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Atlas Men's Well-being Programme: Evaluation Report

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EXECUTIVE SUMMARY

Background to the evaluation

Men's mental health and well-being is increasingly of concern. In England and Wales, the suicide rate is now almost four times higher for men (78%) than women (22%). Rates of diagnosis of men's mental health problems do not capture distress among men well, as men may express distress in atypical ways (eg acting out, blunting emotions), suggesting that we need a deeper understanding of male experiences of distress and 'men-friendly' services to better help men. One such service, Atlas, was designed as a potential way of improving access to mental health services for men. Atlas was originated by Professor Damien Ridge, co-designed by Prof Ridge and Professor David Peters, and managed and governed by adapting University of Westminster Polyclinic guidelines, developed over 15 years. The Atlas Men's Well-being Programme was designed to be 'male sensitive', to provide counselling and/or acupuncture for men suffering from stress or distress. Based at the Victoria Medical Centre (VMC), a busy NHS GP practice in central London, the pilot Programme ran from March 2013 until July 2014 for practice patients only. Our evaluation collected quantitative patient outcomes and qualitative data, to examine clinical changes in patients and their experiences of the Programme. In addition, interviews were conducted with a wide range of key stakeholders involved in the Programme. The aims of the interviews were to (a) understand the Programme from the perspectives of key stakeholders, and (b) improve the Programme early on by identifying any problems and feeding them back to the people who needed to know.

Methods

Questionnaires: All patients using the Atlas service were invited to take part in the evaluation. Questionnaires were used to collect predominantly quantitative data and were completed by patients prior to using the Programme as well as on finishing the Programme. Measures collected included anxiety, depression, perceived stress, positive well-being, physical health and outcomes for problems identified as most important by each individual patient. Open-ended questions collected written data regarding patient experience of the Atlas Programme.

Interview data: Semi-structured interviews with 14 key stakeholders (including Atlas practitioners, VMC GPs, VMC administration staff and other VMC practice staff) were conducted five to six months into the Programme. In addition, narrative interviews were conducted with six men who used Atlas to provide deeper insights behind the numerical results. The narrative interviews provided an understanding of men's distress and Atlas. All qualitative data were analysed using thematic analysis.

Cost implications: Additional questions regarding patients' employment and service use were collected on patient questionnaires (before and after engaging in Atlas services) and formed the basis for the cost implications analysis.

Key findings

- GPs played a key role in referring and encouraging men to attend Atlas.
- Patients took a variety of routes through the service, using counselling and acupuncture in different combinations, according to their needs, in consultation with their GPs and practitioners.

- Of the 107 patients using the Programme, 102 (95%) completed a pre-treatment questionnaire, and 82 (80%) of those went on to complete their post-treatment questionnaire.
- Men said that they were attending the Programme to help reduce psychological and physical symptoms, promote positive mental states and relaxation, improve daily functioning, understand and manage their problems, talk things through, and deal with a range of specific issues affecting their lives such as work and relationships.
- Comparisons between pre- and post-treatment revealed statistically significant improvements in anxiety, perceived stressed, positive well-being, physical health and patient-centred outcomes (ie problems rated as most important to each patient at the time of first attendance).
- Overall there was no change in depression, but this is likely to be because a significant proportion of the men using the Programme were not initially identified as depressed. However, the sub-sample (n=50) of men who were at risk of depression (as identified using recommended cut-off scores on our depression scale) before using the Programme did experience a statistically significant improvement in depression post-treatment.
- 78% of patients said that they felt better after their Atlas sessions, 13% reported no change and 4% felt a little worse.
- Patients reported an improvement in their understanding and awareness of themselves and/or the situation that they found stressful, and found ways of coping with and managing their issues as a result of using the Programme.
- Some patients described being able to talk to an objective professional as helpful, although challenging at times. Some patients wanted a more structured or directive approach to working with their problems than counselling could provide.
- The unanimous opinion among stakeholders was that the Atlas Men's Well-being Programme functioned well. Some minor challenges for professionals included pressures on scarce room space, a lack of clarity regarding which health professionals were able to refer to Atlas, and occasional difficulties for receptionists with appointment bookings. Some patients wanted to have more than their allocated six or 12 sessions. When the demand for the Programme allowed, practitioners were able to provide up to six additional sessions.
- Professional stakeholders felt that having a male-only service sent an implicit message to men that validated their emotional needs and normalised the idea of getting help for stress/distress, and attuned practitioners and GPs to the emotional needs of men. Other stakeholders felt the Programme should also be available to women. In interviews, men said that it being a male-only service had not occurred to them (GP referral was the most likely route rather than the flyer) and was not of particular significance. However, many agreed there was an unmet need for male mental health services, and that having a male-only service may improve access for other men.
- Often counselling was more acceptable to patients than acupuncture as a way of helping them with their mental health problems. However, the acupuncture service was well used and was reported to reduce stress, and patients evaluated it well.

- Qualitative data suggested a synergy between counselling and acupuncture: Atlas practitioners considered that acupuncture might help patients to be more emotionally 'open' in counselling sessions, or that acupuncture could help relax patients after a challenging counselling session. Further research will be needed to explore this interaction.
- Atlas reduces costs, when taking costs related to health and social care usage and lost employment into account; reductions in these costs exceeded the cost of the Atlas counselling and acupuncture sessions, with an average saving of nearly £700 per patient.

Quotes from Atlas participants

"It was great to have someone independent from the situation to talk to and get objective feedback from. The action of talking about issues is itself a therapeutic process and helps one understand." P2

"A good blend of professional and approachable. I guess these things can be a little strange at the beginning (especially if you are not pre-disposed to talking about your issues such as I), but she made me feel comfortable early and established credibility and trust early too. This helped develop the relationship quickly, which in turn helped get maximum benefits from the conversations." P2

"The realisation that I was suffering from serious stress, which I wasn't addressing and how to stop that happening in the future. I got a much-needed sense of perspective and was able to see that things had become almost unbearable in terms of not communicating how I was feeling." P109

"It helped understand the reasons behind thoughts and emotions I had been experiencing. This led to a better acceptance of my moods/worries." P13

"Helped me to understand myself better – ideally what's important to me, what makes me special, who I am. Helped to identify my strengths and what makes a brilliant person. It was the first step on the road to recovery." P22

"[Acupuncture practitioner] found ways of exploring my depression which were helpful, even though I sought only treatment via acupuncture." P79

Conclusions

The evaluation demonstrates a hitherto under-investigated pathway by which men experiencing mental health problems can be identified in primary care and helped to talk about the problems that are concerning them, and/or receive physical therapy aimed at reducing stressed-related symptoms.

Findings from this evaluation suggest that the Atlas Men's Well-being Programme was helpful for stressed and distressed men, particularly in terms of reducing anxiety and stress and improving physical health, positive well-being and individual problems important to each patient.

The Programme also promoted relaxation as well as better understanding and coping with problems. Consistent with previous research in this area, the study found that a

‘one size fits all’ approach is unlikely to be useful for men, and indeed men using Atlas had varying preferences and expressed diverse needs in relation to the Programme.

We found that it is possible to effectively develop and deliver a primary care-based programme offering help to men for their mental and physical symptoms of stress and distress. Flexibility (timing and treatment options), the close involvement and encouragement of GPs, and high-quality branding appear to be important considerations when providing men’s mental health services. This evaluation highlighted the value of engaging GPs in encouraging stressed/distressed men to identify – and seek help for – mental health problems.

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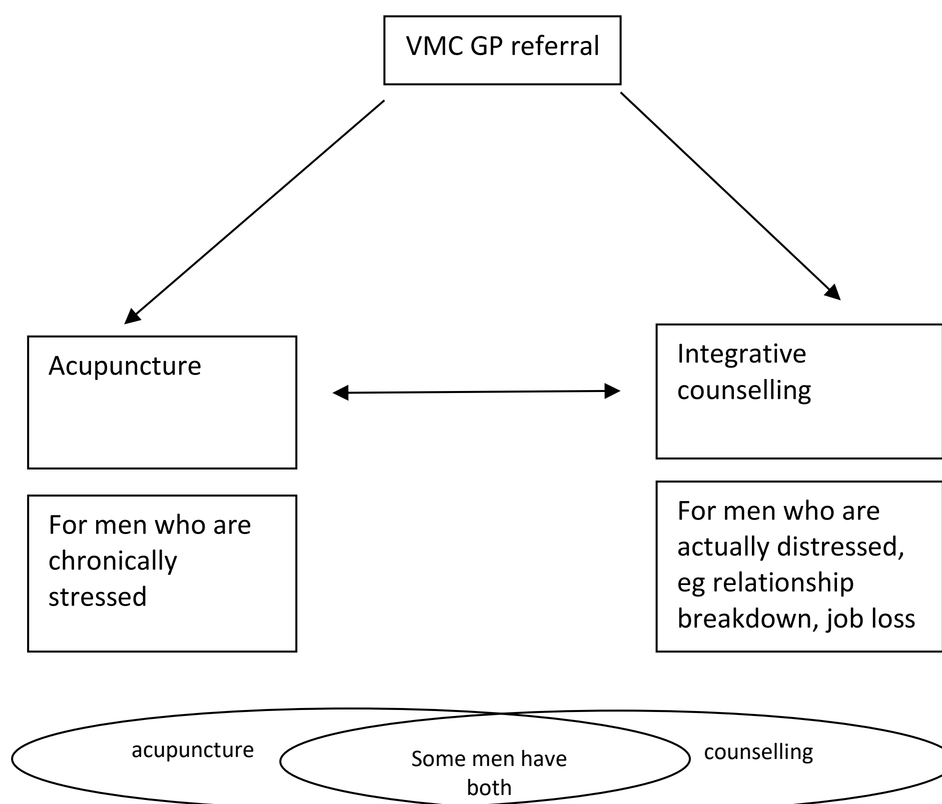
- All patients who participated in the Programme and completed the evaluation assessments and all stakeholders who took time to participate in evaluation interviews.

Introduction to the Programme and evaluation

Based on an original concept by Prof Damien Ridge, and co-designed by Prof David Peters and Prof Ridge, the Atlas Men's Well-being Programme was delivered at the Victoria Medical Centre (VMC) – a large GP practice in Central London – between March 2013 and August 2014. The aims of this pilot programme were to provide a 'male-friendly' service, sensitive to the needs of men who were stressed or distressed (Figure 1): A review of the literature (see below) suggested that the needs of this group of patients can be easily overlooked in healthcare settings. The objectives of the Programme were to:

- Provide a service (Atlas) that would encourage more men who feel stressed or distressed to identify their needs as legitimate and seek appropriate treatment.
- Provide a physical treatment for stress (acupuncture) that would be appropriate to treat somatic symptoms with which men often present, as a less threatening entry into 'stress management' for men.
- Provide counselling for men in distress.

Figure 1 – The Atlas Men's Well-being Programme model



The aim of this report is to present the Atlas evaluation findings. The report begins by setting the findings in context, presenting the background literature from the areas of men's mental health and mental health services for men. This is followed by details of the Atlas Men's Well-being Programme. Evaluation methods are then presented. Findings are presented in three sections: 1. Patient outcomes, 2. Patient and stakeholder perspectives, and 3. Cost implications.

