Evaluation of Well Men Health Service Pilots
EVALUATION OF WELL MEN HEALTH SERVICE PILOTS

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<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>BMI</td>
<td>Body mass index</td>
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<tr>
<td>BP</td>
<td>Blood pressure</td>
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<tr>
<td>DCE</td>
<td>Discrete choice experiment</td>
</tr>
<tr>
<td>DEPCAT</td>
<td>Deprivation category</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HISD</td>
<td>Health Improvement Strategy Division</td>
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<tr>
<td>ISD</td>
<td>Information Services Division</td>
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<tr>
<td>L1</td>
<td>Level 1 refers to awareness raising activities</td>
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<tr>
<td>L2</td>
<td>Level 2 refers to brief health checks</td>
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<tr>
<td>L3</td>
<td>Level 3 refers to a comprehensive health assessment</td>
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<td>L4</td>
<td>Level 4 refers to follow up mark</td>
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<tr>
<td>L5</td>
<td>Level 5 refers to men engaging with the wider community</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual and transgender</td>
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<tr>
<td>LHCC</td>
<td>Local Health Care Cooperative</td>
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<tr>
<td>MF</td>
<td>Monitoring Framework</td>
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<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>QALY</td>
<td>Quality adjusted life year</td>
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<td>RAG</td>
<td>Research Advisory Group</td>
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<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
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<tr>
<td>SE</td>
<td>Scottish Executive</td>
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<td>SEHD</td>
<td>Scottish Executive Health Department</td>
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<td>SHS</td>
<td>Scottish Household Survey</td>
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<tr>
<td>WMS</td>
<td>Well Men Services</td>
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<tr>
<td>WTP</td>
<td>Willingness to pay</td>
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<td>UK</td>
<td>United Kingdom</td>
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SUMMARY

Introduction

This report provides a summary of the results of a mixed method evaluation study of the Well Men Services (WMS) pilot programme, announced by the Scottish Executive (now known as the Scottish Government) in October 2003. The WMS pilot was one of a number of innovative programmes introduced by the SE as part of its commitment to improving the health of Scotland in the new millennium and in fulfilment of the government agenda set out in A Partnership for a Better Scotland: Partnership Agreement (SE, 2003). Although men’s health has been improving over time, it was a particular policy concern as: men have lower life expectancy than women; there are marked health inequalities between men in different social circumstances; and men are less frequent users of health services, particularly primary care, where earlier intervention may be possible.

In March 2004, the Scottish Executive Health Department (SEHD) invited partnerships between health professionals, local authorities, voluntary and private organisations to submit bids to pilot WMS in their health board areas. The Scottish Executive (SE) Men’s Health Strategy was based on three key principles: establishing strong community links; developing appropriate support mechanisms and providing a comprehensive health assessment.

The pilots aimed to:
- promote healthier lifestyles and attitudes among men;
- provide men with an opportunity to undertake a health assessment and to obtain advice and support on health and lifestyle issues;
- effectively engage all men.

Eighteen pilots, in seven health board areas, were subject to an independent evaluation and were funded from June 2004 till March 2006.

Aims of the Evaluation

The main evaluation aims were to:
- assess how far the objectives had been met at the level of individual pilots and in terms of the Men’s Health Strategy as a whole;
- identify the factors which were likely to facilitate or inhibit the development of effective WMS with regard to the objectives of the strategy;
- identify good practice in tackling men’s health issues through WMS.

Methods

This evaluation used a mixed-methods approach to address the study questions.
- a systematic review to assess the effectiveness of health care interventions aimed at improving men’s health;
- a secondary analysis of routinely collected health and illness data (Scotland only);
- a Monitoring Framework (MF) developed to direct the collection of monitoring information on the operation and outcomes of all pilots;
• an analysis of the resultant MF data;
• in-depth interviews with key service providers and partner agency representatives;
• three case studies, designed to capture the key features of the processes at work. These included interviews with WMS (non) users and further staff interviews;
• an economic evaluation to assess the costs and benefits of the individual pilots, and to consider the cost-effectiveness of the different approaches taken in the projects.

Meeting Pilots’ Objectives

Engaging with all men

Engagement includes the involvement of men in the planning, development and ongoing management of services. A wide variety of stakeholder groups were involved in the WMS pilots and men participated in their management through steering groups, and in community development work in a small number of cases.

The comprehensive health check data suggested that WMS users were not generally the most ‘hard-to-reach’ although they were more likely to be from deprived areas and unemployed. There were examples of projects successfully targeting specific groups, such as the homeless.

Pilot staff reported using a range of different strategies to encourage men to use their pilots. These included: offering services in areas where the specific target group lived or worked; individualised approaches e.g. GP letters to men, face-to-face contact in health and other community centre; and/or promotional work using various media.

The same factors encouraged some men and inhibited others from using the WMS. These could be categorised according to a. individual motivation and beliefs, b. perceptions about the service characteristics and c. external social circumstances and networks. Curiosity, seeking reassurance, gaining access to a health care professional other than a GP, and the presence of a spouse or partner were generally associated with use. Service use was generally inhibited by fear about health problems being detected, and perceptions of service inaccessibility.

Providing health assessments

Most pilots had established some form of health assessment, which represented a partial achievement of the Men’s Health Strategy objectives. There was wide variation in data collection practice across the pilots, and subsequent underreporting of activity. Data were returned on 3,367 men who received comprehensive health checks; 72% were given advice during their health check. A similar percentage were referred to another health service, predominantly the GP or practice nurse.

Promoting healthier lifestyles

Collectively, WMS pilots offered five possible levels of engagement with men: awareness raising activities (health fairs and marketing events); brief or comprehensive health assessments with specially trained (usually nursing) staff; community development endeavours and potential follow-up work. A range of services were offered including fixed and mobile nurse-led clinics, outreach work and community development orientated projects. For example, health assessments were held at a snooker club in Inverness, health awareness
days were held at a FE college of in Dundee, and outreach work was carried out in council offices in Fife.

WMS users were interested to find out about or were concerned about diet, weight management or physical activity. They also reported some behavioural change as a consequence of contact with the pilots. Fifteen percent of WMS users were referred to exercise services or to a dietician.

Development of Effective WMS

Most pilots reported considerable delays in starting up due to the time taken to negotiate the local health board personnel and finance processes and, to a lesser extent, the perceived burden placed on projects by the external evaluation. Some pilots changed or evolved in response to men’s uptake over their lifetime. Community development work was considered essential by some pilot staff as a means of encouraging longer-term use of the WMS.

While it was difficult to establish factors that were associated with successful pilot implementation due to the short time scale, those pilots that were beginning to show signs of promise had common features:

- defined (realistic) objectives or a more detailed project plan;
- motivated and committed staff;
- good partnership arrangements;
- good access to existing local resources and support services;
- a supportive wider organisational context.

Lack of follow up was considered a key service weakness by the users and providers.

Good Practice in Men’s Health

Literature review

The systematic review indicated that little evidence existed about the effectiveness (or otherwise) of WMS in general or about alternative methods of service delivery. We found evidence of effective interventions with men relating to smoking, diet and physical activity, cardiovascular disease, cancer, preventive health screening and alcohol.

Men’s response to the WMS

This study indicated that no single service model suits all men. In general, service users tended to favour a more medicalised service, clinical tests were considered a valued and missing aspect of the service. Cholesterol and blood pressure tests were particularly sought.

Some very targeted approaches engaged with specific groups of men. For example, the East Glasgow pilot was successful in recruiting homeless men by basing the service within the heart of this community.

