm had arranged services for her in her area, a day centre and a psychiatrist, though she felt that she had to wait a long time for these to start. She was concerned that she had been too negative in the interview, as she spoke in a rather melancholic tone about the persistence and irretrievable difficulties, or mess, she faced. She thought the staff were “fantastic” but that, “in the back of my mind all problems are still going to be there when I leave”. She said they offer good advice and talk but “You’re in such a state, or I was then, not thinking clearly or listening half the time. I didn’t know whether I wanted to talk or sleep”. She thought perhaps her expectations had been too high but it was “not the right formula for me”. Her view of what would have been helpful was a “central point of call... someone to coordinate” especially with regard to her practical needs, which included housing.

The interviews with Guests B and E indicate that some guests’ perceptions of the Place of Calm are tempered by the specific difficulties they experience. They do provide some indications that the 24-hour stay at the Place of Calm is not a panacea. It would be surprising if a 24-hour stay produced unambiguously positive changes for individuals with longer-term mental health issues particularly, when they are accessing multiple services on a regular basis over time. On the other hand, the evidence of positive feedback from, particularly, guests in the Recent group indicate that the Place of Calm can have a powerful impact for some guests, reducing suicidal feelings and addressing the factors that brought about the suicidal episode. The accounts provided by guests in these interviews also identify the aspects of the Place of Calm approach that are felt to be important, including practical help and the empathic approach of the peer support counsellors. The levels of enthusiasm for the Place of Calm shown by some guests in both the interviews and the survey, are important to note.

4.6 Referrers’ views and experiences

The Place of Calm operates within a system in which referrals can be made by Street Triage and AMPHS after a mental health assessment. After three months of operation a third route was added through the Department of Psychiatry at Eastbourne Hospital. The mental health assessment ensured that a risk assessment was also undertaken, and referrals to the Place of Calm could be made only if the individual had been assessed as not needing detention under the Mental Health Act. Each of the three sources made referrals as shown in Table 8:

Table 8: Referrals to the Place of Calm

Referrer	Number referred
Street Triage	11
AMHPS	4
Department of Psychiatry (DOP)	10
Police	1
Total	26

Health referrers referred a majority of local people (9/10), as did AMHPs (4/4) whilst Street Triage (8/11) referred more who were from out of the immediate area.

Three themes predominated discussions with referrers; firstly, that the *Place of Calm* is a welcome additional resource for professionals working at the sharp end of assessing risks for suicidal people and applying assessments through the Mental Health Act, and, secondly, that the experience of referring to the *Place of Calm* was a positive one, with positive outcomes for individuals. Thirdly, however, all referrers commented on the limitations within the referral process in that the assessment of individuals' risks resulted in few individuals being suitable for the *Place of Calm*.

All referrers commented positively on the *Place of Calm*. These include:

'it is very easy to refer: it is what it says on the tin' (MH Trust)

'trying to get resources can be extremely difficult, but that is not the case with the *Place of Calm*, it is a smooth, quick process' (AMHP)

'there is someone there to greet him, to show him the facilities, he valued it' (AMHP)

'it's another resource that helps' (Street Triage)

'I hope it will be able to continue' (MH Trust)

'colleagues are becoming more aware and are more likely to refer' (MH Trust)

'Street Triage find it useful, service users find it useful' (MH Trust Manager)

'I have not heard any negative feedback – which is the best way of saying there have not been any problems' (NHS Trust Manager)

'it is good at doing what it does' (AMHP)

All referrers therefore reported positive experiences of making a referral, and were

similarly positive about the service provided by the *Place of Calm* for individuals they referred. All however identified limitations arising from the need to ensure safety of individuals within the framework of the risk assessments they are required to undertake. AMPHS assess individuals of which a very high proportion – estimates range from between 80% - 90% - were thought to require detention under the Mental Health Act. Most people they assess who have gone to Beachy Head meet these criteria. Street Triage are referred 20 people a week on average and of these the majority require admission to a place of safety. A second group consists of those individuals assessed as not requiring detention on a Mental Health Act section and who wish to return to their own homes, and, for those out of area, to return to their home area. Therefore, the Place of Calm is identified as suitable for a niche segment of people: those who are feeling suicidal but neither require detention, nor are able or wish to return home immediately:

‘A segment of people suitable for Place of Calm – not too high risk, or needing repatriation immediately, or they prefer to return to their own home’ (AMPH)

The Place of Calm then is located for these referrers as a third option, which is felt to be valuable, since the absence of the provision would leave this relatively small proportion of people without a suitable option, and referrers with a problem of how to identify an outcome that fits the immediate need. Without the Place of Calm some of these people may have been admitted to hospital including to a Section 136 suite.

A theme implicit in these discussions was that referrers were primarily concerned with immediate risks rather than more therapeutic issues. Therefore, their expectations of the Place of Calm were limited to allowing some time to make appointments with agencies and services, especially for practical issues such as housing or transport arrangements which an overnight stay could provide. However, some referrers recognised the value of having time to attend to physical needs, for example, for someone who was homeless, and for attending to emotional distress.

‘It’s a combination of practical and emotional issues; these get worked with by the Place of Calm’ (AMHP)

For example, an AMHP spoke of one individual who though not imminently suicidal was distressed and ‘did not know which way to turn’. The stay allowed for some time to reflect and to make links with services; it could be explored, for example, why an individual had not been in contact with his social worker.