Background Literature

Men's mental health and well-being

Men's mental health is of increasing concern, as male suicides in England and Wales have increased in recent years to become the leading cause of mortality in adult males under the age of 49. In the UK, the suicide rate is up to four times higher for men than women [1-4]. Young and middle-aged men are at particularly high risk: in England and Wales suicide is the leading cause of death for men aged 20 to 34 years old (26% of all deaths in 2012) and for men aged 35 to 49 years (13% of all deaths in 2012) [5]. In 2012, the highest suicide rate was among men aged 40 to 44, at 25.9 deaths per 100,000 population [3]. These figures are supported by the latest suicide prevention strategy for England which identifies young and middle-aged men as a priority population for suicide prevention [6]. A recent report by the Samaritans also identifies middle-aged men as a high-risk group, but additionally points to low socio-economic status as a risk factor for suicide, with men in the poorest socio-economic category approximately 10 times more at risk than those in the most affluent category [7]. In addition, men are more likely to manage their emotions using alcohol [7], and in the UK alcohol-related deaths are approximately twice as high for men as they are for women [8].

It is estimated that 30% to 70% of those who die by suicide have a mood disorder, with major depression being the most common of these [9]. However, fewer men are diagnosed with 'common mental disorders' [10] and depression [11-13] than women. However, gender differences are far less apparent in low income populations [10] and when questions are asked more directly (ie have you ever been very depressed?) as opposed to asking questions to make a clinical diagnosis [14]. In addition, men report work stress more frequently than women [15, 16]. These findings highlight disparities between male suicides and reported mental health, and the need to better understand male experiences of distress.

Research on men and emotional distress is limited. Existing research does highlight differences between the genders in the experience, expression and management of distress, but also uncovers many similarities too [17]. For example, women may experience distress as sadness and anxiety, while men may mask their distress with alcohol and substance use [18]. One study of online cancer support found that while women clearly expressed their emotion with a focus on nurturing, men were more likely to imply emotion and focused on, for example, battle metaphors [19]. Research suggests that help-seeking in men is more complex than the commonly held view that men are reluctant to seek help for problems [20]. For instance, some research points to a reluctance to seek help for symptoms by both males and females or that men are not reluctant to seek help [4, 17]. Other research suggests that men are more reluctant to seek help than women [14, 17]. This may be because men are more likely to report wanting to deal with the problem themselves [14], or that they reach higher thresholds of distress before they seek help compared to women [17]. Further research implicates dominant/traditional masculine identities as disincentives to seeking help for mental health problems (although masculine ideals can support help-seeking at times, eg seeking help to regain strength) [21], and that the pressures of attempting to conform to these ideals could contribute to suicidal behaviour [22]. Often overlooked in the help-seeking equation is professional reluctance to identify and engage with men in distress

[23]. And what we do know about men who turn up for help is that they are frequently socially isolated [24].

Men tend to under-utilise health services, particularly mental health services [25]. Thus, it is important to find ways to reach out to men [26]. Primary care services play an important role in identifying and supporting men with mental health problems [26]. Common presentations of symptoms for men with depression are somatic symptoms such as sleep problems, fatigue and pain, rather than classic symptoms [27]. This can create challenges for GPs in recognising depression, requiring them to be skilled in looking beyond the physical problems presented to recognise anxiety and depression [26, 28]. The Samaritans recommend that GPs be better supported to identify and respond to hidden presentations of distress in men [7].

These differences in the experience, expression and management between men and women may account for the differences in prevalence rates of distress. If men do express their distress differently from women (eg as anger directed at others, use of alcohol, physical symptoms), it may be that their symptoms are not always picked up by psychiatric diagnostic approaches, nor identified by health professionals in general [21]. In addition, if men are reluctant to express their vulnerability and seek help for mental health problems, this may lead to under-reporting of the problem [21].

Causes of any gender differences are likely to be complex. They may be genetic, but certainly social and life experience play an important role. Cultural/social expectations that men should not have certain emotions, or express vulnerability, may lead to men not giving priority to their mental well-being [26]. One report suggests that men and boys are portrayed negatively in the media and advertising, and this may make it difficult for boys to find positive role models for their well-being [26]. CALM (Campaign Against Living Miserably), a charity for young men aimed at preventing male suicide, states that providing support to men is not enough to improve men's mental health and that more needs to be done to change culture, attitudes and organisations so that men are able to seek and access help when they need it [29]. They declared 2014 'Year of the Male' in order to better examine what it means to be a man as part of their ongoing campaign to reduce male suicide [30].

Services for men

There is some evidence that men may want different things from women from their health professionals. For example, Emslie et al. [31] found that while both men and women with depression could find it challenging to communicate about their problems to health professionals, women emphasised the importance of being listened to, while men valued health professionals who enabled them to talk about their distress. Furthermore, men emphasised getting practical help from talking therapies rather than 'just talking'. There was variation between individuals in what type of relationship was most useful to facilitate communication, but these preferences were not related to gender. Thus the assumption of stereotyped masculine roles is inappropriate; it is instead important that services are sensitive to gender variations, but also flexible to the needs of a diverse range of individuals [17]. It is important that men using mental health services should be valued as individuals in their own right [26].

Oliffe and colleagues [21] highlight the need for 'men-friendly' mental health services to be delivered through diverse modes and methods. They also emphasise the role policy has to play in reaching out to men [21]. Fortunately, policy is beginning to focus on men's health needs, for example the Irish Men's Health Policy, the Australian Men's Health Policy and the American Men and Families Health Care Act [17]. In the UK, mental health charities like CALM, the Samaritans and Mind are increasingly highlighting the need to address men's mental health with approaches that enthusiastically engage men [7, 26].

Counselling and acupuncture for distressed men

The Samaritans report on suicide recommends that when working with men, psychological factors be addressed alongside the prescription of psychotropic medication [7]. Patients with symptoms of anxiety and depression are themselves keen to access non-pharmacological help such as self-help, psychological treatments and complementary therapies [32-35]. They value not only improvements in their symptoms, but also broader changes such as improvements in understanding, coping, daily functioning and quality of life to which these treatments often lead [36].

Counselling: NICE guidance suggests that, in the first instance, psychological/ psychosocial interventions and self-help should be offered to patients with mild to moderate depression and generalised anxiety disorders [37, 38]. The Increasing Access to Psychological Therapies (IAPTs) service was created in 2011 as a first-line treatment for depression and anxiety disorders. The programme is based on cognitive behavioural therapy (CBT) and is accessed through primary care. However, recent data suggest that only half of the people referred to IAPTs entered treatment [39] and waiting lists can be long. One in 10 people wait over a year to be seen, with more than half waiting more than three months for an initial assessment, often with a further long wait to begin treatment [40]. These figures highlight a serious need to expand psychological services in the NHS. Additionally, the longer someone has to wait for treatment, the greater the risk they will become more unwell and potentially require intensive treatment as a result. In addition, IAPTs has been criticised for only offering a CBT-based approach. Different types of therapy work for different people and other options need to be available [40]. Therefore, it is important to offer a range of psychological and psychosocial interventions to men [41]. Moreover, many GP surgeries do not provide a range of psychotherapeutic options [42], and certainly, we are not aware of surgeries that have specifically designed services to overcome barriers to men getting psychological help, and engaging with men in a 'male-friendly' way.

Counselling is one therapeutic option that can be provided for patients with anxiety and depression, as an alternative to CBT-based therapies. A Cochrane review of the literature of counselling for mental health and psychosocial problems found that counselling was more effective than usual care (the routine care received by patients for illness prevention/treatment) in the short term, but not in the long term. It also found that patient satisfaction with counselling is high and that the overall costs of counselling and usual care were similar [43, 44]. Other systematic reviews have found that counselling may be helpful for heterogeneous primary care populations [45, 46]. For example, Brettle et al. [45] found that in the short term, counselling for primary care patients is as

effective as CBT and more effective than usual care for the treatment of non-specific/generic psychological problems, anxiety and depression. In addition, these randomised control trial (RCT) findings have been shown to translate into 'real life' practice; an evaluation of counselling interventions in primary care found that counselling has considerable potential to alleviate distress for a range of psychosocial difficulties that commonly present in primary care [47].

While some men prefer the more outcome-orientated service offered by IAPTs [31], others prefer an approach that more deeply explores their feelings and psychological issues [48]. A survey conducted in 2010 by the British Association for Counselling and Psychotherapy (BACP) to explore attitudes to counselling and psychotherapy found that men were more likely to think that counselling and psychotherapy should be reserved for more serious problems [49]. However, a further survey conducted in 2014 of 258 BACP members found that 62% of respondents had greater percentages of male clients compared to five years ago (unpublished) [50], suggesting that a historical shift in attitudes among men regarding talking therapies is underway.

Acupuncture: Private acupuncturists commonly treat stress, anxiety and depression [51], but acupuncture is rarely made available on the NHS to treat these conditions. There is evidence that acupuncture may alleviate certain stress-related problems, including generalised anxiety disorder, anxiety neurosis [52], and some forms of post-traumatic stress disorder [53]. A review of the literature on acupuncture treatment for depression concluded that due to the small number of trials and participants studied, there was not yet sufficient evidence to recommend acupuncture to treat depression [54]. Since this review, however, a landmark RCT has been published comparing acupuncture (n=302), counselling (n=302) and usual care (n=151) for patients in primary care with depression. Results showed that compared with usual care, there was a statistically significant reduction in depression at three and six months for both the acupuncture and counselling groups. Differences between acupuncture and counselling were not significant [55].

Many men affected by stress often prefer to do something physical, like exercise, rather than talk about the causes of their stress or their troubles coping [26, 56]. Frequently men will try to suppress their difficult feelings, sometimes through drugs and alcohol, but these feelings build up and can result in men 'acting out' (eg aggression) [57]. Because some men find it difficult to reveal or articulate their feelings (at least initially) [58], and because they commonly experience stress and depression physically [27, 59], our hunch was that there would be clear advantages in offering a physical therapy option – like acupuncture – particularly for somatic presentations [60]. Moreover, we anticipated that acupuncture would be a way to initially engage 'stressed' men in a treatment that is not predicated on talking about difficult emotions, thereby providing them with a pathway into professional care that explores psychological options, either with the acupuncturist [61] and/or via additional referral. Oliffe and colleagues [21] have highlighted the need for specific, 'men-friendly' mental health services to be delivered through diverse modes and methods. The Atlas Men's Well-being Programme offers an example of one such approach, providing counselling and acupuncture for men who are stressed/distressed.

The Atlas Men's Well-being Programme

Atlas was developed out of the current literature and theorising on men, gender and distress, and in consultation with recruited Atlas practitioners and VMC staff (GPs, nurse, counsellor, IAPTs practitioners), to ensure it was attuned to the needs of male patients. The Atlas Men's Well-being Programme ran from March 2013 until July 2014, and offered counselling and acupuncture to men who were patients at the VMC. Prof Ridge originally developed a proposal to develop and study a 'male-friendly' counselling and acupuncture service for men in distress in 2012 [17, 62]. He sought expert input from Prof David Peters to further develop the project. Professors Ridge and Peters, as co-designers of the resulting Programme, Atlas, then sought expert input from VMC staff (Senior GP Dr Rankine, other VMC GPs, other VMC staff) to finalise and establish the intervention at the VMC. This included, for example, discussing how stressed/distressed men present (eg with gastrointestinal symptoms, denial of mental health problems), and identifying which male patients GPs felt were currently poorly served by existing mental health services. From these extensive discussions, we co-designed an approach (including which men should be targeted by the Atlas Programme, pathways into the Programme, and appropriate terminology such as 'stress' and 'well-being' as opposed to 'mental health' language). Dr Anna Cheshire, as the research fellow working on the evaluation, helped Prof Ridge to design the evaluation, with input from the Expert Advisory Panel. GPs were informed of the Atlas referral process, and experienced and senior practitioners (who had proven they could work in a 'male-sensitive' manner via a highly competitive interview selection process) were recruited (through appropriate routes such as professional magazines and online recruitment sites) to provide integrative/humanistic[1] counselling [63] and acupuncture to men. The Atlas Men's Well-being Clinic was physically based at the VMC GP Practice. Referrals were made to the Programme by VMC GPs, and inclusion criteria included:

- Male
- Registered patient at the VMC (or Lees Place surgery, a branch of the VMC)
- Aged 18 years or over
- Suffering from stress or distressed, including somatic symptoms presentation.