There was general ambivalence about the need for a men’s health service amongst users and nonusers, although some users were extremely enthusiastic about the existence of such a
service. However, the WMS provided an opportunity for men to raise health concerns that they would not have thought appropriate to see their GP about. This was true both of men who had been in contact with their GP in the past year and those who had not.

**Economic Analysis**

The economic analysis focussed on the costs and outcomes relating to the comprehensive health assessment. Staff variation was the main factor in different session costs and attendance rate was the main factor in cost per health assessment. Similar costs could be achieved in different settings, but workplace delivery had the lowest range of costs.

Outcomes were considered in terms of contacts, onward referrals and potential health gain. Sessions held in community venues or workplaces were more likely to contact men who had not seen their GP in the past two years, but these men did not appear to have greater health needs. Projects with higher staffing levels at sessions tended to have higher rates of onward referral. There was considerable potential for health gain with men reporting problems with smoking, alcohol and exercise. However, referral rates for alcohol and exercise were very low, suggesting that an opportunity for health gain was being missed.

Although potential health gains could be achieved through WMS at a cost per QALY below the threshold for many clinical interventions, the limited data collected for this evaluation cannot provide clear evidence of cost-effectiveness. Opportunistic intervention in primary care is likely to be more cost-effective for the majority of men but may have limitations for hard-to-reach men. A combination of approaches may be more likely to achieve the desired combination of efficiency and wide coverage.

**Learning Points and Conclusions**

**Development and Implementation**

The expectation that the projects would have been able to address all three overall pilot aims (promoting healthier lifestyles and attitudes amongst men; providing men with the opportunity to undertake a health assessment; and effectively engaging all men), even within a time frame unaffected by subsequent implementation difficulties, was rather optimistic. Interventions need longer lead times, realistic aims and measurable objectives and outcomes.

Partnership working was a factor in successful engagement. Promising pilots appeared to have more defined objectives; good partnership arrangements; good access to existing local resources; and a supportive wider organisational context.

Organisational restructuring, bureaucratic procedures and mixed messages about the purpose of the funding delayed implementation. Lack of follow up was a key service weakness.

**Impacts**

All of the pilots undertook activities directed towards the first objective of promoting healthier lifestyles and attitudes amongst men. The emphasis on general awareness raising activities varied. The third objective, effectively engaging with all men, was also partially
achieved. Attempting to achieve multiple objectives probably slowed down the development of each one within the time available.

The projects with the strongest community links were those where pre-existing partnership working was in place and the timescale of the pilots provided limited opportunities for new community development work to establish results. Key referrals were made to existing ‘easy’ to access health services; other services were well less used.

**Policy learning**

Similar issues were both motivating and inhibiting factors for WMS uptake for different men. Men favoured mainstream health services, but one size does not fit all men. Men liked physical tests and measurements and valued follow up.

Risks of smoking are accepted by men; but alcohol misuse and physical inactivity were not regarded as problems. There was a lack of referrals for health promotion services other than smoking cessation, possibly through lack of availability.

Primary care services should develop a gender-friendly health improvement ethos to make both men and women feel welcome.

**Project planning and evaluation**

Despite the ‘demonstration’ nature of the pilots, evaluation was not high on the agenda of most service providers, and there was a lack of planning for their contribution to the evaluation process.

The project changed and evolved in response to population uptake during the implementation phase making it harder to measure cause and effect.

A theoretical underpinning would help guide future projects.

Research gaps have been identified in several areas.
CHAPTER ONE  INTRODUCTION

Background

1.1 This report provides a summary of the results of a mixed method evaluation study of the Well Men Services (WMS) pilot programme, announced by the Scottish Executive (now known as the Scottish Government) in October 2003. The WMS pilot was one of a number of innovative programmes introduced by the SE as part of its commitment to improving the health of Scotland in the new millennium and in fulfilment of the government agenda set out in A Partnership for a Better Scotland: Partnership Agreement (SE, 2003). Although men’s health has been improving over time, it was a particular policy concern as: men have lower life expectancy than women; there are marked health inequalities between men in different social circumstances; and men are less frequent users of health services, particularly primary care, where earlier intervention may be possible.

1.2 A service mapping exercise (Johnson and Rafferty, 2004) identified a range of men’s health initiatives which were operating within Scotland at this time. One of the larger and, perhaps, better known of these initiatives was the Camelon Well Man’s clinic which had been operating in NHS Forth Valley since 2002. The Camelon model was established to provide men with a comprehensive health assessment by specially trained nurses within a traditional primary health care setting. Over time the service in Forth Valley was subsequently delivered in other community venues, with support from other programmes to address issues such as smoking, weight, physical activity and stress.

1.3 This initiative was used as the basis of the SE Men’s Health strategy, with partnerships of Health Boards, local authorities, voluntary organisations and community groups across Scotland invited to submit bids in March 2004 to develop and pilot Well Men Services in their area.

The pilot projects

1.4 The WMS pilot programme was set up to address the policy concerns around men’s health and to evaluate the relative success of alternative approaches to meeting men’s needs. This strategy was based on the key principles of the Camelon model:

- establishing strong community links;
- developing appropriate support mechanisms; and
- providing comprehensive health assessments.

1.5 Following a commissioning process, 16 pilot projects were funded by the SE in 7 Health Board areas (3 additional health boards were funded by the SE but did not form part of the external evaluation) (see Annex 1). The pilots were locally developed and varied in the content of the proposed service, the method of service delivery, the target group and the type of location. The characteristics of the projects, as they appeared in the funding bids, are set out in Annex 2.
The WMS Pilot Project: Aims and Objectives

1.6 The WMS pilots aimed to:

- promote healthier lifestyles and attitudes amongst men;
- provide men with the opportunity to undertake a health assessment and to obtain advice and support on health and lifestyle issues; and
- effectively engage all men.

1.7 The pilots aimed to identify effective ways of engaging with all men, and in particular, those who were hardest to reach as a consequence of social exclusion or discrimination. They were also intended to identify what worked in promoting and sustaining health awareness and improvement in men.

1.8 The term ‘hard-to-reach’ was defined by the SE (2004a) as people who were socially excluded “by either their age, faith/religious beliefs, sexuality, disability, race/ethnicity or because of a general lack of interest or concern…” and this was interpreted differently by each individual pilot project, which reflected the specific concerns of different Health Board areas. This provided one of the challenging aspects of the evaluation. Apart from identifying deprived areas or communities, specific groups defined and targeted as hard-to-reach by different Health Boards included ethnic minorities, homeless men, unemployed young men, gypsy travellers, those with learning difficulties, gay and bisexual men, substance misusers and men not in regular contact with health services.

Evaluation Aims and Structure of the Report

1.9 The main aims of the evaluation, were to:

- assess how far the objectives of the pilots had been met at the level of individual pilots and in terms of the well men services strategy as a whole;
- identify the factors which were likely to facilitate or inhibit the development of effective well men services with regard to the objectives of the strategy; and
- identify good practice in tackling men’s health issues through well men services.

1.10 The original evaluation brief outlined a comprehensive range of questions (Annex 3), and the projects generated a great deal of information, selected parts of which will be more relevant to some individuals and organizations than others. This report presents a summary of the key findings from the evaluation in a concise format. The short lifespan of the pilots should be taking into account when considering these. Further information about the projects and further detailed information is available on request from University of Aberdeen.