Some cases illustrated tensions on the boundary between being detainable or being suitable for the Place of Calm. One health referrer described how it was possible for one individual, not on a mental health act section, to stay at the Place of Calm whilst

waiting for an inpatient bed to become available. In contrast, in another case where a person had travelled to Beachy Head and was assessed as detainable, the immediate action was for a nurse to sit with them, rather than look after them at the Place of Calm, whilst they awaited transport to hospital in their own area. Arranging transport had also been very difficult in this case. Another case involved a person who was not detainable but who felt she needed a Place of Safety and she found the Place of Calm not safe because she could make the choice to leave. This person was then returned to hospital.

Referrers all expressed the hope that the Place of Calm would be able to continue, despite the perceived limitation that only a minority of people they assessed could be referred. The referrers proposed different solutions for extending the opportunities for referral to Place of Calm. AMPHS suggested it could be 'upgraded to a Place of Safety' which would require some changes to the Place of Calm but these were thought to be feasible. The need was supported by the view that the local health based section 136 suite can be busy. AMPHS also thought that a longer stay – perhaps 48 hours should be available for people with more complex domestic situations and needs. On the other hand, Street Triage and Psychiatric Liaison referrers thought that the *Place of Calm* could not, or should not, be changed into a Place of Safety, and that the specific criteria for the Place of Calm needed to be retained. Street Triage cautioned against making the Place of Calm too comfortable and thus 'creating a service'. Health referrers felt it should be retained as an alternative to hospital admission for suitable cases as it reduced admissions; they foresaw the facility to take only one person at a time as a limitation which might restrict opportunities to refer as its use increased.

4.7 The Place of Calm in the wider local networks

The *Place of Calm* pilot is situated within a wider network of health, criminal justice, social care and third sector services and resources working to prevent suicide and to assess mental health risks. The evaluation therefore took into account the importance of these wider networks as impacting strategically and practically on the Place of Calm. Interviews and discussions were undertaken with members of the relevant services, many of whom are represented on the Beachy Head Risk Management Group (see Appendix VI).

A key consideration is the changing nature of statutory provision. One of the aims of the Place of Calm was to reduce the number of inappropriate admissions under section 136 of the Mental Health Act. In 2012-2013, a study by Professor Gillian Bendelow (in progress) showed that detention under Section 136 of the Mental Health Act in Sussex was well above the national average. However, since the introduction of Street Triage and a hospital based Section 136 suite in Eastbourne Hospital, the numbers in police cells have reduced from between 40 -50 a month in

2013 to zero in February 2016. The current policy is that Eastbourne police station is not to be used for detention except in an emergency. Since 2008 the Section 136 suite in the hospital has become the primary resource for people detained. The key issue therefore has become one of assessing whether risks determine whether hospital based detention is necessary. As discussed above, there is consensus that the Place of Calm offers an alternative – within limitations – for those not assessed as needing formal detention to a place of safety. A key limitation is the need for safety planning; Health managers emphasise the unpredictability of further suicide attempts and aggressive behaviour by people who arrive following assessments. The potential for involving the Place of Calm in collaborative safety planning was mentioned as meriting further exploration. The idea that the Place of Calm could adapt to become an Alternative Place of safety is contraindicated by the experience in West Sussex of the Home Office/Richmond Fellowship pilot where numbers referred were low (7 in a 12-week pilot period) and the small numbers are seen as relating to the introduction of Street Triage (Home Office 2015).

The wider networks ‘definitely think the Place of Calm has a place’ (Health Manager) with considerable benefits of offering a non-medical and non-medicalising option which reduces stigma for suicidal people. Value is also added by bringing a different approach to the field, to offer options to overcome the ‘one size fits all’ approach to suicide prevention. One view expressed is that there could be greater clarity about what the Place of Calm offers, and its positioning between ‘somewhere to go’ and offering a counselling approach could be advantageous to draw on. This means addressing the issue of relatively low take up, and funding. An aspect of this is that initial reluctance to refer was linked with anxieties about risk, and ‘a little less gatekeeping would be helpful’ as one professional expressed. Greater confidence is being expressed by organisations as the Place of Calm impresses referrers, as discussed above. Risk assessments thus restrict the number of people eligible for referral to the Place of Calm, and, to counteract this, health managers have suggested possibilities for multiple use of the Place of Calm, diversification in effect. Two possibilities have been mentioned; either for the Place of Calm to ‘plug a gap’ for a Personality Disorders pathway, along the lines developed in West Sussex (Lighthouse), also delivered by Sussex Oakleaf¹² and to connect the Place of Calm with the counselling initiative. The Community Counselling Service¹³ provided as one of the strands of the East Sussex initiative has attracted 160 referrals for one-to-one and group counselling. This project can only accept referrals of local people and thus is not focussed on the Beachy Head out of area factor. The emphasis is on the working with both suicidal clients and those bereaved by suicide.

¹² <http://www.sussexoakleaf.org.uk/what-we-do/lighthouse-recovery-service/>

¹³ <http://sussexcommunity.org.uk/wellbeing-safety/counselling/>

A constant in the overall picture is the continual use of Beachy Head for suicide attempts: the Beachy Head Chaplaincy Team reported that in 2015 around 500 searches were undertaken with 300 people found. Therefore, care for out of area people continues to play a significant part in the local suicide prevention strategy.