Exclusion criteria:

- Current substance abuse issues
- Serious mental health problems.

Patients could have up to 12 sessions of counselling and/or six sessions of acupuncture. Owing to funding restraints, this schedule was altered six months after the setup of the Programme to be up to six sessions of counselling if patients were also having six sessions of acupuncture (12 sessions in total, rather than the original 18). However, in exceptional circumstances, the option remained for patients to obtain additional counselling/acupuncture appointments if agreed by the patient's Atlas practitioner, the patient and the Atlas Service Director (Prof Peters). As the referral numbers built up, the

[1] Humanist therapy includes a broad range of approaches that take a non-medical, non-pathologising approach, treating the individual as unique, with a potential to grow, focusing on a holistic approach, where the therapist-client relationship is important.

Atlas practitioners made a staggered start over the first three months of the Programme, so that practitioner allocation could be increased as demand grew. Most practitioners provided two three-hour sessions a week. Most patients were seen within two to four weeks unless they chose not to: this compares very favourably to average waiting times in the NHS for mental health services, which can be over six months.

GPs decided in consultation with the patient which treatment(s) to refer patients to using a specially designed referral form for Atlas that was made available through the electronic patient notes system (EMIS, Egton Medical Information System). GPs recommended counselling to patients who would benefit from talking to a professional about their problems, and acupuncture to patients who could benefit from de-stressing, presented with somatic symptoms and/or who might be willing to subsequently engage in talking therapy following acupuncture. In addition, Atlas practitioners could cross-refer their patient to the other Atlas modality if they felt that would be helpful for the patient. All Atlas sessions were held on VMC premises, and patients were able to book their Atlas appointments through the VMC reception (in the same way they would book routine appointments). The option of providing online counselling (eg via video link, instant text relay) for men with this preference was discussed in the Programme planning phase. However, there did not appear to be any impetus from patients for this option, nor from GPs or counsellors, and so online sessions did not become a feature of Atlas.

Counselling

Patients referred to counselling received up to 12 weekly sessions (lasting one hour) of integrative/humanistic counselling. This approach meant that counsellors used a variety of tools appropriate for that patient, but always in a patient-centred way. During the first session, an assessment was conducted with the patient and an agreement to undertake a therapeutic counselling relationship agreed. Sessions were delivered by experienced counsellors (each had between five and seven years post-qualification experience). Two were male and one was female; all had experience in working with men and were able to demonstrate a male-friendly approach at interview (eg experience and successes with male clients, being 'male positive', understanding the specific concerns and the needs of men). Counsellors were all registered with professional bodies (The UK Council for Psychotherapy and/or The British Association for Counselling and Psychotherapy).

Acupuncture

Patients referred to acupuncture received up to six weekly sessions (lasting 30 minutes) of individualised Traditional Chinese Medicine (TCM) acupuncture treatment. Acupuncture sessions were delivered by senior acupuncturists: one male (11 years post-qualification experience, trained in traditional styles of acupuncture), and one female (17 years post-qualification experience, trained in TCM acupuncture). Both had experience of working in the NHS and with men, and were registered with the British Acupuncture Council. During the first session a full case history was taken along with traditional pulse and tongue diagnosis. From these, a treatment plan was developed to reduce patients' psychological and/or somatic symptoms, which could be adjusted each week depending on the patient's response to treatment.

The Evaluation

Methods: questionnaires

Bespoke questionnaires – designed in close consultation with our Expert Advisory Panel to include accepted scales – were used to collect predominantly quantitative data from patients pre-treatment (before attending their Atlas sessions) and post-treatment (on completion of all their Atlas sessions). Additional open text (qualitative) questions were included on the questionnaires. The following data were collected:

Anxiety and depression were measured using the Hospital Anxiety and Depression Scale, HADS [64]. The HADS measures both anxiety and depression and is quick and easy to complete. The two subscales each contain seven items. Each item is scored on a scale of 0 to 3, therefore scores range from 0 to 21, with higher scores indicating greater anxiety and greater depression. The HADS was designed to detect anxiety and depression in non-clinical populations. The HADS performs well in identifying and assessing the symptom severity of anxiety disorders and depression in the general population, and somatic and primary care patients; and provides recommended cut-offs for low, medium and high risk of anxiety and depression [65].

Perceived stress was measured using the Perceived Stress Scale (PSS)[66]. The PSS was designed to measure the degree to which participants appraise situations in their lives as stressful. Thus, the authors designed it to be a direct measure of the stress experienced by the respondent, not a measure of psychological symptomology. The 10 PSS items explore feelings and thoughts during the last month and respondents are asked how often they felt a certain way. Each item is scored on a scale of 0 to 4, which are summed to give a total score of between 0 and 40. Higher scores indicate increased stress. The PSS has established validity and reliability [66].

Positive well-being was measured using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) [67]. The WEMWBS is a measure of positive mental well-being encompassing items which assess both the hedonic (pleasure) and eudaimonic (virtue, using one's potential and skills) perspectives of happiness. We used the shorter seven-item version of the scale which not only is quicker to complete but may also be more robust than the 14-item version [68]. Items have five response categories (none of the time, rarely, some of the time, often, all of the time). Responses are scored from 1 to 5, providing a total score ranging from 7 to 35. The scale has established validity and reliability [67].

Patient-generated outcomes were also assessed, using the Psychological Outcome Profiles (PSYCHLOPS) [69]. The PSYCHLOPS is a patient-generated mental health outcome measure that has been developed for use before and after primary care-based talking therapy. It is based on the Measure Yourself Medical Outcome Profile (MYMOP) and comprises four main items: patients are asked to select then rate the severity on a six-point Likert scale of their two main 'problems'; patients are then asked to rate their functioning and well-being on six-point scales. Items are summed to provide a total score ranging from 0 to 20. The scale is less widely used than MYMOP, but it has been shown to be valid and reliable [70, 71] and has been approved by the plain English campaign.

Physical health was measured using an 11-point Likert scale anchored 0 (extremely poor) to 10 (Excellent).

Participants were also asked if they were using **anything to help deal with their stress** (ie prescription medication, over the counter remedies, alcohol, other).

To assess the Programme's cost implications, patients were asked about their **employment status, number of days off work due to illness**, and **health and social care service use** (service, private/public sector, number of visits), over the preceding 12 weeks.

On the pre-treatment questionnaire only **demographic data** (age, ethnicity) were collected and patients were asked **how they had first heard about Atlas**.

Qualitative data were collected via open-ended questions (providing free text boxes for answers) at the end of questionnaires. The pre-treatment questionnaire asked patients to name the main benefit they hoped to gain from attending.

The post-treatment questionnaire also asked patients about benefits; anything they had learnt from using Atlas; what they thought about practitioners and the service they provided; any improvements that could be made to the Programme; and if there was any other comments they would like to make about the Programme.

Participants

All patients referred to Atlas were invited to take part in the evaluation. In total, 142 patients were referred to the Programme, of whom 35 (25.3%) did not attend any appointments and five did not want to participate in the evaluation. Therefore data were available for 102 patients. See Appendix 1 for a flow diagram of how participants moved through the evaluation.

Procedure

On referral to Atlas by their GP, patients were asked to go to reception and pick up an evaluation pack and book their Atlas appointments. Evaluation packs comprised a covering letter, patient information sheet, consent form, pre-questionnaire and stamped addressed envelope for returning the questionnaire to the Evaluation Team. Patients could return their completed pre-treatment questionnaire and consent form to the Evaluation Team prior to their first session, either through the post or via VMC reception (there was a box behind reception where completed questionnaires could be left for the researcher to pick up). Patients were sent their post-treatment questionnaire by the researcher once they had finished using Atlas (ie completed all their counselling/ acupuncture appointments or withdrawn). Identical copies of the questionnaires were also available to be completed online, according to patient preference. Questionnaires did not use patient names, rather date of birth and initials for identification.

Ethical approval for both parts of the evaluation (patient outcomes and stakeholder perspectives described below) was obtained from the University of Westminster Research Ethics Committee. An application was made to NRES Queries, who confirmed on 17 July 2012 (ref 04/26/50) that NHS ethical approval was not required due to the service evaluation nature of the study.

Data analysis
Quantitative data were analysed using SPSS version 19. Statistical significance was set at the 5% level. To ensure a conservative analysis, non-parametric tests (Mann Whitney-U, Wilcoxon Signed Rank, Kruskal-Wallis, McNemar and Chi-square as appropriate) were used throughout. Initially, data were examined for differences between those who did and did not return their post-treatment questionnaire on baseline variables. To examine patient outcomes Wilcoxon Signed Rank tests were used to compare pre- and post-treatment data including the HADS, PSS, PSYCHLOPS, WEMWBS and physical health. Effect sizes were calculated by dividing the z value by the square route of N. Magnitude of effect sizes were established using the Cohen [72] criteria of 0.1 = small effect, 0.3 = medium effect and 0.5 = large effect. Differences in patient outcomes by treatment received (ie acupuncture, counselling or both) were not examined due to insufficient numbers in the treatment groups.

Percentage of participants experiencing a clinically meaningful improvement for the HADS was determined using the recommended change of 1.5 points on each subscale [73].

Qualitative data collected from open-ended questions on the questionnaires were analysed using thematic analysis [74]. The researcher (Dr Cheshire) immersed herself in the data, highlighting key sections of text and words. An initial list of themes/codes was developed and then organised into themes to create a final coding list. Data were inputted and explored in the qualitative data analysis software environment, NVivo [75]. All data were assembled into themes, and full reports on themes were analysed and debated with Prof Ridge, in order to arrive at conclusions that explained all the data. Typical quotes are used to illustrate findings.

For the cost implications, the costs of service use and the cost of lost employment were estimated for both the 12-week period before the baseline visit and the 12 weeks prior to follow-up. Public sector unit costs for services were obtained from the Personal Social Services Research Unit 2013 report, *Unit Costs of Health & Social Care 2013* [76], and the *2012/3 National Schedule of Reference Costs for NHS trusts and NHS foundation trusts* [77], produced by the Department of Health. Private sector unit costs were estimated from web searches. Unit costs were multiplied by the number of hours of use of each service to estimate the total costs. Based on estimates of annual salaries, the cost of lost employment was estimated by multiplying the daily salary by the number of days lost to illness for those who reported time off work.

The baselines cost for those who completed the follow-up questionnaire were compared to those for participants who did not return for the follow-up questionnaire, to determine if there was a difference in terms of service use and/or lost employment costs. These differences were tested statistically with t-tests. Paired t-tests were then used to examine the difference in the estimated costs between baseline and follow-up, the null hypothesis being that there was no change in costs between baseline and follow-up. The change in costs between baseline and follow-up were then divided by the change observed on each of the study's clinical outcome measures to estimate the cost per unit change for each measure.

Methods: interviews

Participants

Stakeholder interviews were conducted with a range of 14 professionals involved in the Programme including Atlas practitioners, VMC GPs, VMC administration staff and other VMC practice staff. Interviews were also conducted with six men using the Atlas Men's Well-being Programme; two men had received counselling only, one man had received acupuncture only, and three had received both acupuncture and counselling.