1.11 This document presents the findings in relation to the progress projects made in meeting their objectives (Chapter 3), the factors facilitating or inhibiting the development of the Well Men’s Services projects (Chapter 4), emerging evidence of good practice in men’s health, including an economic analysis of such a service (Chapter 5), and the main conclusions and lessons learned (Chapter 6). Key points are summarised at the beginning of each chapter. Chapter 2, provides a brief account of the research methods used to evaluate the pilots.
CHAPTER TWO METHODS

Introduction

2.1 The WMS initiative was a complex (multi-faceted), community-based, health promotion intervention (Hawe et al. 2004), of the kind where causation and attribution are often difficult, if not impossible, to establish (Wimbush & Watson 2000). The evaluation of such initiatives often has two major problems: unrealistic expectations of the evaluation and of the intervention itself (Nutbeam 1998). Therefore, such initiatives require mixed methods of enquiry which take account of the contextual and mediating variables likely to have an impact or effect on the outcome(s). Hence the project used qualitative methods to help to understand each project’s structure and process, whilst at the same time collecting quantitative, standardised data for comparative analysis as outlined below:

- systematic literature review;
- secondary analysis of routinely collected men’s health and health service use data in all pilot project health board areas;
- development and analysis of WMS pilot project monitoring framework (MF);
- interviews with key informants associated with all pilot projects;
- case studies; and
- economic evaluation.

Systematic literature review

2.2 A scoping search identified existing systematic reviews of effectiveness of interventions aimed at improving men’s health. A systematic search was conducted to identify studies in the English language since 1999. Further details can be found in a separate report (Robertson et al. 2006).

2.3 A systematic review of primary studies was also conducted in April 2006. The search strategy was designed to be sensitive enough to allow for diversity in the types of possible studies. Key journals were hand searched: *Journal of Men’s Health Gender, Men’s Health Journal* and *International Journal of Men’s Health*. Reference lists of included studies were scanned. Relevant citations were downloaded into Refworks (2006). Primary studies focusing on men’s health had to target men by intention. Studies were excluded if they were (a) part of the systematic reviews; (b) cost-effectiveness only studies; or (c) used historical controls.

Secondary analysis of routinely collected data

2.4 A secondary analysis of men’s health and health service use data from all pilot areas was conducted to establish a baseline to assess whether projects were reaching their target population. Data were extracted from the Registrar General for Scotland, NHS Scotland Information Services Division (ISD), Census 2001 and The Scottish Health Survey 2003. Information included, for example, age, educational attainment, healthy life expectancy, marital status, smoking status, GP and dentist attendance.
Development of WMS pilot project monitoring framework (MF)

2.5 The WMS research brief required the development of a consistent framework for the collection of monitoring information on the operation and outcomes of the pilots. However, it became clear that a framework on its own would not support staff working in the pilots to collect useful or useable data for evaluation purposes, internal or external. Therefore, two data collection tools were developed to support the MF across all pilots. The first collected data from the projects on awareness raising and outreach activities and the second collected data from individual men who underwent a comprehensive health check.

2.6 The MF and the data collection tools were developed through extensive consultation with the various stakeholder groups as described by Douglas et al. (2006b). This process involved:

- formal and informal consultation with all individual project leads;
- various Research Advisory Group (RAG) meetings;
- consultation with Scottish Executive Health Department (SEHD) and Health Improvement Strategy Division (HISD); and
- discussion with pilot project staff.

Data analysis

2.7 Quantitative data analysis was carried out on the WMS pilot project monitoring data. T-test & Chi-squared tests were used to describe details of service users.

Interviews with key service provider informants – all pilot projects

2.8 Semi-structured interviews took place with key service provider informants in two phases. Both phases were carried out in all 18 projects with interviews lasting between 20-60 minutes. Specifically designed interview schedules were used. However, the researchers explored any lines of enquiry thought to be of interest and relevant during the interview.

2.9 The first stage included 30 project staff and 14 partner agency staff. For the second phase, not all individuals were contactable, and one declined to take part again. The first phase interviews were predominantly face-to-face with the researchers visiting all project areas. All second phase interviews were conducted by phone. A thematic data analysis approach was employed (Gomm et al. 2000), supported by QSR NVivo (Gibbs 2002). The full evaluation report (Douglas et al. 2006b) presents verbatim quotes to illustrate the findings.

Case studies

2.10 Three individual projects were selected for case study investigation. The aim of the case studies was to capture and explore in more detail the operation and outcomes of a range of pilots that were generally representative of the types and locations of the services being piloted within the WMS project overall. Projects were selected on the basis of:
a. the type of service delivered by the pilot (*service delivery*):

b. whether the service was new or a development of an existing service (*service development*) and

c. whether the project area could be considered urban, rural or remote (*geographical location*).

The case studies used additional interviews with, for example, project staff and (non-) users; mapping of supporting services; analysis of project documentation; and observation. The case study were projects in Highland, Fife and East Glasgow (Douglas *et al.* 2006a).

2.11 Documents studied included meeting minutes, bid documents and any reports. These were scrutinized for relevant data and to determine if they were consistent with other findings. Service mapping information, e.g. supporting structures and partnerships essential for service delivery, came from project bid documents, interviews and project documentation. Draft service maps were produced and checked for accuracy with project co-ordinators. Researchers observed projects, especially clinics, although it was not possible to directly observe a client consultation. Extensive notes were made during these observation periods and these data were used alongside interview data.

**Economic evaluation methods**

2.12 The economic evaluation considered the cost-effectiveness of various approaches taken in the pilot projects. Project findings have also been integrated with information drawn from the literature and other sources to provide a more complete model of costs and consequences.

2.13 Intervention costs came from projects’ accounts and other documentary evidence supplemented by a questionnaire. The range of outcomes or consequences from pilots was potentially wide and diverse. The relatively short timescale of the interventions made it impossible to measure changes in final health outcomes, and information from the literature was used to model health effects. Data on lifestyle factors amongst WMS users, their willingness to change behaviour and the rate of referrals for interventions, were combined with information about the effectiveness of interventions to estimate health outcomes. This framework was also used to estimate the added value of the WMS based on assumptions about alternative provision, such as routine GP visits.

2.14 The value which men placed on different attributes of WMS was elicited directly by the use of a discrete choice experiment (DCE) approach. A postal survey of a large population-based sample was carried out in an area where no WMS had been established.
CHAPTER THREE PILOTS’ OBJECTIVES

Key Findings

Engaging with men
- There was evidence that all projects specifically targeted hard-to-reach and socially excluded men. However, more hardest-to-reach men attended the projects than we received data for.
- The same factors acted both to encourage and inhibit use, and could be categorised according to a. individual motivation and health beliefs, b. perceptions about service characteristics, and c. external social circumstances and networks.
- Curiosity, seeking reassurance, desire to gain access to a health professional other than a GP and the presence of a spouse or partner generally encouraged use. Fear about what would be found out about one’s health, and accessibility (in terms of time and location) were key inhibitors to use.

Providing health assessments
- All pilots had established some form of health assessment, which represented a partial achievement of the Men’s Health Strategy objectives. Data were returned on 3,367 men. However, a greater number of men were in contact with the WMS pilots than was recorded in the data returns.
- WMS users were more likely to be unemployed and living in a deprived area. However, they were also older, better educated and more likely to be married than the national average.
- WMS users had visited a GP less frequently than the national average, and there was evidence of unmet health need amongst those who did visit their GP. Most onward referrals were to GPs and practice nurses.
- All WMS users (except those living in Glasgow) reported better health than the national average.

Promoting healthier lifestyles
- In terms of lifestyle, WMS users were less likely to drink heavily, smoke, and be physically active, but (paradoxically) more likely to binge drink.
- WMS users’ health concerns were largely associated with diet, weight management or physical activity, and this was reflected in the advice given by the projects.
- There were some claims from men about behaviour change resulting from engaging with a WMS pilot.