4.8 Costs analysis

The budget for the Place of Calm pilot is £100,000; the costs are shared by Sussex Oakleaf, lead provider, and Recovery Partners. Of the total, £4000 was spent on refurbishment and safety enhancement of the room. Pipes were boxed in, redecoration, and provision of a telephone line and a laptop for guests use. On-going buildings costs are zero as Place of Calm shares a building used for an existing resource. Staff costs include the project coordinator, peer mentors and bank staff. Staff are paid a call out fee, which helps retention and recognises unsociable hours and weekend work, and the irregularity of referrals. Staff training included safeguarding, recovery and Assist training; the latter was additionally paid for by East Sussex Public Health and cost £3,000.

Assessing cost effectiveness for a new pilot project is complex. A new project requires an amount of time and cost allowed for lead-in, setting up and getting established in the networks, along with gaining a reputation that instils confidence and trust in professionals. Referral patterns to the Place of Calm suggest that the lead-in phase could be considered as taking the first six months; referrals increased in the third quarter, and this can be used as the unit for evaluation when calculating costs based on a cost for each individual against the running costs of the Place of Calm.

The second consideration is how to assess cost effectiveness with regard to reduction of suicide. This would require evaluating the effectiveness of the Place of Calm, compared with usual treatment, for a controlled sample of individuals. This is of course beyond the scope of this evaluation, although a worthwhile aspiration for a future study. Measures for assessing the reduction of suicide risks are also complicated; they can be based on individual report, using established measures, and subsequent service use. The high rates of repetition of self-harm (including suicide attempts) mean that, to prevent suicide, care is likely to be needed for some time after an initial episode. It is not realistic to say that a short-term intervention prevented suicide, as this has to be measured over a longer period of time, and a more accurate view is to note the reduction (or not) of suicidal intent at the time. The costs of service provision in the short-term need to be offset against the long-term cost effectiveness of saving lives. The economic cost of a suicide has been shown to be very high (NICE 2011). Preventing suicide may well involve a short-term increase in service use following an episode, and one of the aims of the Place of Calm is to signpost individuals to services following the stay. Some guests, in the Continuous

group draw on services extensively, whilst others, in the 'Recent' group, are more likely to underuse services before the stay at the Place of Calm. Thus use of services is likely to increase after a stay at the Place of Calm following a suicide episode.

A further measure of effectiveness is patient/client satisfaction with a service. This is important in the field of suicide prevention because there is an acknowledged history of dissatisfaction with the response of mainstream services (Saunders et al 2011) and one of the aims of Place of Calm is to contribute to reducing the use of inappropriate detention. The importance of de-stigmatising responses to suicidal people is that in the longer term this can lead to reduced suicide attempts, since the shame and humiliation of stigmatisation increases negative views of the self and this in turn contributes to suicidal feelings. It is also an important goal in its own right to provide services that service users feel are satisfying.

The evaluation of cost effectiveness presented here accepts the limitations of the data available. Taking the third quarter of the Place of Calm's operation as the baseline, it is possible to make a calculation of costs per individual. Secondly, guest reports of suicide reduction, patient satisfaction and de-stigmatisation can be used as criteria for an indicative view of cost effectiveness.

Costs per guest of a stay at the Place of Calm. Taking the third quarter as the baseline, 15 guests stayed at the Place of Calm in that period, the equivalent of 60 a year. Costs per guest, calculated as annual running costs divided by the number of guests per year, are £1,575. Secondly, a similar calculation for the maximum number of guests that the Place of Calm can accommodate, 2 per week, shows that the cost on the basis of maximum occupancy is £945.

Comparison with other resources is difficult to make as there are no exact equivalents. Key comparisons as built into the objectives for the Place of Calm are admission to hospital and detention in a police cell. The latter is almost redundant, as discussed elsewhere in this report. Costs for a police custody suite have been estimated at £1300 per day in 2013 (Home Office 2015). Hospital stay costs are not identical since the option of a stay following admission includes features that meet the security requirements for individuals detailed under the Mental Health Act, that is a health based place of safety, for which costs range between £1200 and £2000 per guest per day. Costs for the alternative West Sussex/Richmond Fellowship Place of Safety project were assessed as £967 per guest per day.

Table 9: Comparison of costs

Provision	Place of Calm	Health Based PoS	Police Custody PoS	West Sussex Alternative PoS
Staff costs	£1000 - £1575	£1200-£2000	£1300	£961

The Place of Calm is likely to lead to an increase in quality-adjusted life-years (QALY) (Phillips 2009) ¹⁴ for guests, based on the criteria of service user satisfaction, de-stigmatisation and suicide reduction. The evaluation shows that the feedback from guests and referrers emphasise all these factors, as discussed above. However, a formal assessment of QALY is beyond the scope of this evaluation and should be undertaken alongside further research assessing effectiveness.

There are, however, staff costs associated with the Place of Calm that could be more effectively deployed with higher referral rates or diversification. Adaptations to the model to increase referrals are discussed below (section 5).

There is growing evidence for the cost effectiveness of recovery oriented services for people with mental health difficulties (Knapp et al 2014). The Place of Calm data suggests that the model could demonstrate cost effectiveness and contribute to widening the evidence base for recovery focussed interventions in the field of suicide prevention.