Procedure

Participants were invited to take part in the evaluation and the interview was arranged at a time that was convenient for the patient. Interviews took place at the VMC (n=17), at the University of Westminster (n=2) and at the participant's place of work (n=1). For stakeholder interviews, a semi-structured interview schedule was used to elicit their views and experiences of the Programme. Topics included ways in which Atlas had been helpful/unhelpful for patients, accessibility of Atlas, the importance of having a male only service, working with Atlas practitioners, and ways the Service could be improved. A narrative approach was adopted, whereby men were encouraged to tell their story from shortly before they entered the Atlas programme and continuing to the present day. Additional topics included experience of the Programme, benefits of the Programme, problems encountered, helpfulness to patients, accessibility of the Programme, having a 'male-only' service and suggested improvements to the Programme. Informed consent was obtained from all participants. Interviews lasted from 10 and to just under 60 minutes. Interviews were recorded, but for two of the stakeholder interviews, notes were taken due to failure of the recording technology.

Analysis

Interviews were transcribed verbatim by a professional transcriber who signed a confidentiality agreement, and the data were analysed using thematic analysis [74] (See analysis section above for the analysis procedure). Participants are identified with a number to protect anonymity, a prefix of 'P' is used for patients and 'S' for other stakeholders.

Evaluation findings – patient outcome data

The aim of this part of the report is to present Atlas patient demographics, programme use statistics and information on patient outcomes (eg changes in anxiety, depression, well-being).

Participant characteristics (n=102)

As can be seen in Table 1 below, there was a wide spread of ages and a mix of ethnicities attending Atlas and participating in the evaluation. Nevertheless, Figure 2 shows the spread of ages is skewed towards the younger and middle age groups. The range of Atlas patients' ethnicities is similar to the ethnic profile of patients registered at the VMC (Table 1). A relatively high proportion (18%) of participants were unemployed, compared with the national and London unemployment rate, which were just over 6% in September 2014 [78] (although unemployment rate is classed as those actively seeking work and claiming Jobseeker's Allowance, the actual unemployment figures will be somewhat higher, as not everyone who is unemployed claims the Allowance). This

finding suggests that socially marginalised men are being reached by Atlas, which is important given that unemployment is a risk factor for suicide [7].

Two-thirds of participants were taking medication/drugs to help deal with their stress/distress, the most popular of which were prescription medication and over the counter remedies. Nearly one fifth were using alcohol to help them cope (see Table 2).

Levels of anxiety and depression pre-treatment were examined, using HADS data. Figures show that patients referred to the services were suffering from a wide range of levels of anxiety and depression, however anxiety was much more prevalent in this population than depression. This reflects the remit of the programme, which was tailored for patients suffering from everyday 'stress or distress' rather than diagnosable depression (see Figure 3).

Table 1 – Participant statistics

Age (years)		mean 41.5 range 18-84
Employment		
Paid or self-employed		74.5%
Voluntary work		2.0%
Unemployed		17.6%
Student		6.9%
Retired		3.9%
Exempt through disability		3.9%
Other		3.9%
Ethnicity	VMC patients	Atlas patients
White – British	44.3%	48.0%
White – European/other	29.0%	26.7%
Black/Caribbean/African	6.9%	7.9%
Asian	10.8%	3.9%
Arabic	0.8%	3.9%
Mixed	3.0%	3.9%
Other	5.3%	3.9%
Missing	-	2.0%

Figure 2 – Histogram showing the age distribution of Atlas participants

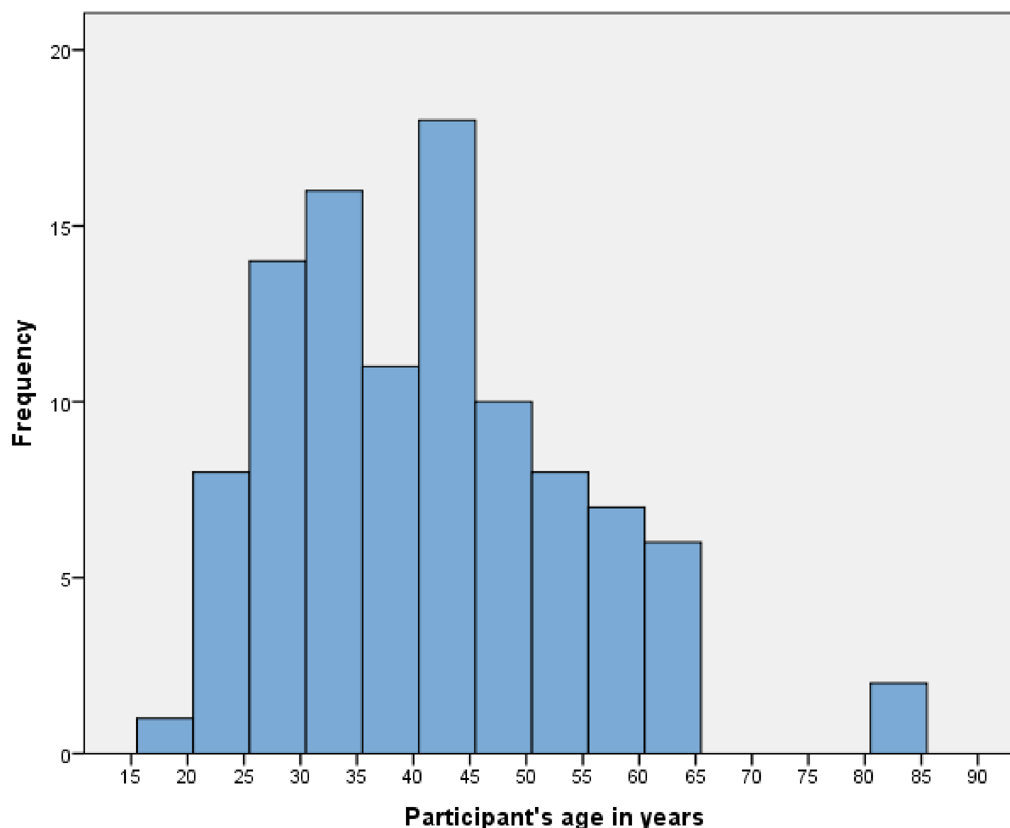
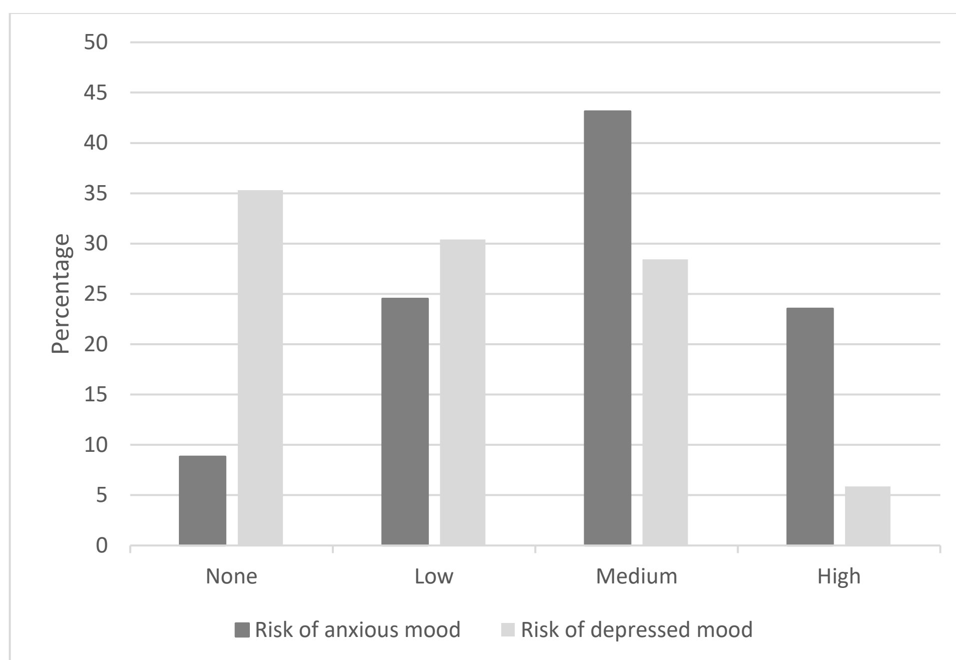


Table 2 – Medication and drugs taken by patients to manage distress, in the two weeks prior to commencing their Atlas sessions

	Percentage of patients
Prescription medication	37.3
Over the counter medication/remedies	24.5
Alcohol	18.6
Illegal drugs*	2.9
Smoking*	2.0
Other	2.0
None	33.3
Missing	5.9

*likely to be under-reported as use was self-reported under the 'other' option, rather than being a specific tick-box option on the questionnaire (see page 10). The Atlas External Advisory Panel requested that participants were not directly questioned about illegal drug use.

Figure 3 – Risk of anxiety and depression in patients prior to commencing Atlas sessions, by percentage



The Atlas Programme (n=102)
Patients were asked how they first heard about Atlas. Overwhelmingly patients had initially heard about the Programme through their GP (88.2%), rather than through the Atlas publicity made available throughout the surgery – leaflets (4.9%), posters (1.0%). This highlights that with promotion from a lead GP 'champion,' and consultation with GPs and other practice staff, GPs readily referred stressed/distressed men into Atlas. The results here also highlight the importance of the role of GPs in encouraging stressed/distressed men to seek help.

Table 3 shows which treatment Atlas patients received (counselling, acupuncture or both). While both treatments were popular, counselling was more commonly used by patients. Prior to the commencement of the Programme, it had been expected that an ostensibly non-talking therapy (acupuncture) would be the more popular option. The popularity of counselling in this setting confirmed that, contrary to popular wisdom, men do want to talk about their problems and emotional difficulties.

Table 3 – Treatments received by Atlas patients

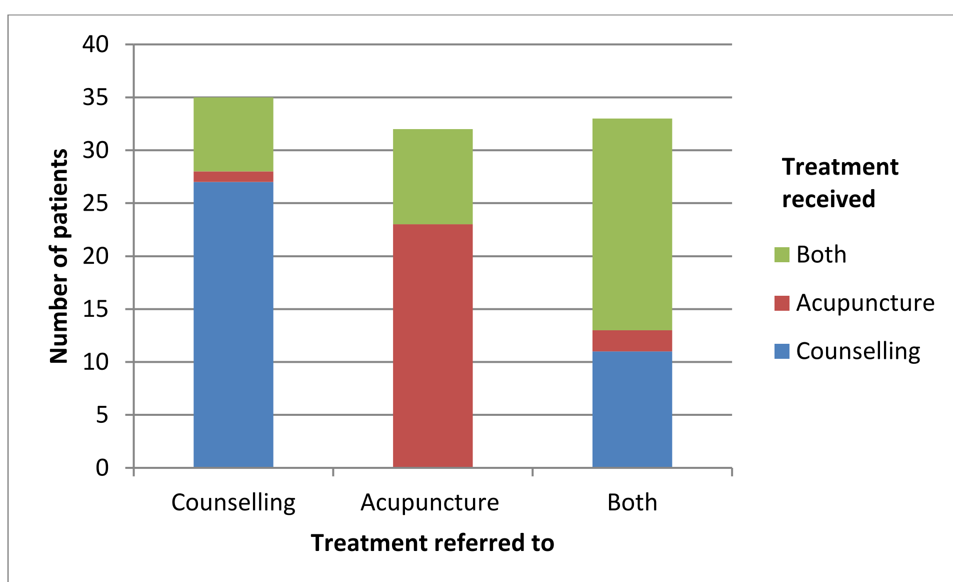
Treatment received	Number	Percentage
Counselling only	39	38.2
Acupuncture only	26	25.5
Counselling and acupuncture	37	36.3

Those receiving counselling had an average of 8.0 sessions (standard deviation: 4.5; range: 1 to 23). Those receiving acupuncture attended an average of 5.5 (standard deviation: 2.0; range: 1 to 11) sessions. These figures suggest there was much more variability in the number of counselling sessions that patients attended compared to

acupuncture, as acupuncture patients were more likely to have their full quota of sessions. There were no statistically significant differences between treatment received (counselling, acupuncture and both) and demographic variables and baseline psychosocial well-being scores. This finding suggests that patient demographics and levels of distress were not related to choice of treatment.