Chapter overview

3.1 This chapter presents findings that relate to the pilots’ objectives: engaging with men, promoting healthy lifestyles and providing comprehensive health assessments. A summary is provided of the views and experiences of service providers about the extent to which men were engaged in developing and implementing the pilots, and the strategies that were employed to encourage men to use WMS services. This is followed by factors that men indicated were instrumental in their decisions to use the WMS pilots, and the barriers that some indicated prevented their use.
It was not possible to include a rigorous assessment as to whether the pilot objectives had been met. The short period over which most of the pilots operated and the limited data available from some projects made this inappropriate.

3.2 The characteristics of men who used the WMS are presented in this chapter for Scotland as a whole, as well as the individual project level data (see Annex 4). When considering characteristics of service users, two broad questions were considered: (1) whether WMS users represent hard-to-reach men, based on their demographic background and service use; and (2) whether WMS users have more health problems and lifestyle issues than the general population. These were assessed by comparing a summary of the aggregated project data provided by service users with routinely collected Scottish data such as the UK Census (GROS, 2001); The Scottish Health Survey (SE, 2005a) and/or the Scottish Household Survey (SE, 2005d).

3.3 Finally, WMS users’ baseline health and lifestyle data are presented. A more detailed account of this discussion, including the presentation of respective primary data, can be found in the full evaluation report. (Douglas et al. 2006b)

Engaging with all men

Engaging men in service planning and development, and implementation

3.4 Men (as intended service users) were involved in the development of the WMS services in different ways. Most commonly their views, which had been sought through past health needs assessments, had been incorporated in WMS development plans. To a lesser extent there was evidence that men were engaged more directly through participation in, and membership of, various WMS steering groups. In some areas, there was also evidence that pilots had attempted to include men in their implementation through community development work, although reports indicated that this work was generally quite limited in terms of scope and duration.

WMS strategies developed to engage with men

3.5 Pilot staff reported using a range of different strategies to encourage men, in general, to use their pilots. These included: offering services in areas where the specific target group lived or worked; individualised approaches, e.g. GP letters to men, face-to-face contact in health and other community centres; and/or promotional work using various types of media.

3.6 All pilots also attempted to engage with socially excluded groups. Project staff reported the use of outreach clinics in non-traditional health care settings, such as pubs or workplaces, as a means of tackling this challenge. The Highland’s WMS pilot funded a mobile unit in order to extend the scope of their outreach. The East Glasgow pilot offered a service designed specifically for homeless men through a homeless day-care centre in the city centre. Many projects also instigated partnership arrangements in order to assist engagement with hard-to-reach or socially excluded groups. The Fife project worked with the lesbian, gay, bisexual and transgender (LGBT) community to target men who have sex with other
men and with Opportunity Centres\(^1\) to target low skilled and unemployed men. Other projects simply advertised the service in an attempt to attract socially excluded men.

3.7 Collectively, WMS pilots offered five possible levels of engagement or contact with men:

- awareness raising activities (health fairs and marketing events);
- brief health assessments;
- comprehensive health assessments with specially trained (usually nursing staff);
- community development endeavours; and
- potential follow-up work.

3.8 A range of services was offered including fixed and mobile nurse-led clinics, outreach work and community development orientated projects. For example, health assessments were held at a snooker club in Inverness, health awareness days were held at a further education college in Dundee, and outreach work was carried out in council offices in Fife.

Factors prompting men’s use of the WMS services

3.9 Factors which encouraged and inhibited men from using the WMS could be categorised according to (a.) individual motivation and beliefs, (b.) perceptions about the service characteristics and (c.) external social circumstances and networks. In some cases similar factors encouraged some men and inhibited others.

*Individual motivation*

3.10 In terms of individual stimuli, WMS users were personally motivated to use the pilots for several reasons. First of all, curiosity about the service itself appears to have been a primary driver. Seeking reassurance about one’s health, or to get a second opinion about a health issue was also a key consideration. The potential to gain access to a health care professional other than a GP (through use of the WMS) was also viewed as a key factor in decisions to use the WMS pilots. Some men expressed doubt about the need for such a service for them at that particular time, but saw a use for it when they were getting older.

*Service characteristics*

3.11 The second key driver was associated with perceptions of the WMS services’ features. Convenience and accessibility relating to opening times and location were viewed very positively by users. Work-based services were considered especially convenient. Some services had been planned for delivery in the evenings, specifically to make them more accessible to working men. However, some men in a large urban centre were inhibited from using the service in the evening because of concerns about their personal safety.

3.12 As outlined above, WMS pilots were situated in a variety of different locations, ranging from traditional health care premises used for primary care, through to pharmacies,

\(^1\) Opportunity Centres offer careers and educational support to adults in Fife.
workplace-based centres, mobile buses to community-based locations, situated in the heart of the communities of concern, e.g. homeless men. There were mixed views amongst men about this strategy, with some participants indicating that they thought that GPs’ practices were places for sickness and ill health, which was at odds with WMS pilots geared towards prevention and health checks. Others indicated a preference for a health centre-based service, while others believed a non-medical environment was more acceptable. Some concerns were expressed about a lack of privacy when pilots were located in pharmacies, community centres or other non-health settings.

3.13 When exploring users’ and non-users’ views about the potential influence that the gender of frontline staff may have had on service use, most of those interviewed indicated that they had no particular preference or concerns about it. Some indicated that they thought it was easier to discuss difficult health issues with a woman, with a small number indicating that they would have preferred to speak to a man.

Social circumstances and networks

3.14 The presence of a spouse or partner was generally associated with use of WMS. Eleven percent of those recorded as using the WMS pilots indicated that they had been urged to do so by partner, family or friends. Similarly, the interview data revealed that partners, spouses and friends had played a key role in encouraging use. Others talked about contacts with other local men, who had encouraged them to use the services.

Providing health assessments

3.15 All pilots had established some form of health assessment, which represented a partial achievement of the Men’s Health Strategy objectives. There was wide variation in data collection practice across the pilots, and subsequent underreporting of activity. Data were returned on 3,367 men who received comprehensive health checks; 72% were given advice during their health check. A similar percentage were referred to another health service, predominantly the GP or practice nurse.

Recorded use of the WMS pilots

3.16 Figure 1 presents selected demographic characteristics, relating to age, qualifications and deprivation category, of the men recorded as using the WMS and having had a comprehensive health assessment. These data have been compared to routinely collected data for Scotland to assess how closely or otherwise they are representative of the Scottish male population in general (GROS 2001).
3.17 There was considerable variability in the characteristics of service users between the pilot areas. In terms of deprivation, Glasgow had the highest proportion (58%) of WMS users living in deprived areas and Highland (1.9%) the lowest as measured by DepCat score. This reflects the fact that Glasgow has the poorest population in Scotland.

**Figure 1: Comparison of WMS users with Scottish average**

![Bar chart comparing WMS users with Scottish average](chart.png)

3.18 Educational attainment levels differed across the study areas. Only 9% of Shetland WMS users reported having no qualifications compared with 29% in Greater Glasgow. The WMS user age profile also varied across the pilots. Shetland recorded greatest contact with the youngest group, 69% of their WMS users were less than 45 years old, and Argyll and Lothian the oldest, as only 31% of their users were less than 45.

3.19 Figure 2 compares the pilot areas by reported health status and GP use. WMS users in all pilot areas, apart from Glasgow, reported better health than the national average; in Greater Glasgow, 10% reported (very) bad physical health. Long-term illness, disability or infirmity showed a similar distribution; WMS users in all pilot areas had less long-term illness, disability or infirmity than the national average, except Greater Glasgow, with 40% of WMS users reporting a long-term illness, disability or infirmity.