5. Discussion of findings

The findings will be discussed by evaluating to what extent the Place of Calm pilot met its aims and objectives (section 2, above) and its success criteria as outlined in section 3.4 of:

- success in attracting referrals of suitable individuals meeting the criteria for the use of the service through the three referral routes
- reduction of suicide risks for these individuals
- reducing the use of inappropriate custody and detention;
- supporting individuals to access appropriate services and support to thus reduce the factors leading to suicidal distress
- providing a cost effective alternative service

These will be discussed here for the following key areas: the Place of Calm intervention model; outcome for guests and in particular with regard to suicidal feelings and well-being; referrals, and future scenarios.

¹⁴ Phillips, C. (2009) What is a QALY? www.whatisseries.co.uk , <http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/qaly.pdf>

Intervention model

The Place of Calm takes an innovative approach to working with people in a suicidal crisis, applying a model of providing practical and emotional support through peer-support or recovery for a period of 24 hours. There are some similarities with other non-mainstream approaches to suicide prevention, such as Maytree and Pieta House, although there are also differences, notably in terms of the referral process, the 24-hour stay and Peer Support method of work. Individuals accessing all three services have similar needs and risks. The findings of this evaluation show that the approach is highly valued by guests and referrers and that staff are dedicated, enthusiastic, reflective and skilful in applying the approach, including the tool of disclosure, and the approach deserves to be known more widely. Although it is new and different, the Place of Calm approach is underpinned by important principles for suicide prevention; non-stigmatising and benign practical and emotional care that offers listening, understanding and containment of individual's emotional experiences. It would be advantageous for the further development of the Place of Calm, and important as an aid to staff training and future outcome research for the model to be articulated as a manual or practice guide.

Outcome for guests

The experiences of guests show a range of responses to the experience of a stay in the Place of Calm. Guests report a reduction of suicidal feelings and an improvement in their mental well-being. They find both practical and emotional support important, and they value the peer support approach. Suicidal people are not homogeneous, and we found differences between individuals who have not previously, or only intermittently encountered suicidal thoughts compared with those who are more continuously engaged with suicidality, have longer-term mental ill health and multiple service involvement. We refer to these as the Continuous, Intermittent and Recent groups. Findings from Place of Calm checklist, WEMWBS scores, guest survey and interviews show that the 'Recent' group experience a significant relief of suicidal feelings and a statistically significant improvement in well-being during their stay, and they also report longer-term benefits afterwards. We understand this outcome of the the stay at the Place of Calm as a consequence of the terrible feelings and desperation that occur in a suicidal state where ordinary and benign relating feels not possible being changed by the powerful effects provided by interest, attention and empathy. It is in this context that it is not surprising that guests speak of meeting 'fantastic people' and 'not knowing there are people like this in the world'. This is an important finding and justifies further research to assess outcomes.

It is not at all surprising that for individuals in the Continuous group the impact of a stay is less transformative; guests in this group reported a mixed picture regarding reduction in suicidal thoughts and well-being. These guests have in many cases long

standing difficulties that require on-going and often intensive help. Some guests questioned aspects of the model, whether 24 hours was long enough; they said that though it provided relief and respite at the time, they did not experience the same longer-term benefits as the Recent group of guests. On the other hand, it was a clear finding that these guests do benefit from a stay, through the provision of support at a time of crisis, which was highly valued by these guests. Moreover, working in conjunction with services, the Place of Calm was highly valued by hard-pressed mainstream services as a resource both to support these individuals and also their services. There is a good case to be made that the Place of Calm could extend its involvement in working with this group of service users, and suggestions include establishing a pathway for people with personality disorder and extending the range of the Place of Calm offer to include a 'crisis café'. One new variation for the guests might be to deliver the Place of Calm approach in different 'units', for example, a 3-hour or 6-hour intervention of peer support and signposting alongside the 24-hour model, and by offering repeated interventions. The Place of Calm model could be refined to include initial assessments of need relating to the different groupings. For all, but especially the Continuous guests, the intervention could be adapted to include particular attention to the experience of leaving, including a 'transitional' offer of a letter, or similar object, as is used in Maytree. A follow-up call soon after the end of the stay could also be included as a way of reaching out to the guest after the stay.

Referrals and future developments

The Place of Calm has been successful in attracting appropriate referrals. As a new, pilot project it is understandable that the flow of referrals has taken some time to establish, and numbers have increased since the opening of the third referral route, through health. However, the conclusion at this point is that the Place of Calm is underused, particularly as the evaluation shows that it is highly valued by guests and referrers, and that its non-stigmatising, non-medical and non-custodial interventions promote the possibility of reducing suicidal feelings and promoting wellbeing. Referrals are limited by some key factors: changes in the overall provision in the area to include Street Triage and a health based place of safety, and the consequent reduction of the numbers in police custody; the risk-focussed approach of practitioners and commissioning; and the requirement for a mental health assessment prior to admission, which effectively leaves the Place of Calm without a real sense of its own agency in taking referrals. Consideration has therefore been given to possible scenarios for increasing referrals to the Place of Calm. These include:

Introducing a self-referral route has considerable advantages and is practical. With a self-referral route, The Place of Calm would be able to take referrals directly, and also in conjunction with local organisations, such as the Sussex Community

Development Association counselling service and the Samaritans. This evaluation recommends that this option is further explored. The addition of a self-referral route would necessitate some changes to the Place of Calm model, primarily introducing the need for an assessment process and criteria for admission, and it is recommended that the Place of Calm explore currently available examples, including Maytree, to help devise an appropriate method, and how it can be implemented. This would involve considering the range of skills needed in the staff team.