To understand how patients used the Atlas counselling and acupuncture treatments, we examined the routes Atlas patients took through the Programme. The Atlas programme had a flexible structure so that if patients were referred for one treatment, but the Atlas practitioner felt that the patient would benefit from another Atlas treatment, as well as or instead of their own, they could cross-refer. Additionally, patients may have been referred for both counselling and acupuncture, but only attended one in the end. Figure 4 shows that the routes patients took through Atlas varied: many patients received the actual treatment they were referred for (73.1%). However, over a quarter received a different treatment: 15.9% were referred for one treatment but ended up having both (cross-referrals between Atlas practitioners), 9.7% were referred for both treatments but only attended one – and this one was nearly always counselling, reflecting qualitative reports that counselling made more intuitive sense to stressed/distressed men.

Figure 4 – Treatment routes taken through the Atlas programme



Patients were asked what they hoped to get out of attending the Programme. For many, their primary goal was to reduce their psychological symptoms, most commonly anxiety and stress, but also depression, panic attacks, anger and other difficult mind-body states. A reduction in physical somatic symptoms (eg pain, tiredness, sleep problems, headache) was also commonly cited, as well as, or instead of, psychological symptoms.

> *"I hope this will help with my constant stress and anxiety." P28*

> *"Hopefully ease the constant pain and depression." P15*

In contrast to a reduction in symptoms, others talked about the benefits they wanted to gain from attending sessions, including positive psychological states (eg relaxation, calm, peace, happiness, and confidence), improvements in functionality (eg focus on study, progress career, perform everyday tasks), and a return to 'normality' (eg get old life back, do normal work tasks).

> *"Calm and peacefulness – relaxed." P97*

> *"To regain confidence to allow me to get my old life structure back." P73*

For many patients, the primary focus was on increasing their understanding of their symptoms and how to manage them. This included learning techniques and information on how to better deal with their problems. Desired skills and knowledge included relaxation techniques, anger/stress management, understanding themselves better, or gaining some perspective. A smaller but significant number of men said that they specifically wanted to talk through deeper issues and problems and to create the 'space' in which to do this.

> *"Understanding stress triggers and how to deal with them." P109*

> *"Help me build confidence in my own strengths and become less confrontational, anger/stress management." P31*

> *"Opportunity to talk about many emotional issues." P18*

Two patients said that they didn't know what they hoped to get out of attending Atlas and were just going because their GP felt it would be helpful. One patient wanted 'professional' help, another hoped to get a name for his particular psychological condition, and another wanted a 'holistic' treatment for his problem. A small number mentioned specific issues that they wanted help with (e.g. relationships, death of wife, drink).

> *"I don't know yet. GP feels that I could benefit from it." P14*

> *"Talking out my problems about my relationship and drink." P93*

Patient outcomes

Of the 102 patients who completed their Atlas pre-treatment questionnaire, 82 (80.4%) also completed their post-treatment questionnaires. Statistically significant differences were found between responders and non-responders on age (p=0.002), and pre-treatment physical health (p=0.012), depression (p=0.037), perceived stress (p=0.027) and positive well-being (p=0.008). Specifically, those who did not complete their post-treatment questionnaire were younger and had poorer physical health and psychosocial well-being. All statistical analyses were based upon the 82 completed data sets.

Changes in anxiety and depression

Comparisons between pre- and post-treatment revealed a statistically significant improvement in anxiety (p <0.001), with a medium effect size (r=0.38). There was no

change in depression (p = 0.660), see Table 4. However, as over a third of patients did not have a problem with depression (classified as at no risk of depression, see Figure 3), a sub-analysis was conducted comparing levels of pre- and post-treatment depression excluding patients with no risk of depression from the analysis. Comparisons of patients at risk of depression (ie low, medium or high risk of depression, n=50) revealed a statistically significant improvement in depression among this group of patients (p <0.001). This suggests that patients who entered Atlas with depression did experience an improvement in their mood.

Applying the change score of 1.5 points for minimally important change (insert ref), 46 (56%) patients experienced a clinically meaningful change in their anxiety and 37 (45.1%) patients experienced a clinically meaningful change in their depression. These figures should be interpreted with caution as the recommended change scores used for this calculation are based on patients with chronic obstructive pulmonary disease who have lower HADS scores than patients in this study [73].

Table 4 – Anxiety and depression scores (HADS) pre- and post-treatment

	Pre-treatment Median (interquartile range)		**Post-treatment Median (interquartile range)**		**p-value**	**Effect size**
HADS – anxiety (range 0-21 ↑ = worse)	13.0	(9.0-15.3)	9.0	(8.0-12.0)	<0.001	0.38
HADS – depression (range 0-21 ↑ = worse)	9.0	(6.0-11.0)	9.0	(6.0-11.0)	0.660	NA

Changes in other study variables

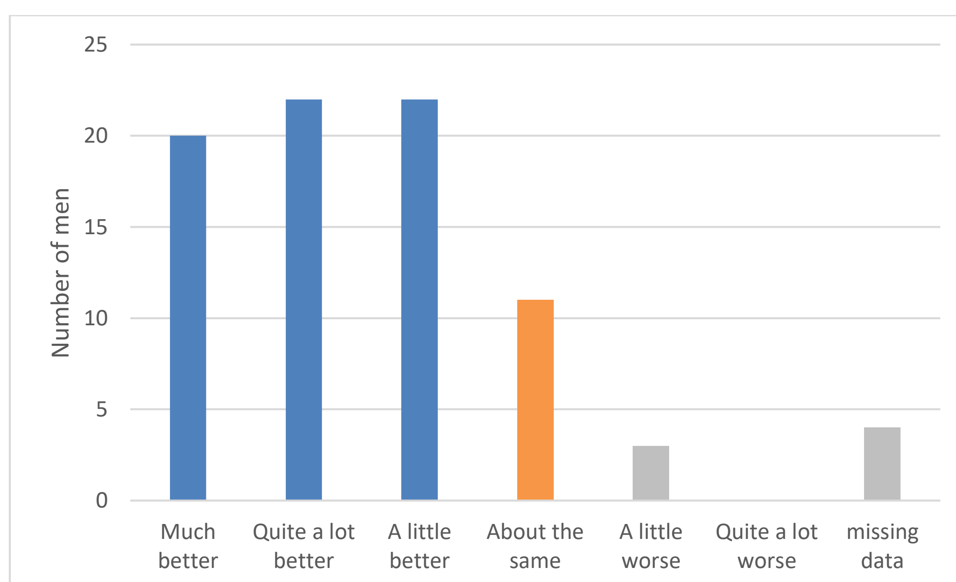
Comparisons between pre- and post-treatment revealed a statistically significant improvement in perceived stress (p<0.001) with a medium effect size (r=0.36); PSYCHLOPS (p=<0.001) with a large effect size (r=0.57); positive well-being (p=<0.001) with a medium effect size (r=0.40); and physical health (p=0.001) with a medium effect size (r=0.38), see Table 5. The effect sizes seen in the Table suggest that there can be reasonably good change in the study variables for men after taking part in Atlas.

Table 5 – Study variable scores over time pre- and post-treatment

	Pre-treatment Median (interquartile range)		Post-treatment Median (interquartile range)		p-value	Effect size
PSS (range 0-40 ↑ = worse)	24.0	(21.0-28.3)	19.0	(12.0 - 24.0)	<0.001	0.36
PSYCHLOPS (range 0-20 ↑ = worse)	16.0	(14.0-17.0)	8.0	(5.0-13.0)	<0.001	0.57
WEMWBS (range 7-35 ↑ = better)	20.0	(16.0-23.0)	25.0	(20.0-28.0)	<0.001	0.40
Physical health (range 0-10 ↑ = better)	7.0	(5.0-7.0)	7.0	(5.0-8.0)	0.001	0.25

An additional question on the PSYCHLOPS post-treatment questionnaire asks: “Compared to when you started your sessions, how do you feel now?” As can be seen in Figure 5 below, the majority of men felt better than they had prior to starting their Atlas sessions: 64 (78.0%), with 11 (13.4%) not feeling much different and only three (3.7%) feeling a little worse.

Figure 5 – Compared to when you started your sessions, how do you feel now?



Evaluation findings – patient and stakeholder perspectives

The aim of this part of the evaluation was to report on qualitative data from patients and stakeholders regarding their views and experiences of the Atlas Men's Well-being Programme. These perspectives provided a more in-depth look into the benefits of the Programme and how it was functioning. A report of the initial findings from the stakeholder perspectives was distributed in July 2011; the aim of this report was to feedback issues identified by stakeholders, to help fine tune the Programme.

Data for this section of the evaluation comes from three sources:

- Stakeholder interviews
- Interviews with men using the Programme
- Qualitative data from open-ended questions on the post-treatment questionnaires.

Findings in this section are structured around the following themes: Benefits to patients, Therapeutic relationship, Functioning of the Atlas Men's Well-being Programme, A male-only service, and Counselling and acupuncture.

Benefits to patients

Supporting the quantitative findings, men using Atlas reported a number of psychological and physical benefits they had gained from attending the programme. Dominant themes included reductions in anxiety and stress, and improvements in positive well-being, particularly improved relaxation.

> *"The counselling settled my mind about family problems. And the acupuncture helped to make me more relaxed and less affected by stress effects." P6*

> *"Lower levels of anxiety. Satisfaction at having worked through issues of concern and reached a reasoned conclusion on the best way of progressing." P40*

Qualitative data also enabled understanding of reported psychological benefits in more detail. Many men reported an improvement in understanding and awareness of themselves and/or the situation that they found stressful, which included realising just how bad their problem had become in some instances.

> *"The realisation that I was suffering from serious stress, which I wasn't addressing and how to stop that happening in the future. I got a much-needed sense of perspective and was able to see that things had become almost unbearable in terms of not communicating how I was feeling." P109*

> *"It helped understand the reasons behind thoughts and emotions I had been experiencing. This led to a better acceptance of my moods/worries." P13*

> *"Helped me to understand myself better – ideally what's important to me, what makes me special, who I am. Helped to identify my strengths and what makes a brilliant person. It was the first step on the road to recovery." P22*

Some men also described a sense of 'release' from feelings and situations.

> *"Being able to talk openly about various thoughts, ideas and worries gave me a tremendous sense of release and in many ways made my thought processes a lot clearer in general." P12*

Men reported improved coping and management techniques for their problems/stress. Some had learnt new skills and/or taken up new hobbies (eg mediation, painting) as a result of attending sessions. Others reported the importance of 'caring' for themselves.

> *"To be kinder to myself. To focus on the here and now and not imagine things which may never happen. To avoid too much wheat and diary." P17*

> *"To let situations distil themselves before reacting – to be a better communicator and listener." P27*

> *"I have begun learning /practising meditation." P13*

Also reflecting the quantitative data findings, qualitative reports of change in depression were fewer.