3.20 Thirty percent of WMS users in Greater Glasgow had not consulted a GP in the last year (see Figure 2), whereas 60% in Tayside had not. Overall, WMS users attended their GP less frequently than the national average (Scottish Household Survey, 2003).

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2 Socioeconomic status was classified using the Carstairs and Morris Index of Deprivation, which is calculated for each postcode area based on four UK Census variables (proportion of households with male unemployment, car ownership, overcrowded housing and the head of household’s social class). There are seven deprivation scores/categories with DepCat 1 being the most affluent and 7 most deprived.

3 P<0.0001
3.21 In conclusion, the comprehensive health check data suggested that WMS users were not generally the most ‘hard-to-reach’ although they were more likely to be from deprived areas, unemployed and were not consulting their GP.

**Promoting healthier lifestyles**

3.22 One of the aims of the WMS pilots was to promote healthy lifestyles, and it was therefore important to establish some appropriate baseline information about WMS users’ health related behaviour, current lifestyles and users’ views about the degree to which they considered their lifestyles to be a problem. Figure 3 compares WMS users with all men living in Scotland in terms of reported tobacco smoking, alcohol consumption and physical activity levels (SE 2005a). It showed that significantly lower proportions of WMS users reported smoking and drinking over 21 units of alcohol per week than the national average. It is important to note that 20% of Glasgow users indicated that they did not drink at all, compared to a national average of 8% according to the SHS. However, a significantly higher proportion of WMS users reported drinking more than 8 units per day.

3.23 WMS users also reported being significantly more physically active than the national average. Physical activity was defined as any activity that makes the individual hot or sweaty, lasts for at least 30 minutes and is carried out at least five times per week. However, it is important to note that the Greater Glasgow data were excluded from this analysis as a different definition was used when collecting data in this area.

3.24 The project dataset indicated that 47% of WMS users reported a dietary, weight or physical activity concern, and 13% indicated that stress was a problem. Only 8% of men were concerned about their alcohol levels despite the fact that 18% drank more than 21 units per week and 41% drank more than 8 units per day. In contrast, 70% of smokers thought their smoking was a problem. The men also reported some behavioural change as a consequence

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4 It was necessary to age-adjust the SHS data to enable a valid comparison.
of contact with the pilots. Fifteen percent of men were also referred to exercise services or to a dietician.

**Figure 3: Weighted comparison of WMS users and men living in Scotland reported physical activity levels and alcohol and tobacco use**

![Weighted comparison of WMS users and men living in Scotland reported physical activity levels and alcohol and tobacco use](image)

**Health and lifestyle advice and physical tests**

3.25 Providing appropriate health advice was considered a key aspect of the WMS and the project data indicated that 76% of WMS users were given some form of health or lifestyle advice by WMS staff. Most commonly, dietary advice (23%) was recorded, followed by lifestyle (18%), alcohol (10%) and smoking (8%) advice. Mental health (8%) and sexual health advice (5%) was also given.

3.26 When WMS users were asked about the type of advice they were given by staff (during the interviews), smoking cessation, diet or weight management featured most often. Dialogue about stress and mental health were generally missing from these accounts. Service provider interviews indicated genuine surprise about the levels of alcohol consumption they had found and the project data indicated that 10% of WMS users had received advice concerning alcohol. However, very few WMS users mentioned receiving any alcohol advice.

3.27 When WMS users’ were asked about their general recollections of their experiences, the process of having physical measurements taken and gaining some kind of test result figured large in these accounts. Most indicated height and weight were recorded and blood pressure measured. A smaller number indicated they had undergone blood tests for glucose and cholesterol, but not all projects offered these tests. The service provider interviews, on the other hand, confirmed that the majority of pilots focused more heavily on offering health and lifestyle advice, and less on providing or offering physical tests and measurements.
There was detectable frustration amongst some men about the lack of testing during clinic visits: one participant said that the prospect of getting advice alone would not encourage him to use the service because this could be obtained from other sources.

**Lifestyle changes made as a result of using WMS**

There was considerable potential for health gain with men reporting problems with smoking, alcohol and exercise (see Table 1). However, referral rates for alcohol and exercise were very low, suggesting that an opportunity for health gain was being missed.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Number of men (% all men) who reported each behaviour</th>
<th>Number of men who saw each behaviour as a problem</th>
<th>Number of men who wanted to change each behaviour</th>
<th>Number of men referred (% of those who wanted to change behaviour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>710 (2%)</td>
<td>485</td>
<td>422</td>
<td>230 (55%)</td>
</tr>
<tr>
<td>Alcohol – all men</td>
<td></td>
<td></td>
<td></td>
<td>28 (7%)</td>
</tr>
<tr>
<td>Drinking more than 21 units per week</td>
<td>549 (18%)</td>
<td>112</td>
<td>205</td>
<td>14 (7%)</td>
</tr>
<tr>
<td>Drinking more than 8 units on heaviest drinking day</td>
<td>1213 (41%)</td>
<td>122</td>
<td>273</td>
<td>15 (5%)</td>
</tr>
<tr>
<td>Physical activity – all men*</td>
<td></td>
<td></td>
<td></td>
<td>634 (5%)</td>
</tr>
<tr>
<td>Not being physically active at all</td>
<td>483 (24%)</td>
<td>310</td>
<td>371</td>
<td>20 (5%)</td>
</tr>
<tr>
<td>Active less than 30 minutes 5 times per week</td>
<td>548 (27%)</td>
<td>206</td>
<td>380</td>
<td>5 (5%)</td>
</tr>
</tbody>
</table>

* excludes Glasgow as data were not collected on the same basis

Men were not asked about their motivation to lose weight but of 354 men with a recorded Body Mass Index (BMI) over 30 (obese), there were 64 referrals (referral rate 18%). Referrals were made to a dietician (n=7), weight management service (37) or exercise interventions (20). For men classed as overweight (BMI between 25 and 30) the referral rate was 3.8%.

Self-reported lifestyle changes were claimed by some users which they linked to their use of the WMS pilots. Most commonly, these changes were associated with diet and physical activity levels. Less often mentioned were reductions in tobacco and alcohol consumption. More exceptionally, claims of major health changes, linked to a changed lifestyle (resulting from WMS service use) were made.
CHAPTER FOUR DEVELOPMENT OF EFFECTIVE WMS

Key Findings

Facilitators

- The WMS funding had coincided with growing interest and local activity in the area of men’s health. Those pilots established within areas with pre-existing men’s health services or partnerships appeared to function more quickly and effectively than those in other areas.
- Other features evident within pilots that appeared promising included:
  - good access to existing local resources and support services;
  - a supportive wider organisational context;
  - defined (realistic) objectives or a more detailed project plan;
  - motivated and committed staff; and
  - the presence of good partnership arrangements.
- Pilots were implemented reflexively, as staff sought to increase the uptake of services by modifying them, e.g. moving to a different location in some cases. Staff commitment was a crucial factor in overcoming early implementation challenges.

Challenges and inhibiting factors

- The WMS pilots’ three aims of trying to establish strong community links, develop appropriate support mechanisms and providing comprehensive health assessments proved to be ambitious within the lifetime of the project.
- Some projects expressed frustration at the perceived implementation of an existing men’s health service model as contrary to the nature of pilot funding and unnecessarily medicalised in its approach.
- Lack of detailed project planning, focussed on outcomes, seemed to be associated with challenges and difficulties staff reported in implementing their pilots at the frontline.
- In most cases, pilots were significantly delayed in starting due to:
  - divergent professional views about the types of services to be offered within the WMS;
  - a changing primary care structure within the NHS at the time; and
  - lack of system capacity to deal with and host the WMS funding.
- In a small number of cases, the planned number of health assessment appointments was cut back to accommodate the collection of required evaluation information.
- Lack of follow up was considered a key service weakness by the users and providers.