Extending the range of the Place of Calm model. As discussed above, the offer could be extended to provide different 'packages' for working with people in crisis, delivering the intervention in 'units', for example, a 3-hour or 6-hour intervention of peer support and signposting alongside the 24-hour model, and offering repeated interventions. As also discussed above, this could be considered in relation to a pathway for people with personality disorder diagnoses. It is recommended that this option is explored.

Exploring closer working with other organisations working with suicidal people including the possibility of building sharing. There are currently close links with the Sussex Community Development Association counselling service that offers support for survivors of suicide, and there may be ways of exploring extending this connection for the benefit of both organisations and the people that use their services.

The Place of Calm as a resource for mental health assessment. For some individuals, the Place of Calm could be a resource for professionals assessing mental health, and provide an important way of contributing to assessing whether detention is necessary. This is envisaged as a stay within the 24-hour period with a mental health professional in attendance or available if required, and the observation of the individual would then feed into the assessment. Additionally, referrers have mentioned the option of a 'sitting with' aspect when an individual to be detained is awaiting transfer, and the Place of Calm intervention could be a beneficial option in such situations, as helpful and de-stigmatising. This option requires discussions between the relevant organisations as a first step.

Establishing the Place of Calm as an Alternative Place of Safety, comparable with the pilot in West Sussex. This option has already been extensively discussed and would require considerable changes to the environment, it does not have support from other key organisations, and it would in essence duplicate local provision. There is no evidence that alternative places of safety increase referrals, based on the experience of the West Sussex pilot.

Thus there are here identified possible future scenarios, all of which require further exploration, aimed at increasing the availability of the Place of Calm to people in suicidal crises and supporting its establishment beyond the pilot phase.

6. References

- Bendelow, G. & Warrington, C. (in progress) Section 136 in Sussex
<https://www.brighton.ac.uk/ssparc/research-projects/section-136-in-sussex.aspx>
- Briggs, S., Webb, L., Buhagiar, J., Braun, G. (2007) Maytree: A respite centre for the suicidal: An evaluation, *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 2007 Vol 28(3) 140-147
- East Sussex County Council (2015) Suicide in East Sussex; Analysis of ONS mortality data, 2006-2013, Public Health Briefing December 2015,
www.eastsussex.gov.uk
- Gould, N. (2016) *Mental Health Social Work in Context*, London, Routledge, Second Edition
- Guest, G. (2012). *Applied thematic analysis*. Thousand Oaks, California: Sage;
- Hawton K et al. (2015) Suicide following self-harm: Findings from the Multicentre Study of self-harm in England: 2000-2012. *Journal of Affective Disorders*, Vol 175, 147-151
- HMG/DH 2012 *Preventing suicide in England: A cross-government outcomes strategy to save lives*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
- Home Office (2015) Alternative Place of Safety: The West Sussex Pilot Evaluation 2015 <https://www.gov.uk/government/publications/alternative-place-of-safety-west-sussex-pilot-evaluation-2015>
- Knapp, M., Andrew, A., McDaid, D., Iemba, V., McCrone, P., et al (2014) *Investing in recovery: making the business case for effective interventions for people with schizophrenia and psychosis*. PSSRU, The London School of Economics and Political Science, and Centre for Mental Health., London, UK,
http://eprints.lse.ac.uk/56773/1/Knapp_et_al_Investing_in_recovery_2014.pdf
- Krippendorff, Klaus (2004) *Content Analysis: An introduction to its Methodology (2nd ed.)*. Thousand Oaks, CA: Sage
- NICE (2011) Self-harm: longer-term management, (Clinical guideline CG133.) 2011.
<http://guidance.nice.org.uk/CG133>
- Phillips, C. (2009) What is a QALY?
<http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/qaly.pdf>

Owens, C., Lloyd-Tomlins, S., Emmens, T. Aitken, P. (2009) Suicides in public places: findings from one English county, *European Journal of Public Health*, Vol. 19, No. 6, 580–582

PHE (Public Health, England) (2015) Preventing suicides in public places: A practice resource, PHE publications gateway number: 2015497

Saunders, K., Hawton, K., Fortune S, Farrell S (2012) Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review, *Journal of Affective Disorders*, 139, 3, 205-16

World Health Organisation (WHO) (2014) Preventing suicide; a global imperative http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

7. Appendices

Appendix I: Participant Information Sheet and Consent Form

University of East London

Stratford Campus

University Research Ethics Committee:

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleateau, Research Integrity and Ethics Manager, Graduate School, EB 1.43, University of East London, Docklands Campus, London E16 2RD (Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

The Principal Investigator:

Professor Stephen Briggs

Cass School of Education and Communities

Stratford Campus

Water Lane E15 4LZ

Telephone 0208 223 4266

Mobile 07957 178938

Email: s.briggs@uel.ac.uk

This research evaluation is commissioned and funded by East Sussex County Council

Consent to Participate in a Research Study:

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title:

Evaluation of a non-statutory 'Place of Calm' for those in Eastbourne who have had suicidal thoughts

Project Description:

This research project aims to evaluate the pilot stage of the Place of Calm. The initiators of this project, East Sussex County Council, recognises the importance of assessing the effectiveness of this provision and therefore commissioned this research. The evaluation will aim to (1) assess how The Place of Calm meets its aims and objectives since opening to clients in June 2015 (2) ensure learning is captured to inform future commissioning and to support future funding applications (3) assess the costs and value for money. The evaluation will therefore identify and report on (a) positive processes and any potential obstacles and (b) outcomes for clients using the service.