> *"[Acupuncture practitioner] found ways of exploring my depression which were helpful, even though I sought only treatment via acupuncture." P79*

Commonly reported physical benefits from attending Atlas sessions included improvements in sleep, stomach problems (eg IBS, pain), circulation, pain, fatigue and night sweats.

> *"Better sleep patterns. Decrease in the occurrence of night sweats." P113*

> *"Settled stomach, less pains in back and shoulder." P66*

Men also discussed what it was about the Programme that had particularly helped them. This included the importance of being able to talk through their problems/express themselves and of being listened to. One interview participant specifically commented on how this type of service was much more helpful than the Cognitive Behavioural Therapy (CBT) that he had previously received. Some men reported that this talking/emotional expression was helped by the professional, independent and objective status of practitioners. Others valued the discreet and confidential nature of the Programme. The opportunity to talk about themselves was also valued within the acupuncture consultation, not just counselling sessions.

> *"It was great to have someone independent from the situation to talk to and get objective feedback from. The action of talking about issues is itself a therapeutic process and helps one understand." P2*

> *"Gave me the opportunity to air vividly attitudes I've kept inside." P37*

“Acupuncture – excellent, very thorough questions, even answering those questions felt therapeutic.” P17

Although the importance of being able talk and express oneself in sessions was highlighted, some participants also described finding it difficult and uncomfortable, at least initially, to do so.

“The initial consultation was quite terse.” P80

“It was hard going at times, especially talking about the inner me in a ‘releasing’ as opposed to an ‘academic’ way.” P32

A small number of men reported that talking alone was not helpful or not the whole solution. These patients wanted support that was more instructive, structured or directive (including CBT).

“Just talking about yourself doesn’t help much, patients need to receive feedback from [the] counsellor.” P62

“Possibly give weekly tasks, like maybe you should think about this or maybe you should do this or maybe, rather than being, because [counsellor] was quite passive about it, and I understand that’s his role.” P35

Therapeutic relationship

Patients had many positive things to say about their Atlas practitioner (counselling and/or acupuncture). Many felt that practitioners presented with a good balance of professionalism and knowledge, but were also approachable and friendly. Human qualities of practitioners were particularly valued, such as kindness, caring, compassion, empathy and warmth.

“[Practitioner] was excellent, both in skill and in manner. They were thoroughly professional yet warm in conversation.” 79

“Excellent skill set; experienced and calm. Fantastic and professional at all times. Kind and helpful, patient, caring; interested and engaged, efficient and business-like, spot on, top of their fields.” P7

Some patients commented on how these practitioner qualities had enhanced the therapeutic process by, for example, allowing men to feel safe when talking about difficult issues, going at the right pace, and enabling men to think about their situation in a constructive manner.

“A good blend of professional and approachable. I guess these things can be a little strange at the beginning (especially if you are not pre-disposed to talking about your issues such as I), but she made me feel comfortable early and established credibility and trust early too. This helped develop the relationship quickly, which in turn helped get maximum benefits from the conversations.” P2

"The practitioner never led, but rather helped and supported me: the practitioner enabled me to start thinking about my situation not just during the sessions themselves but also between the sessions, which were in many respects when I really started to make progress." P5

"I felt someone was giving me 'empathy'; this has helped me to express deep felt frustrations." P96

While all these men stressed the importance of the distinctive therapeutic relationship, a very small number of men felt they had not connected with their counsellor and their style of counselling and that this had hindered their session attendance.

"My counselling sessions did not go very far as I felt that I was not getting a lot from therapy, so I stopped going. I did not want to offend the person by speaking out, although I felt he was not digging in to help me get out the stuff I wanted to deal with." P97

Functioning of the Atlas Men's Well-being Programme

The overriding opinion among stakeholders was that the Atlas Men's Well-being Programme functioned well. When men were asked about any improvements to the Programme, many said that they could think of no improvements that could be made. For professionals, challenges included pressures on room space in a busy GP practice, lack of clarity regarding which health professionals were able to refer to Atlas (eg nurses, IAPTs practitioners, VMC in-house counsellor) and appointment booking for reception (eg large number of appointments to book at once). While many patients specifically commented how easy booking had been and how helpful reception were, a small number reported challenges with appointments including booking, availability, checking in and cancelling.

"There did appear to be a disconnect between the reception and the practitioner in terms of contact/communication. One morning I tried to cancel the appointment due to illness and there was no one to take my call in the surgery. Either that or the phone line wasn't working." P2

Some GPs felt they would like more feedback than they had received regarding their patients they had referred to Atlas. The Atlas practitioners responded to this feedback by writing one or two lines on the EMIS patient records system about patient's progress after each appointment, written in a way that they perceived would honour client/counsellor confidentiality.

"Just some information about how the patient's got on with it really. How they found it, what they've had done or whatever it is because sometimes when I get letters back about patients I like to be able to look up what I've seen them about, and that helps me in my medical knowledge and how to deal with other patients with similar problems." S9

Referrals to the Programme were appropriate according to stakeholders. They felt that the referral system had been clarified by the consultation with GPs prior to the Programme beginning. Additionally, due to a pre-existing counselling service at the VMC,

GPs already had experience of the kinds of presentations that would benefit from counselling. Referrals covered a wide age range, but were initially predominantly middle class, younger men (under 50) and White ethnicities. GPs were encouraged to make more diverse referrals to the Programme, where appropriate, which they did. Although Atlas did not make provision for self-referrals, many of the GPs interviewed supported the notion of self-referral to Atlas. Other stakeholders suggested more integration with existing psychological services (eg a single point of referral for GPs to all well-being services, such as Atlas, counselling and IAPTs, where a counsellor/psychologist then made the decision about which well-being treatment would be best for patients).

> *"I think the self-referral. … We don't write a huge amount on that form anyway other than name and address and they fill that in. And then I also think the advantage of self-referral is it shows willingness to book appointments and your DNA rates and all those sorts of things." S10*

One of the main issues raised by patients was the limited number of sessions they were allowed. Many men wanted to continue with their weekly sessions past their allotted number or to have follow-up/maintenance sessions at a later date. Some men felt that they still had more to work on post-sessions, or that counselling sessions raised deeper issues that could not be fully resolved in their allocated number of sessions. Some men discussed how ending sessions was challenging.

> *"It came to an end while I felt it was very much a work in progress." P111*

> *"While realising NHS cost problems, still the limited period is somewhat nerve-racking especially towards the end of the series." P37*

> *"I would have benefited from further sessions until my well-being was restored. We worked to a limited [degree] (this was extended once) but an open-ended approach would improve the programme possibly moving from once per week, to bi-monthly then monthly, quarterly etc. A future review would also be beneficial." P7*

The out of office hours timing of appointments was helpful for patients, although a small number said they would have liked even more availability at weekends as these time slots were popular and filled up quickly.

> *"The fact that it was free was marvellous, as was the fact that it was made available on the weekend." P2*

> *"For people who work full-time, it is not easy to book an appointment on Saturday." P53*

Some men said they would have liked more information – either during or at the end of their sessions. Some of this desired information was about understanding the treatment/therapy and what it offered, while other clients wanted more sources of support, help and advice. A few men discussed the drawbacks of receiving interpersonal therapies like counselling and acupuncture in a clinical setting.

"I felt that the medical clinic for the counselling sessions was not ideal. Particularly the way the chairs were arranged in the room – we were seated face to face, I felt the setting was somewhat 'confrontational' and often made me uneasy. Perhaps a less 'clinical' environment can be considered. I think a better way to conclude both the acupuncture and counselling sessions would be helpful. Perhaps some information on how we can continue these therapies on our own, whether in the forms of recommended literature or other services available. I felt the ways the sessions ended were a bit abrupt." P27

"The environment, in a medical setting is slightly constraining, cold." P37

"More detailed hand-out on the methodologies and aims/practices of counselling and acupuncture." P32

A male-only service

One of the aims of this evaluation was to understand how to engage and support men to improve their psychosocial well-being. Thus, the data collected by this evaluation examined the significance of having a male-only service and if this helped to engage men. The patient questionnaire did not specifically ask about this topic and only a small number (two) of participants wrote about the importance of having a male-only service on their questionnaires:

"I think it is important that men are being offered alternative ways to look after their health." P53

"The clinic (or the services/focus on men's health) should be made available all the time through the GP's office (and the doctors coached on utilising them). It is very helpful to know that there are treatments available for men's health (stress) related issues." P104

Interview participants and stakeholders were specifically asked about what they thought of having a male-only service. In interviews, men said that Atlas being a male-only service had not occurred to them personally (a GP referral was the most likely route to Atlas). However, they agreed that there was an unmet need for male mental health services, and felt that having a male-only service may improve access for other men.

"I didn't even notice, no. No, well you don't really see anyone, you don't really see anyone else, so you don't notice, you don't know. I think it's a good idea from your end, from the clinical end, because I know for a fact that young, lots of young males do have to get over a hurdle mentally before they go and seek any counselling, and that is a problem. And these kind of services, so those kind of services need to exist in the fact that they're there for young men, these young men often think they don't need any help from anyone, stupidly. So that's a, it's good that it's there, for that purpose, but I, and I think that's good, but I didn't take anything from it." P1

Stakeholders felt that having a male-only service sent an implicit message to men that validated their emotional needs and normalised the idea of talking to a counsellor.

“I’ve always emphasised that it’s men only. That seems to have gone down well. Even the name, the Atlas and the carrying the weight of the world and being a man about these things, but you can talk to somebody about it. … I think you’d lose something, personally, if you didn’t make it a man’s service, it makes them feel that this is important. This is just for me and my kind and these are the steps that I need to take.” P11

Stakeholders also felt that Atlas attuned practitioners and GPs to the emotional needs of men, enabling them to support men more effectively. However, some stakeholders felt that the service should also be available to women.

“Hones the GP, or myself, into thinking more about male stress. Whereas maybe you, we’ve got so many other things to think of in a consultation, but perhaps it just makes you think about it. So the whole publicity and marketing of it, and the whole discussion with all the doctors, and having everybody behind you and everything like that, isn’t just about providing the service. It’s also made us more aware, made us think more about it.” S1

“So my energy when I’m working with just men, it allows me to access parts of me that I feel work better with, with male clients. So it enables me to focus on that, so if I’m seeing just men, then I can be in a different energy, in a more male energy, and then that keeps me in a place of kind of understanding.” S5

“Because maybe females might have benefitted as well, I don’t know, in the whole acupuncture, and being able to have the different types of therapy because I’ve actually assessed a lot of females with work-related stress and bullying.” S13

Acupuncture and counselling

When discussing an Atlas referral with their patients, GPs had often found that while patients felt that counselling could help them with their problems, they sometimes found it difficult to understand the benefits of acupuncture for their issues, and needed persuading to attend their acupuncture appointments. This finding is supported by the figures in Table 3, which show that when referred for both counselling and acupuncture, 33% of these patients only attended counselling sessions (whereas only one patient (3%) only attended acupuncture).

“I think counselling is something a bit tangible. They’ll talk about it, there’s a beginning, middle and end and we come to some arrangement. They might not know what that is, but that adds the sort of feeling they have. Whereas acupuncture, I’ve had a few turn around and say well, how’s it going to help?” S11

However, this was not the case for all patients; one patient described how acupuncture was useful to help him manage what he was experiencing, and he felt that talking would not change his situation:

“[Acupuncture] sort of helped release the pressure and the pain a little bit, it took my mind off it, because it’s constant. … [Counselling] is not, nothing’s going to change, my counselling, nothing can help. I know what I’m doing and talking about it is a waste of time to me.” P15

The acupuncturists and counsellors within the Atlas team enjoyed working as part of a team, accepting and making cross-referrals, learning about each other's modalities, and working with patients who also received the another treatment modality.