Developing the pilots: The context

4.1 A key evaluation objective was to identify factors that facilitated or inhibited the development of effective WMS as an aspect of the Men’s Health Strategy objectives which were about:

- establishing strong community links;
- developing appropriate support mechanisms; and
- the provision of a comprehensive health assessment.
4.2 It is important to point out that the Camelon project, the basis on which the WMS pilot’s project was conceived, had developed over time. Camelon had started providing health assessments before developing links with support mechanisms and services and had then eventually moved into community development work. The WMS pilots were in reality tasked with doing all three aspects simultaneously. Moreover, partnership bids were invited from health, local authority and voluntary sector organisations to propose innovative WMS pilots for their local communities. Bidders were also asked to include local men in their development and implementation. These commissioning factors help explain the relative success of those that were already well placed with community links and support mechanisms.

4.3 A wide range of agencies contributed to the development of the pilot proposals, and many indicated that multi-agency steering groups played an important role in this process. The SE funding announcement had coincided with a lot of local interest, activity and enthusiasm for men’s health. On the whole, the bid and partnership development seems to have been led by personnel from local NHS organisations although the national and some local Men’s Health Forums played an important role in local development plans. Furthermore, public health nurses played an influential role in taking the issue forward within various Local Health Care Cooperatives (LHCC’s) in many cases. The Camelon project, regional health targets and the GP contract were also given by respondents as factors in the WMS development.

4.4 Some stakeholders regarded the WMS pilots as an opportunity to develop initiatives based on ideas that emanated from their local communities. However, the invitation to bid also indicated that pilots should also attempt to incorporate aspects of the Camelon model and this was interpreted by some as counter to the ‘piloting’ nature of the project, and limited the amount of external influence that could be brought to bear on their proposals. Hence, there was some frustration expressed amongst a few pilot projects at having to comply with a project development and evaluation framework regarded as irrelevant, or lacking the potential to address men’s health problems properly. There was a common view that the scope of WMS pilots had to be extended beyond the Camelon model, which was perceived by some as limited or overly medicalised.

4.5 Nevertheless, there was evidence to suggest that voluntary agencies, men’s groups and community activists had been responsible for adding additional dimensions to some of the local pilots during the development phase, or for shifting the focus in a very small number of cases to a so-called ‘social model’ of men’s health, and incorporating more services and dimensions than might have been the case otherwise. Many staff informants also viewed community development as an essential component of their pilots and they invested considerable energy in trying to establish this type of work with men from their local communities.

4.6 A review of the pilots’ bid documentation was undertaken at the start of the evaluation. This revealed that project plans generally lacked clearly articulated, realistic and measurable aims and objectives, and a well-defined programme plan or theory. In the small number of cases where these features were more evident, those initiatives tended to report more success in achieving their aims than others pilots. However, there was a common view that there had not been enough time to work through every detail of the original bid before
submitting it, including insufficient time to build partnership alliances to meet the funding requirements.

4.7 Consequently, staff did not appear to foresee the delays linked to the impact of other (sometimes competing) NHS policies, and there were obvious debates within projects associated with differences in opinions and perspectives between professional groups about the nature of the men’s health problems and the services that should be offered. Furthermore, there was a lack of clarity and consensus about the intended outcomes amongst the various stakeholder groups in some pilots and about the precise nature of the services that would be subsequently offered in others. In some cases, these issues were unresolved some months after the funding had been awarded.

**Early implementation**

4.8 It was very obvious during the early fieldwork stage that participants’ initial enthusiasm had been somewhat tempered by delays that most had experienced in setting up their pilots, and that a lot of frustration had developed as a result. The main theme to emerge during implementation was a prevalent view that unknown or new NHS human resource policies and procedures, associated with staff employment and recruitment, had inhibited progress. In addition, structural changes taking place in the NHS and the apparent lack of strategic direction and ownership at a local level, led to project staff questioning whether or not there was any real organisational commitment to men’s health.

4.9 One of the larger pilot regions also reported substantial resistance from their local Managed Clinical Network to their plans to offer certain screening tests including cholesterol testing. This debate had created large delays in agreeing local WMS protocols. A number of project staff expressed strong views that they believed that these ‘tests’ needed to be an integral feature of the service, as past experience had led them to believe they were exactly what would attract men to the service. This was borne out by the interviews with users which confirmed the attraction of such tests.

4.10 There were also problems associated with initial system capacity to deliver the WMS projects. Some staff reported significant delays in receiving their allocated SE money after it had been released to the health boards. This was exacerbated in some cases by a lack of facilities, equipment, or personnel to set up and operate some of the pilots. Some staff also claimed to have reduced the planned number of appointments during each session the pilots operated, to accommodate the collection of monitoring data. There were concerns expressed generally by project staff that potential service users would be deterred from using or returning to the pilot because of the perceived demands of the external evaluation. Men and frontline staff also considered the lack of follow up work a service limitation, but a potentially very useful element of a WMS.

4.11 Most projects did not start to function properly until May/June 2005, six to eight months after the start date most had indicated in their original bids; the issues highlighted above provide some insight into why this was the case. Furthermore, when it was announced in November 2005 that there would be no further national funding, most project managers communicated to the evaluators that either their pilot would be wound up at the end of March 2006 (the end of the funding period) or that services would be cut back to try to extend the life of their pilot beyond the end of funding period. Therefore, many projects were evaluated
on the basis of less than one year’s operation before they were terminated: a few were offered for slightly longer, but were arguably diluted as a result. It is fair to say that as a consequence, the services that were ultimately delivered did not fully reflect their intended nature, as described in the original bids.

4.12 The WMS pilot projects were heterogeneous. They varied according to the methods used to engage with men; the type of service they offered; their location; and their intended target group (within the broad umbrella term of hard-to-reach men).

4.13 Project staff reported implementing their new services reflexively, with several describing pilots evolving or changing during their lifetimes. For example, if attendance was low in one venue, the service was withdrawn and relocated elsewhere. Local developments in other linked services also resulted in changes being made to the services the pilots offered.

4.14 Some staff thought there was lack of ‘fit’ between the evaluation and the pilots’ objectives and some believed that the ‘goal posts’ had changed after the pilots had been commissioned. However, one staff informant felt that it was more the case that there was a lack of clarity amongst the pilot staff themselves about the importance of evaluation in the WMS.

4.15 Other challenges associated with implementation mentioned less often by informants related to practical issues and ideological positions. For example, one pilot indicated that delivering their services in a large, geographically diverse region was challenging, unsurprisingly. In addition, the perceived, overly clinical focus of the WMS remained a key stumbling block for some. There was also a perception that there was a lack of transparency concerning the rights and responsibilities of the different partner organisations involved in delivering the pilots.

Service delivery

4.16 The commitment of frontline staff played a crucial role in enabling the pilots to operate in the face of many challenges. However, staffing difficulties were an ongoing concern. Difficulties were perceived to emanate from factors such as a failure to employ permanent coordinators, and high staff turnover. Another common problem was the fact that services were not fully integrated and known to be time limited. This was exacerbated by the common practice that emerged amongst pilots of employing part-time and seconded staff. This negatively impacted on the services delivered, a common problem for public health work within the NHS (Whitelaw et al. 2006).