To achieve these aims we will (1) assess routinely collected written data and surveys collected by The Place of Calm (2) interview guests who have stayed at The Place of Calm, staff who work there and professionals who have made referrals. Interviews will be transcribed and analysed using qualitative methods. When we have evaluated our findings we will write a report for East Sussex County Council, who may publicise the report. If we have important findings to share with others, we may write one or more articles in professional journals and make presentations at conferences.

Your participation in this project will involve meeting with the one of the researchers in the team at The Place of Calm or suitable alternative venue for an interview lasting not more than 1 hour. The interview will consist of some open questions about your experiences and reflections of The Place of Calm. It is possible this will arouse feelings and we recognise that it is possible it may be distressing or thought provoking. We will ask you if you are experiencing any of these feelings during the interview. If this is the case we will be pleased to discuss how you may be supported.

Confidentiality of the Data

We will transcribe interviews and store these on a password protected UEL computer using a numbered key to protect confidentiality. Once the interview has been transcribed, the tape will be erased. When the evaluation has been completed the data will be retained in accordance with the University's Data Protection Policy. The data will be available only to members of the research team. Confidentiality of all stored data can be subject to legal limitations e.g. freedom of information enquiries.

We will protect your confidentiality in written and any conference reports by using pseudonyms and removing any identifying information. Anonymised quotes from your interviews may be used in publications.

However, as this is a small study with few participants it will not be possible to wholly protect your confidentiality and you may be recognizable. We will take every step to minimize the risks of recognition and we will offer you the opportunity to read and comment on any report involving your interviews. Should the interviews involve information about risks of imminent harm to anyone, we will need to ensure with you that these are acted upon appropriately.

Location

We will undertake the interviews at The Place of Calm but if for any reason this is not possible an alternative location will be identified. Some interviews will take place by telephone by mutual agreement.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

Evaluation of a non-statutory 'Place of Calm' for those in Eastbourne who have had suicidal thoughts

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I

understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed. It has been explained that full anonymity may not be possible in this study and that there are legal limitations to data confidentiality

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Investigator's Name (BLOCK CAPITALS)

.....

Investigator's Signature

.....

Date:

Appendix II Interview Schedules

Evaluation of a non-statutory 'Place of Calm' for those in Eastbourne who have had suicidal thoughts

Semi-structured Interview: Schedules

1. Schedule 1: Guests/ex guests of The Place of Calm

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your experiences of The Place of Calm and we would like to hear your thoughts about what it was like before during and after [adapt as appropriate] your stay. Is that OK? Do feel free to stop the interview at any point and ask any questions along the way if you want to
So the first question is

1. How are things for you now?

(prompt for good/positive aspects and things that might be more difficult)

2. What was it like just before you went to stay at The Place of Calm?

(empathic prompts especially if/when talking about difficulties/distress)

3. How did you come to stay at the Place of Calm?

(prompt about how did the participant hear about PofC, who was involved?)

(prompt about factors in decision to stay)

4. What is/was it like at The Place of Calm?

e.g. the routine, the setting, who was there, who does/did participant relate to? how do/did you spend your time?

5. How do you think about the way Place of Calm tries to help?

(Prompt: What is/was most important in making a difference talking/atmosphere/attitudes of staff, space to self etc

Prompt: Are there any criticisms? Or are there things you don't like or think The Place of Calm could improve?)

6. How do you see things going from now and into the future?

(Prompt – what supports you – relationships/ work/things you do/interests etc

Prompt: Relationships – how do you feel about people closest to you? e.g. helpful/supportive?)

7. (a) (For current guests) How are you planning for the future after leaving here?

(Prompt immediate and longer-term plans, who is important in making these plans, what issues are involved. How is The Place of Calm helping with

making plans (add specifics about with whom and in what ways) and how does the participant view this help)

(b) (for ex-guests) Can you take us through how you planned for leaving the Place of calm?

(prompts as above, and reflections on how this worked out)

8. Are there any other comments you would like to make?

Thank you for your time

2. Referrers' interview schedule

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your experiences of The Place of Calm and we would like to hear your thoughts. Do feel free to stop the interview at any point and ask any questions along the way if you want to.

So the first question is

1. Have you referred service-users to the Place of Calm? If No go to Q6
2. Can you tell us about how the experience of referring? (Prompts: did it go well, and in what ways? Were there any difficulties or problems in the referral process?)
3. How did you feel about making these referrals?
4. How do you think the stay at PoC turned out for the people you referred?
5. Would you make further referrals? (Prompt: what factors influence this)
6. From what you know of PoC would you consider making referrals (Prompt: factors influencing this, any barriers whether individual or institutional)
7. How do you see the strengths of PoC (prompt also for any limitations)
8. Do you have any further comments

Thank you for your time

3. Place of Calm staff interview schedule

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your work at The Place of Calm and we would like to hear your thoughts and experiences. Do feel free to stop the interview at any point and ask any questions along the way if you want to

So the first question is

1. Can you please say what is your role at Place of Calm?
2. What is it like working here? (prompt for what is stressful/difficult when working with people with suicidal thoughts, how stressful moments are worked with, supervision etc)

3. Can you describe an example of your work with a guest? (Prompt: key tasks and focus, prompt for description, emotional experience, how did it work out? Ask about future planning and process of leaving PoC; changes in guest's emotional and mental state, mention suicidal feelings, ask for comparisons with other guests)
4. So, following on, can you summarise the main methods of work you use and how these work in practice?
5. Do you feel well trained for the role? (Prompt: key training factors, what's most important, additional training that would be beneficial, mention ASIST)
6. Can you summarise the strengths of PoC? (prompt for any limitations)
7. Do you have any further comments?