> *"I find them very good, actually, it makes me feel comfortable, and kind of proud that I'm in, in a team where there's other practitioners who are just, just very keen and interested and enthusiastic, yeah, so that's been really good. … I think this was an instance where probably the acupuncturist saw that, and had an intuitive sense that this patient could benefit from counselling, and they were 100% right." S5*

Atlas practitioners found the synergy between acupuncture and counselling to be interesting and felt that it was potentially helpful for patients to receive both modalities. For example, both counsellors and acupuncturists stated that patients were sometimes able to open up more in counselling sessions if they were having acupuncture. Other times acupuncture was able to help patients cope with the emotional demands of counselling and feel relaxed after counselling sessions.

> *"It's very subtle. They begin to loosen up a bit, as it were. And you think, oh they're more engaged. Then they'll say 'I've had acupuncture' not that I've necessarily asked them, but it comes up. I've just had acupuncture, and so that's fascinating." S3*

> *"One chap for example, before he goes into counselling he's quite calm and quite relaxed, and then he has a counselling and he says, after the counselling he feels really agitated. I've seen him walk out and being very agitated and quite concerned and just a very intense look on his face. Whereas when he's had the counselling first he comes in [for acupuncture] quite agitated and he leaves completely calm and he prefers it that way round. But I would do different treatments because one is kind of me treating him and the other one is me treating him after he's had a counselling session. And they're two different things. Same person but different things. And some people talk more, actually the same chap, he says he talks more in the counselling session if he's had the acupuncture beforehand." S2*

One acupuncturist appreciated knowing that an experienced colleague would be able to work with a patient on any more challenging emotional issues that may come up in acupuncture sessions. Another found the exact benefits of interdisciplinary work could sometimes be difficult to articulate.

> *"It seems to work well together, because I have seen quite a few patients who've been seeing the acupuncturist as well. But now details of, of how, how effective it is together I don't know, but it seems to be working." S5*

> *"I've been able to touch upon stuff and then know that it can be referred on to people with more expertise in dealing with emotional stuff, which it by and large is, without worrying about getting in too deep, too deep water myself." S4*

However, acupuncturists felt that, as acupuncture was not usually provided within the NHS, it was important for counsellors to personally experience it. This was to ensure a fuller understanding of the modality and the experiences of their clients who were also having acupuncture. In addition, working jointly with patients brought up some boundary issues for counsellors, who viewed patient confidentiality differently from acupuncturists (ie between patient and counsellor versus within a professional team caring for the patient).

> *"There was some difficulty for myself initially of again maintaining my clinical boundaries in terms of I'm a professional, you're the provisioner, these are my boundaries, you have your boundaries and sort of overcoming that, some clients may want to talk excessively." S3*

Two patients specifically said that they thought the combination of counselling and acupuncture was useful. One of the patients went into more detail about this:

> *"Having had the opportunity to participate in both the acupuncture and counselling sessions did help very much. They both helped me in very different ways. I think offering both to patients would be very helpful. … With [acupuncturist] we shared common interest in Chinese cultures particularly with meditation and food, so going to the acupuncture sessions were very enjoyable. Due to the nature of the counselling sessions which relied often on discussing issues which were more difficult, I felt the sessions with [counsellor] were a lot more tense, but I felt these had a more significant impact on me – in a positive way." P27*

Qualitative conclusions

Qualitative data from patients and stakeholders support the quantitative findings pointing to improvements in men's psychological and physical health as a result of attending Atlas, providing further details on how men improved their understanding, awareness and coping. Results also showed that some men valued talking, finding it both helpful and challenging; while other men wanted a more structured and directive approach to helping them with their problems. Findings also highlight the importance of practitioner qualities and the therapeutic relationship on men's experience of the Programme. The relational nature of the sessions – and deeper problems presented by men – meant that many men felt they would have benefited from ongoing sessions, and thus 'short-termism' in mental health care needs addressing. Generally, the Atlas Programme functioned well, with challenges around pressures on room space in the busy GP practice; some lack of clarity regarding which health professionals were able to refer to Atlas; appointment booking at reception; and patients wanting more appointments than the Service was able to offer. Professional stakeholders felt that having a male-only service sent an implicit message to men that validated their emotional needs and normalised the idea of talking to a counsellor, and attuned practitioners and GPs to the emotional needs of men. Other stakeholders felt the Service should also be available to women. There was less in men's narratives that suggested that having a male-only service was personally important to them, although they believed that other men could benefit from such a service. Often counselling made more sense to patients than acupuncture, in terms of how it could help them with their problems. Data suggested an interesting synergy between counselling and acupuncture; having acupuncture may help

patients to be more 'open' in counselling sessions, or acupuncture may help relax patients after a challenging counselling session.

Evaluation findings – cost implications

An examination of the cost implications related to Atlas was undertaken. No statistically significant differences were found between responders and non-responders (to the post-treatment questionnaire) on baseline costs related to health and social care, or lost employment in the 12 weeks prior to starting Atlas (Table 6).

Findings from the cost analysis point to reduced costs related to health and social care utilisation post-treatment (in the 12 weeks prior to finishing Atlas) compared to pre-treatment (with the 12 weeks prior to patients starting Atlas sessions). In addition, costs related to lost employment were greater pre-treatment, compared with post-treatment. Findings also indicate that the reductions in these costs exceed the cost of the Atlas counselling and acupuncture sessions (Table 7), with an average saving of nearly £700 per person. This suggests that compared to the actual cost of Atlas sessions, Atlas reduces costs, when taking costs related to health and social care usage and lost employment into account.

Table 8 shows the cost per unit of change for each study outcome measure (eg how much it costs to get a one point change on the Perceived Stress Scale for each patient). Using these figures, attaining a minimally important change would cost £316.50 for anxiety and £2,611.50 for depression (using the recommended change score of 1.5 points to represent a clinically meaningful improvement [73]). Findings also suggest that for the average cost of treatment per patient (£661, see Table 7), on average a patient reports a 15% improvement in their anxiety, 2% improvement in depression, 17% improvement in their stress, 15% improvement in their well-being and a 32% improvement in the problems the patient said were most important to them.

A further study with control group data is now necessary to confirm the differences found by this study.

Table 6 – Comparison of baseline costs between responders and non-responders

	Responders (n=82) Mean (SD)	**Non-responders (n=20) Mean (SD)**	**p-value**
Health and social care costs	727 (4,071)	373 (1,029)	0.7013
Lost employment	719 (2,420)	1,593 (3,098)	0.1746
TOTAL	1,446 (4,673)	1,966 (3,183)	0.6389

Table 7 – Summary of costs (in £) related to Atlas per patient

	Pre Mean (SD)	**Post** Mean (SD)
Counselling/Acupuncture sessions cost	0	661 (371) [n=102]
Health and social care costs	658 (3,675) [n=102]	92 (194) [n=82]
Lost employment	891 (2,574) [n=102]	53 (200) [n=82]
TOTAL	1,548 (4,411) [n=102]	855 (504) [n=82]

Table 8 – Mean difference in costs and outcomes; cost per unit change on clinical outcome measures

Outcome	**Difference in cost (£) [1] (95% confidence interval)**	**Difference in outcome [2] (95% confidence interval)**	**Cost per unit of change on outcome (£)**
HADS anxiety	592 (-427 to 1,610)	2.80 (1.75 to 3.86)	211
HADS depression	592 (-427 to 1,610)	0.34 (-0.77 to 1.46)	1,741
PSS	618 (-838 to 2,074)	6.39 (4.10 to 8,68)	97
PYSCHLOPS	642 (-428 to 1,712)	6.18 (5.11 to 7.25)	104
WEMWBS	609 (-421 to 1,639)	3.75 (2.51 to 5.00)	162

[1] Pre – post, thus indicating savings over time.

[2] Direction of scoring taken into account so that positive difference indicates improvement over time.

Conclusions

The evaluation demonstrates a hitherto under-investigated pathway by which men experiencing mental health problems can be identified in primary care and helped to talk about the problems that are concerning them, and/or receive physical therapy aimed at reducing stressed-related symptoms.

Findings from this evaluation suggest that the Atlas Men's Well-being Programme was helpful for stressed and distressed men, particularly in terms of reducing anxiety and stress, and improving physical health, positive well-being and individual problems important to each patient.

The Programme also promoted relaxation as well as better understanding and coping with problems. Consistent with previous research in this area, the study found that a 'one size fits all' approach is unlikely to be useful for men, and indeed men using Atlas had varying preferences and expressed diverse needs in relation to the Programme.

We found that it is possible to effectively develop and deliver a primary care-based programme offering help to men for their mental and physical symptoms of stress and distress. Flexibility (timing and treatment options), the close involvement and encouragement of GPs, and high-quality branding appear to be important considerations when providing men's mental health services. This evaluation highlighted the value of engaging GPs in encouraging stressed/distressed men to identify – and seek help for – mental health problems.

In further developing the pilot Atlas programme, we recognise the value of the Atlas branding; the trained workforce of 'male-friendly' practitioners readily available; the interest shown from charities, clinical commissioning groups and even secondary care; the potential to deliver Atlas in locations outside of London and deliver training/learnings more widely to practices; and ways of extending the benefits of Atlas, for example by developing follow-on support groups for men who have completed Atlas. It is also important to investigate comparisons with usual care as well as cost-effectiveness in more detail. Thus the team will take steps to develop an Atlas Men's Well-being social enterprise with the University, to develop research and upscale Atlas in the NHS, via charities, the private sector and the University of Westminster Polyclinic.

References

1. Scottish Public Health Observatory, *Suicide Statistics for Scotland*. 2013, Office of National Statistics.
2. Northern Ireland Statistics and Research Agency, *Statistical Bulletin: Deaths in Northern Ireland 2012*. 2013, Northern Ireland Statistics and Research Agency,.
3. Office for National Statistics, *Statistics Bulletin: Suicides in the United Kingdom, 2012 Registrations*. 2013, Office for National Statistics.
4. CALM. *Suicides in the UK 1981-2013 (ONS Table 7) updated and Formatted by CALM* 2014 19.11.14]; Available from: https://www.thecalmzone.net/about-calm/suicide-research-stats/.
5. Office for National Satistics. *Leading Causes of Death*. 2013 [cited 2015 16 March 2016]; Available from: http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2012/info-causes-of-death.html.
6. Department of Health, *Preventing suicide in England: A cross-government outcomes strategy to save lives.* 2012, Department of Health.
7. Wyllie, C., et al., *Men, suicide and society*. 2012, Samaritans.
8. Office for National Statistics, *Alcohol related deaths in the United Kingdom, registered in 2012*. 2014.
9. Wearden, A.J. and R. Emsley, *Mediators of the effects on fatigue of pragmatic rehabilitation for chronic fatigue syndrome.* Journal of Consulting and Clinical Psychology, 2013. **81**(5): p. 831-838.
10. McManus, S., et al., *Adult psychiatric morbidity in England, 2007: Results of a household survey*. 2009, National Centre for Social Research: London.
11. Olsen, L.R., P. Munk-Jørgensen, and P. Bech, *The prevalence of depression in Denmark.* Ugeskrift for laeger, 2007. **169**(16): p. 1425-1426.
12. Beaudet, M.P., *Psychological health–depression.* Health reports, 1999. **11**(3): p. 63-75.
13. McDougall, F.A., et al., *Prevalence of depression in older people in England and Wales: the MRC CFA Study.* Psychological Medicine, 2007. **37**(12): p. 1787-1795.
14. Welford, J. and J. Powell, *A Crisis in Modern Masculinity: Understanding the Causes of Male Suicide*. 2014, CALM,: London.
15. European Foundation for the Improvement of Living and Working Conditions, *Fourth European Working Conditions Survey*. 2006, Office for Official Publications of the European Communities: Luxembourg.
16. European Foundation for the Improvement of Living and Working Conditions, *Second European Quality of Life Survey, Living conditions, social exclusion and mental well-being.* 2010, Office for Official Publications of the European Communities: Luxembourg.
17. Ridge, D., C. Emslie, and A. White, *Understanding how men experience, express and cope with mental distress: where next?* Sociology of Health & Illness, 2011. **33**(1): p. 145-159.
18. Mirowsky, J. and C.E. Ross, *Sex Differences in Distress: Real or Artifact?* American Sociological Review, 1995. **60**(3): p. 449-468.
19. Gooden, R.J. and H.R. Winefield, *Breast and Prostate Cancer Online Discussion Boards: A Thematic Analysis of Gender Differences and Similarities.* Journal Of Health Psychology, 2007. **12**(1): p. 103-114.