4.17 Flexible delivery approaches are also associated with increased uptake by men. It is clear that some found it easier to access services in the evening due to work or family commitments. Yet others indicated that services offered during the day were easier to attend, and those living in urban areas were less concerned about personal safety issues at this time. There was also evidence that some pilots successfully adapted their service delivery strategy (mid pilot) in order to encourage more men to use their service, after they had gained some experience in dealing with their target group.

4.19 Pilots located in areas with existing complementary services and resources, and pre-existing community coalitions or activists, were able to establish themselves more quickly.
For example, the service mapping exercise (see 2.11) indicated that the Glasgow pilot appeared to have much more scope to refer men to existing support services and had higher referral rates.

4.19 In several areas, men’s health had been an area of interest within the NHS prior to the pilots, hence they appeared more integrated within mainstream services and this positively affected service delivery.
CHAPTER FIVE     GOOD PRACTICE IN MEN’S HEALTH

Key Findings

- There is little evidence in the literature about the effectiveness (or otherwise) of WMS in general or about alternative methods of service delivery.
- No one service model suited all men. Users seemed to favour medical/physical tests; this contrasted with some service providers who viewed lifestyle advice and community development work as more appropriate.
- There was general ambivalence amongst users and non-users regarding the value of male specific services.
- Comprehensive health assessments could be delivered at similar costs in different settings, but workplace delivery had the lowest range of costs.
- Sessions held in community venues or workplaces were more likely to contact men who had not seen their GP in the past two years, but these men did not appear to have greater health needs.
- Potential health gains could be achieved through WMS at a cost per Quality Adjusted Life Year (QALY) below the threshold for many clinical interventions, if changes in health behaviours were achieved. However, opportunistic intervention in primary care is likely to be more cost-effective for the majority of men.

Introduction

5.1 This chapter presents the main points to emerge from a systematic literature review that was conducted to establish any existing evidence for men’s health improvement practice. It also presents information about the preferred attributes of a WMS from the perspective of potential users. The second half of this chapter focuses on the main findings relating to the potential costs and benefits of the pilots.

The existing evidence base

5.2 The systematic review indicated that little evidence existed about the effectiveness (or otherwise) of WMS in general or about alternative methods of service delivery. The review suggested that some interventions either showed limited effectiveness and/or an effect under specific conditions or in a specific context. The review revealed some evidence of effective interventions that specifically targeted men related to smoking, diet and physical activity, cardiovascular disease, cancer, preventive health screening and alcohol. The full review report has been produced separately for reference (Robertson et al. 2006). However, this report confines itself to a discussion of the nature of the evidence related to three specific health issues - smoking, diet and physical activity - as illustrative examples.

5.3 In terms of smoking cessation, three studies reported effective interventions for men. Two reported interventions aimed at individuals; one used self-help manuals (Pallonen et al. 1994) and one used video and nicotine replacement therapy plus other support materials
(Stanton et al. 2004). The latter study involved male partners of pregnant women. The third study - a controlled before-and-after study of a media-led anti-tobacco campaign - reported that smoking prevalence fell by 2.2% points over 2 years in its target area and increased by 1.3% points in the control area (Jenkins et al. 1997).

5.4 Two studies were found that reported on the effectiveness of diet and physical activity interventions. One small Randomised Controlled Trial (RCT) (n=45) compared a combination of nutrition counselling (NC) and serum cholesterol (SC) measurement with no intervention. In the NC+SC group, there was a significant reduction in fat intake (3.2%) over a 6-week period based on self-reported food intake (Williams and Lewis 2002). A workplace intervention, consisting of a monthly health promotion workshop, showed significant self-reported changes on some indicators e.g. vegetable intake, physical activity, dietary knowledge, and improved blood pressure (Cook et al. 2001).

5.5 Services for the general male population were found in 4 UK-based process evaluations. Two of the reports related to a nurse-led service targeting men through GP practices (Camelon) (Lieshman and Dalziel, 2003a; 2003b); the other projects were more community-based and had developed a diverse range of services in various settings (Turnbull 2004; White and Cash, 2005).

Men’s response to the WMS

5.6 This evaluation indicates that no single service model suits all men. Some very targeted approaches were successful in engaging with specific groups of men. For example, the East Glasgow pilot was successful in recruiting homeless men by basing the service within the heart of this community.

5.7 Interviews held with men indicated that there was general ambivalence about the need for a men’s health service amongst users and non-users, although some users were extremely enthusiastic about the existence of such a service. However, the WMS seems to have provided an opportunity for men to raise health concerns that they thought inappropriate to raise with their GP. This was true both of men who had been in contact with their GP in the past year and those who had not.

5.8 In general, service user interviews indicated that men favoured a more medicalised type of service, and that clinical tests were considered a valued and sometimes missing aspect of the service. Cholesterol and blood pressure tests were particularly sought. A Discrete Choice Experiment (DCE) approach was also used to identify men’s preferences for different attributes of the WMS using a sample of men from the general population. On average, men in this sample also showed a preference for a service in a health centre that provided detailed health advice and follow up sessions, and test for blood pressure and cholesterol, provided on weekday evenings. The results were tested to identify whether there were clusters of men within the sample who expressed different preferences for service attributes and this was found to be the case. Further analysis was undertaken to explore the possible sources of variation in men’s preferences. However, using the socio-demographic data available, area of residence, age, income, education, employment status and hours worked, preference clusters were not sufficiently well identified to inform the targeting of

5 Please see http://qshc.bmj.com/cgi/content/full/10/suppl_1/i55 for more information on this technique.
services. Analysis of these two data sources reinforces the notion that similar factors may impact on different men in opposite ways. The next section put the above findings in a cost and benefit context.

Economic Analysis

5.9 The economic analysis focussed on the costs and outcomes relating to the comprehensive health assessment based on different delivery modes, where possible. Some of the individual pilots adopted more than one approach to the delivery of health assessments and the amount of diversity across a small number of pilot areas made systematic comparisons difficult. Three main service locations were able to be analysed to some extent; health clinics, workplaces, and community venues including pharmacies.

5.10 Detailed costs were provided by some of the pilot areas, in some cases at the level of individual clinics, and this enabled a cost comparison of delivery modes to be carried out on the basis of cost per session and cost per health assessment (See Table 2). Staff variation was the main factor in different session costs and attendance rate was the main factor in cost per health assessment, particularly at drop-in type services in community venues, where attendance was unpredictable. Similar costs could be achieved in different settings, but workplace delivery had the lowest range of costs.

Table 2: Cost comparison of delivery modes

<table>
<thead>
<tr>
<th>Location</th>
<th>Cost per session</th>
<th>Cost per assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Range</td>
</tr>
<tr>
<td>Health clinics</td>
<td>9</td>
<td>£189- £836</td>
</tr>
<tr>
<td>Workplaces</td>
<td>2</td>
<td>£208-£220</td>
</tr>
<tr>
<td>Community venues (incl. pharmacies)</td>
<td>6</td>
<td>£101-£428</td>
</tr>
</tbody>
</table>

5.11 Outcomes were considered in terms of contacts, particularly with ‘hard to reach’ men, onward referrals and potential health gain.

5.12 Sessions held in community venues or workplaces were more likely to contact men who had not seen their GP in the past two years, but these men did not appear to have greater health needs. Men who smoked or drank more than guidelines were slightly more likely to have seen their GP in the past 2 years than the average but those who had a BMI over 25 or who were less physically active were slightly less likely to have seen their GP in the past 2 years. Men who had blood pressure or cholesterol levels recorded were less likely to have seen their GP in the last 2 years irrespective of the result. Projects which had a larger element of workplace recruitment had higher proportions of men reporting good or very good health but targeting of blue collar workforces in one area meant that a higher percentage of men were seen from DEPCAT 6 and 7.