Thank you for your time

Appendix III: Checklist for Place of Calm Stays

Check	Additional Info	Any actions Required	Tick
Referrer			
Telephone No.			
Date			
Time of call (24hr clock)			
Guest Name			
Date of Birth			
Home address			
Telephone No			
Family/next of kin -name Address			
Telephone			
Client description			
Police/crime no			
Guest Arrival time			
Estimated length of stay			
Reason for delay/cancellation			
Mental health act assessment	*Prompt for relevant information		
Mental health assessment completed			
Onward travel plans- Money/ have travel tickets issued?			
Practical Support Needs Identified	-Intervention <input type="checkbox"/> -Guidance/practical support <input type="checkbox"/> -Rest, food and sleep <input type="checkbox"/> -Other (specify) <input type="checkbox"/>		
Other services used/involved			

What would have been offered if PoC was not available?	-A and E <input type="checkbox"/> -136 suite <input type="checkbox"/> -Sent home <input type="checkbox"/> -B and B <input type="checkbox"/> -Social Services <input type="checkbox"/> -Other <input type="checkbox"/>		
Time of Guest departure			
Staff names/rota hours	1. 2.		

Appendix IV: Place of Calm Guest Survey.

<https://www.quicksurveys.com/s/Nr39L>

Being a guest at the Place of Calm improved my mental health and well-being while I was there? (e.g. symptoms such as anxiety and depression)

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Not applicable

Please comment/explain if you wish:

Being at the Place of Calm reduced my need for other treatment at the time

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Not applicable

Please comment/explain if you wish:

Being at the Place of Calm made me feel less isolated at the time

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Not applicable

Please comment/explain if you wish:

Being at the Place of Calm made me feel less hopeless at the time

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Not applicable

Please comment/explain if you wish:

Being at the Place of Calm made me feel less suicidal at the time

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Please comment/explain if you wish:

I believe being at the Place of Calm saved my life, that day

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Not applicable

Please comment/explain if you wish:

Since being at the Place of Calm the frequency of my self-harm has

- Increased
- Decreased
- Stayed the same
- Not applicable

Please comment/explain if you wish:

**Regarding the support you received at the time, how would you rate the following?
Peer Support (support from a worker with lived experience of suicidal thoughts and feelings)**

- Very Unimportant
- Somewhat unimportant
- Neither important nor unimportant
- Somewhat important
- Very important
- N/A

Safety or wellbeing plan

- Very Unimportant
- Somewhat unimportant
- Neither important nor unimportant
- Somewhat important
- Very important
- N/A

Practical support such as signposting and contact with other organisations

- Very Unimportant
- Somewhat unimportant
- Neither important nor unimportant
- Somewhat important
- Very important
- N/A

Practical support such as a shower and time to rest

- Very Unimportant
- Somewhat unimportant
- Neither important nor unimportant
- Somewhat important
- Very important
- N/A

Since being at the Place of Calm my mental health and wellbeing has improved

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Since being at the Place of Calm my relationships with other people e.g. family and friends have improved

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Since being at the Place of Calm I have reduced my use of drugs and/or alcohol

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Since being at the Place of Calm my involvement in criminal activity has reduced

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Since being a guest at the Place of Calm, I have been able to contribute towards society

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Being a guest at the Place of Calm has contributed to me getting paid or voluntary work, or remaining in my current job

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Being a guest at the Place of Calm has helped me get into education

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Being a guest at the Place of Calm has increased my access to benefits/money advice

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Being at the Place of Calm has helped me to use the right medication for me

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Since being at the Place of Calm I have reduced the number of times I have self-harmed by

- 1-3
- 4-9
- 10-20
- 20+
- N/A

Please comment if you wish:

Since being at the Place of Calm I have reduced the number of times I attempted suicide by

- 1-3
- 4-9
- 10-20
- 20+
- N/A

Please comment if you wish:

Since being at the Place of Calm I have reduced the number of times I felt in crisis by

- 1-3
- 4-9
- 10-20
- 20+
- N/A

Please comment if you wish:

Being at the Place of Calm has reduced my number of visits to A&E by

- 1-3
- 4-9
- 10-20
- N/A

Since being at the Place of Calm I have reduced my number of hospital admissions by

- 1-3
- 4-9
- 10-20
- 20+
- N/A

Please comment if you wish:

Since being at the Place of Calm I have reduced my stays in the section 136 suite or police custody by

- 1-3
- 4-9
- 10-20
- 20+
- N/A

Please comment if you wish:

Since being at the Place of Calm I have reduced my calls to '999' by

- 1-3
- 4-9
- 10-20
- 20+
- N/A

Please comment if you wish:

Being at the Place of Calm has increased my access to appropriate services

- Yes
- No
- N/A

Please specify which services and comment if you wish?

Do you feel we have valued you and treated you as an individual?

- Yes
- No

Please comment if you wish:

Do you feel we have been honest about how we work and what we can offer you?

- Yes
- No

Please comment if you wish:

Have we been reliable?

- Always
- Mostly
- Sometimes
- Never

Please comment if you wish:

Do you feel we have listened to you?