20. Möller-Leimkühler, A.M., *Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression.* Journal Of Affective Disorders, 2002. **71**(1–3): p. 1-9.
21. Oliffe, J.L. and M.J. Phillips, *Men, depression and masculinities: A review and recommendations.* Journal of Men's Health, 2008. **5**(3): p. 194-202.
22. Cutcliffe, J.R., *Adapt or adopt: developing and transgressing the methodological boundaries of grounded theory.* Journal of Advanced Nursing, 2005. **51**(4): p. 421-428.
23. Bergin, M., J.S.G. Wells, and S. Owen, *Gender awareness, symptom expressions and Irish mental health-care provision.* Journal of Gender Studies, 2014: p. 1-14.
24. Kawachi, I. and L. Berkman, *Social ties and mental health.* Journal of Urban Health, 2001. **78**(3): p. 458-467.
25. White, A., *The State of Men's Health in Europe*. 2011, European Union: Belgium.
26. Wilkins, D. and M. Kemple, *Delivering Male: Effective practice in male mental health*. 2010, Mind: London.
27. Montano, C.B., *Recognition and treatment of depression in a primary care setting.* Journal of Clinical Psychiatry, 1994. **55**(12, Suppl): p. 18-34.
28. Goldman, L.S., et al., *Awareness, Diagnosis, and Treatment of Depression.* Journal Of General Internal Medicine, 1999. **14**(9): p. 569-580.
29. CALM. *About CALM*. 2014 [cited 2014 31 March]; Available from: http://www.thecalmzone.net/about-calm/
30. CALM. *CALM name 2014 year of the male*. 2014 [cited 2014 31 March]; Available from: http://www.thecalmzone.net/2014/01/yotm/.
31. Emslie, C., et al., *Exploring men's and women's experiences of depression and engagement with health professionals: more similarities than differences? A qualitative interview study.* BMC Family Practice, 2007. **8**(1): p. 43.
32. Prins, M.A., et al., *Health beliefs and perceived need for mental health care of anxiety and depression—The patients' perspective explored.* Clinical Psychology Review, 2008. **28**(6): p. 1038-1058.
33. Jorm, A.F., *Mental health literacy: Public knowledge and beliefs about mental disorders.* The British Journal of Psychiatry, 2000. **177**(5): p. 396-401.
34. Jorm, A.F., et al., *Public beliefs about the helpfulness of interventions for depression: effects on actions taken when experiencing anxiety and depression symptoms.* Australian and New Zealand Journal of Psychiatry, 2000. **34**(4): p. 619-626.
35. Kessler, R.C., et al., *The Use of Complementary and Alternative Therapies to Treat Anxiety and Depression in the United States.* The American Journal of Psychiatry, 2001. **158**(2): p. 289-294.
36. Zimmerman, M., et al., *Remission in depressed outpatients: More than just symptom resolution?* Journal of Psychiatric Research, 2008. **42**(10): p. 797-801.
37. National Institute for Health and Care Excellence, *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults*. 2011.
38. National Institute for Health and Care Excellence, *Depression*. 2009.
39. Health and Social Care Information Centre, *Psychological Therapies, Annual Report on the Use of Improving Access to Psychological Therapies Services - England, 2012-13*. 2014, Health and Social Care Information Centre.
40. Mind. *Access to talking therapies – new data out today*. 2014 20 March 2013]; Available from: http://www.mind.org.uk/news-campaigns/news/access-to-talking-therapies-%E2%80%93-new-data-out-today/.

41. National Collaborating Centre for Mental Health, *The NICE guideline on the treatment and management of depression in adults*. 2010.
42. NHS Choices. *Can I get free therapy or counselling?* 2011 20 March 2014]; Available from: http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/free-therapy-or-counselling.aspx.
43. Bower, P., *Counselling for mental health and psychosocial problems in primary care.* Cochrane Database of Systematic Reviews (Online), 2011. **9**: p. CD001025.
44. Bower, P., N. Rowland, and R. Hardy, *The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis.* Psychological Medicine, 2003. **33**(2): p. 203-215.
45. Brettle, A., A. Hill, and P. Jenkins, *Counselling in primary care: A systematic review of the evidence.* Counselling & Psychotherapy Research, 2008. **8**(4): p. 207-214.
46. Rowland, N., et al., *Counselling in primary care: A systematic review of the research evidence.* British Journal of Guidance & Counselling, 2000. **28**(2): p. 215-231.
47. Mellor-Clark, J., et al., *Counselling outcomes in primary health care: A CORE system data profile.* European Journal of Psychotherapy, Counselling and Health, 2001. **4**(1): p. 65-86.
48. Emslie, C., et al., *Men's accounts of depression: Reconstructing or resisting hegemonic masculinity?* Social Science & Medicine, 2006. **62**(9): p. 2246-2257.
49. Minichiello, V., R. Aroni, and T. Hays, *In-depth Interviewing: Principles, Techniques, Analysis.* . 1995, Melbourne: Longman Cheshire.
50. O'Reilly, M. and N. Parker, *'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research.* Qualitative Research, 2012.
51. Hopton, A.K., et al., *Acupuncture in practice: mapping the providers, the patients and the settings in a national cross-sectional survey.* BMJ Open, 2012. **2**(1).
52. Pilkington, K.G.H.M.J., *Acupuncture for anxiety and anxiety disorders -- a systematic literature review.* Acupuncture in Medicine, 2007. **25**(1/2): p. 1-10.
53. Hollifield, M., et al., *Acupuncture for Posttraumatic Stress Disorder: A Randomized Controlled Pilot Trial.* The Journal of Nervous and Mental Disease, 2007. **195**(6): p. 504-513 10.1097/NMD.0b013e31803044f8.
54. Smith, C.A., P.P.J. Hay, and H. MacPherson, *Acupuncture for depression (Review).* Cochrane Database Of Systematic Reviews (Online), 2010(1): p. Article number: CD004046.
55. MacPherson, H., et al., *Acupuncture and counselling for depression in primary care: a randomised controlled trial.* Plos Medicine, 2013. **10**(9): p. e1001518-e1001518.
56. Good, G.E., D.A. Thomson, and A.D. Brathwaite, *Men and therapy: Critical concepts, theoretical frameworks, and research recommendations.* Journal Of Clinical Psychology, 2005. **61**(6): p. 699-711.
57. Brownhill, S., et al., *'Big build': hidden depression in men.* Australian and New Zealand Journal of Psychiatry, 2005. **39**(10): p. 921-931.
58. Mahalik, J.R., G.E. Good, and M. Englar-Carlson, *Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training.* Professional Psychology: Research and Practice, 2003. **34**(2): p. 123-131.
59. Robertson, S., *'I've been like a coiled spring this last week': embodied masculinity and health.* Sociology of Health & Illness, 2006. **28**(4): p. 433-456.

60. Schroer, S., H. MacPherson, and J. Adamson, *Designing an RCT of acupuncture for depression—identifying appropriate patient groups: a qualitative study.* Family Practice, 2009. **26**(3): p. 188-195.
61. Lacour, M., et al., *An interdisciplinary therapeutic approach for dealing with patients attributing chronic fatigue and functional memory disorders to environmental poisoning - a pilot study.* International Journal of Hygiene and Environmental Health, 2002. **204**(5-6): p. 339.
62. Ridge, D., *How narrative professionals understand men, their distress, and good treatment approaches.* (unpublished), 2012.
63. Rowan, J., *What is Humanistic Psychotherapy? .* British Journal of Psychotherapy, 1992. **9**(1): p. 74-83.
64. Zigmond, A.S. and R.P. Snaith, *The hospital anxiety and depression scale.* Acta Psychiatrica Scandinavica, 1983. **67**(6): p. 361-70.
65. Bjelland, I., et al., *The validity of the Hospital Anxiety and Depression Scale. An updated literature review.* Journal of Psychosomatic Research, 2002. **52**(2): p. 69-77.
66. Cohen, S., T. Kamarck, and R. Mermelstein, *A global measure of perceived stress.* Journal of Health and Social Behavior, 1983. **24**(4): p. 385-96.
67. Tennant, R., et al., *The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation.* Health and Quality of Life Outcomes, 2007. **5**(1): p. 63.
68. Stewart-Brown, S., et al., *Internal construct validity of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a Rasch analysis using data from the Scottish Health Education Population Survey.* Health and Quality of Life Outcomes, 2009. **7**: p. 15-15.
69. Ashworth, M., et al., *A client-generated psychometric instrument: The development of 'PSYCHLOPS'.* Counselling & Psychotherapy Research, 2004. **4**(2): p. 27-31.
70. Evans, C., M. Ashworth, and M. Peters, *Are problems prevalent and stable in non-clinical populations? Problems and test-retest stability of a patient-generated measure, PSYCHLOPS (Psychological Outcome Profiles), in a non-clinical student sample.* British Journal of Guidance & Counselling, 2010. **38**(4): p. 431-439.
71. Ashworth, M., et al., *Measuring mental health outcomes in primary care: the psychometric properties of a new patient-generated outcome measure, 'PSYCHLOPS' ('psychological outcome profiles').* Primary Care Mental Health, 2005. **3**(4): p. 261-270.
72. Cohen, J.W., *Statistical power analysis for the behavioural sciences (2nd edn)*. 1998, Hillsade, NJ: Lawrence Erlbaum Associates.
73. Puhan, M.A., et al., *The minimal important difference of the hospital anxiety and depression scale in patients with chronic obstructive pulmonary disease.* Health and Quality of Life Outcomes, 2008. **6**: p. 46.
74. Braun, V. and V. Clarke, *Using thematic analysis in psychology.* Qualitative Research in Psychology, 2006. **3**(2): p. 77-101.
75. QSR International, *NVivo 9*. 2011.
76. Curtis, L., *Unit Costs of Health and Social Care*. 2013, Personal Social Services Research Unit,: Kent, UK.
77. Department of Health. *NHS reference costs 2012 to 2013*. 2013; Available from: https://www.gov.uk/government/publications/nhs-reference-costs-2012-to-2013.

78. Office for National Statistics. *Labour Market Statistics, November 2014*. 2014 20.11.14]; Available from: http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/november-2014/index.html.

Appendix 1 – Flow of participants through the Atlas Men's Well-being Clinic evaluation