- Always
- Mostly

- Sometimes
- Never

Please comment if you wish:

Do you feel you have been supported and encouraged to give us feedback and your opinion about the service? For example by completing this survey?

- Always
- Mostly
- Sometimes
- Never

Please comment if you wish:

The Place of Calm is an effective treatment for those who are considering suicide

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- N/A

Please comment if you wish:

Compared to traditional approaches to suicide, the Place of Calm is...

- More effective
- Less effective
- N/A

Please comment if you wish:

Would you recommend the Place of Calm to someone who is important to you?

- Yes
- No
- N/A

Please comment if you wish:

Have you recently had contact with mental health services? [Any comments on the next four questions can be made later]

- Yes
- No
- Prefer not to say

Have you recently been in a mental health hospital?

- Yes
- No
- Prefer not to say
- Other, please specify

Do you have history of self harm?

- Yes
- No
- Prefer not to say

Have you recently had contact with the criminal justice system?

- Yes
- No
- Prefer not to say

What is your occupation? Do you have any comments on this section?

(Write up to 1000 characters)

Are you...?

- Male
- Female
- Prefer not to say

Do you identify as a transgender or trans person?

- Yes
- No
- Prefer not to say

To which of these ethnic groups do you feel you belong? If your ethnic group is not specified please describe it below.

- White British
- White Irish
- White gypsy/Roma
- White Irish Traveller
- White other
- Mixed White and Black Caribbean
- Mixed White and Black African
- Black or Black British Caribbean
- black or Black British African
- Black or Black British other
- Mixed White and Asian
- Asian or Asian British Indian
- Asian or Asian British Pakistani
- Asian or Asian British Bangladeshi
- Asian or Asian British other
- Arab
- Chinese
- Mixed other
- Prefer not to say
- Other, please specify:

Do you consider yourself disabled as set out in the Equality Act 2010? [physical or mental health condition likely to last more than 12 months and impacts on day to day activities]

- Yes
- No
- Prefer not to say

If yes, please tell us the type of impairment that applies to you. Please select all that apply to you or give brief details at the end.

- Physical impairment

- Sensory Impairment [hearing and sight]
- Long standing illness [or health condition such as cancer, HIV, heart disease, diabetes or epilepsy]
- Mental health condition
- Learning disability
- Other, please specify:

Do you consider yourself to have be on the autistic spectrum or have Asperger's Syndrome?

- Yes
- No
- Prefer not to say

Do you regard yourself as belonging to any particular religion or belief?

- Christian
- Hindu
- Muslim
- Buddhist
- Jewish
- Sikh
- Prefer not to say
- None
- Other, please specify:

Sexual Orientation: Are you...?

- Heterosexual
- Gay Man
- Gay Woman/Lesbian
- Bisexual
- Prefer not to say
- Other, please specify:

Are you a carer?

- Yes
- No
- Prefer not to say

Are you currently pregnant or have you been pregnant in the last year?

- Yes
- No
- Prefer not to say

Are you married or in a civil partnership?

- Yes
- No
- Prefer not to say

What is your date of birth? [dd.mm.yyyy]

What is your postcode? [up to 8 characters including the space between the 2 parts]

Would you be prepared to contribute to some academic research about The Place of Calm (for example a short follow up survey)

- Yes
- No

Please give your preferred details/contact number:

Is there anything else you would like to say?

(Write up to 1000 characters)

Appendix V: Place of calm referrer survey

(<https://www.quicksurveys.com/s/r8R7CiQ>)

Thank you for completing the Place of Calm Pilot survey for referrers. Your input will help shape the project and contribute to an academic evaluation in the latter stages of the pilot. Thank you!

Where was the person before being referred to The Place of Calm? Please tick all the boxes that apply.

Section 136

Police custody

A & E

Chaplains

Street triage

Approximately how long were they there for? Please explain below if necessary. (up to 1000 characters)

How long would they have stayed there if not at The Place of Calm?

Would this have been appropriate?

What would have been offered if there was no PoC?

Returned home

Accident and Emergency

GP support

Family & friends

Bed and breakfast

Mental health team

Samaritans/crisis line

Police station

Chaplains

Section 136 suite

Why are you referring this person to PoC. Please tick all that apply.

ASIST suicide intervention and safe plan

Peer support

Emotional support

Signposting & advice

Rest/sleep/shower

Other practical support

Did you receive a warm welcome from The Place of Calm staff?

yes

no

Did you feel reassured by and trust The Place of Calm staff?

yes

no

Would you recommend our service to other professionals and service users?

yes

no

Is there anything you thought we did particularly well?

Would you be willing to undertake a short follow up interview with a researcher who is evaluating the project?

Yes

No

Appendix VI

Membership of Beachy Head Risk Management Group

Consultant in Public Health, ESCC (Chair)

Project Manager, Public Health, ESCC

Director of Nursing Standards and Safety, SPFT

Interim Deputy Director Adult Services, SPFT

Interim General Manager, Acute Services, SPFT

Chief Inspector, Eastbourne District,

Sussex Police

Eastbourne Samaritans

Trustee, Beachy Head Chaplaincy Team

Professor of Sociology in Health and Medicine, Brighton University

Coastguard

Consultant Psychiatrist, SPFT

Counselling Partnership Project

Director, Place of Calm

Specialist Advisor (Downland),

Eastbourne Borough Council Practice Manager, Approved Mental Health Practitioner and Emergency Duty Service, Adult Social Care, ESCC