5.13 The number of referrals per man assessed varied from 0.2 to 2.1, with the lowest rate observed where there was a large workplace component and the highest rate observed with a clinic centred approach with additional specialist staff at the clinic. These differences in referral rates carried through to the direct costs per referral (range £507 for the lowest referral rate to £90 for the highest referral rate). Twenty eight percent of men seen by the projects were referred to their GP for action and 15 % were referred to the practice nurse. Thereafter
the main categories of referral were smoking cessation 9.3%; exercise referral 7.3%; dietician 7.2%; and weight management 5.7%.

5.14 In order to illustrate the potential health gains from well men services, changes in final health outcomes were modelled for five modifiable risk factors: smoking, alcohol, physical activity, BMI and blood pressure. Combining the results of all 5 potential areas of health gain, the cost per Quality Adjusted Life Year (QALY) was estimated to be between £3,000 (at £100 per health assessment) and £6,000 (at £200 per health assessment) depending on the assumptions made. This figure could be more than halved if referrals for alcohol and exercise interventions were increased to the levels achieved for smoking cessation.

5.15 However, the underlying cost per QALY for the smoking and physical activity interventions, in particular, without the prior health assessment, are much lower than these figures for the combined WMS and follow on interventions; £73-£487 per QALY for smoking cessation (Woolacott et al. 2002) and £20 - £670 per QALY for physical activity interventions (Matrix Research and Consultancy, 2006). The initial results also assumed that no intervention would take place in the absence of the WMS. However, if GPs offered lifestyle advice during routine consultations then, for example, the additional cost per QALY for smoking cessation provided through the WMS would be £9,828 (£100 per assessment) to £19,383 (£200 per assessment). For alcohol interventions and exercise, the referral rates from WMS were so low that any reasonable assumptions about GP intervention rates produce outcomes that dominate the WMS (i.e. they produce more benefit at less cost).

5.16 Although potential health gains could be achieved through WMS at a cost per QALY below the threshold for many clinical interventions, the limited data collected for this evaluation cannot provide clear evidence of cost-effectiveness. Opportunistic intervention in primary care is likely to be more cost-effective for the majority of men but may have limitations for hard-to-reach men. A combination of approaches may be more likely to achieve the desired combination of efficiency and wide coverage.
CHAPTER SIX LEARNING POINTS AND CONCLUSIONS

Key Findings

Development and Implementation
- Interventions need longer lead times, realistic aims and measurable objectives and outcomes.
- Partnership working was a factor in successful engagement.
- Organisational restructuring, bureaucratic procedures and mixed messages about the purpose of the funding delayed implementation.
- Promising pilots appeared to have more defined objectives; good partnership arrangements; good access to existing local resources; and a supportive wider organisational context.
- Lack of follow up was a key service weakness.

Impacts
- Attempting to achieve multiple objectives probably slowed down the development of each one within the time available.
- Key referrals were made to existing ‘easy’ to access health services; other services were well less used.

Policy learning
- Similar issues were both motivating and inhibiting factors for WMS uptake for different men.
- Men favoured mainstream health services, but one size does not fit all.
- Risks of smoking are accepted by men; but alcohol misuse and physical inactivity were not regarded as problems.
- Men liked physical tests and measurements, and valued follow up.
- Primary care services should develop a gender-friendly health improvement ethos to make both men and women feel welcome.
- There was a lack of referrals for health promotion services other than smoking cessation, possibly through lack of availability.

Project planning and evaluation
- Despite the ‘demonstration’ nature of the pilots, evaluation was not high on the agenda of most service providers, and there was a lack of planning for their contribution to the evaluation process.
- The project changed and evolved in response to population uptake during the implementation phase making it harder to measure cause and effect.
- A theoretical underpinning would help guide future projects.
- Research gaps have been identified in several areas.

Introduction

6.1 This chapter discusses the main themes and conclusions to emerge from the study. It presents the main lessons learned about the development, implementation and impact of the WMS, including the extent to which the pilots’ objectives were achieved within the lifetime of the WMS project. It concludes by discussing the main implications to emerge for any future men’s health policy or practice developments and some of the challenges that emerged from conducting this evaluation.
Development and Implementation

Scope and timescale

6.2 The expectation that the projects would have been able to address all three overall pilot aims (promoting healthier lifestyles and attitudes amongst men; providing men with the opportunity to undertake a health assessment; and effectively engaging all men), even within a time frame unaffected by subsequent implementation difficulties, was rather optimistic. Health promotion programmes can take at least a year to be implemented, and the first year is often characterised by little obvious impact (HEBS, 1999; Whitelaw et al. 2006; SE, 2005c). Although the WMS project was commissioned to run for a period of two years, most pilots ran as functioning services for a very short period. The strategic context, which sought both community development and service delivery, also contributed to widening the scope of the projects.

Planning

6.3 A striking feature of the pilots’ original bids was the lack of explicit discussion or apparent cognisance of possible threats or challenges to successful implementation, illustrated by the delays in starting up the pilots. Pilots lacked realistic and rigorous objectives, or theoretical underpinning. Those that had some of these features tended to report more success in achieving their aims than other pilots, and the authors believe that these features contribute to more effective programme implementation and evaluation design that is fit for purpose.

Partnership working

6.4 Most pilots were led from within the NHS, which brought a certain perspective and both barriers and opportunities. Those pilots that reported considerable investment in developing their partnerships during the process of creating and submitting their bid, or where partnerships existed prior to the WMS, were arguably more successful in engaging with their intended target group of men, and in making links with other support services. It is recognised that the development of successful community-based partnerships requires long-term commitment.
Introducing new initiatives within the existing health care system

6.5 Embedding WMS within health services meant that projects could draw upon existing resources. However, organisational restructuring, perceived lack of senior management commitment, and the administrative requirements of a large bureaucracy led to frustration amongst staff who were keen to get on with the job but felt a lack of strategic direction. More lead time needs to be factored in at the planning stage before projects are likely to be fully implemented.

Different values and perspectives about funding

6.6 The strategic aims of the Men’s Health strategy and the wide scope of the pilot objectives meant a rather mixed message was received about the aims and purpose of the funding. In particular, there were tensions between the community development aspects of the WMS and the delivery of comprehensive health assessments. There was a perception held by some project staff that the Camelon model had been imposed on the pilots. There is a need to ensure either that objectives are clear and consistent or that a framework is established for setting priorities between multiple objectives.

Pilots that showed promise

6.7 While it was difficult to establish factors that were associated with successful pilot implementation due to the short time scale, those pilots that were beginning to show signs of promise (e.g. getting clients through the door) had common features. These included having defined (realistic) objectives or a detailed project plan; motivated and committed staff; good partnership arrangements; good access to existing local resources and support services; and a supportive wider organisational context. Lack of follow up was considered a key service weakness by the users and providers.

Impacts

Achieving objectives

6.8 All of the pilots undertook activities directed towards the first objective of promoting healthier lifestyles and attitudes amongst men. The emphasis on general awareness raising activities varied, as did the degree to which these were documented by the projects. The scale of activity achieved through the pilots would not have been sufficient to have a significant impact at the population level, during their period of operation. Most pilots achieved the second goal of establishing a formal health assessment, although the nature of this varied. For example, some included a physical assessments others conducted a brief ‘MOT’ type assessment.

6.9 The third objective, effectively engaging with all men, was also partially achieved. Although 3,367 men were recorded as using the WMS, the pilots did not generally reach the hardest-to-reach men although there were some notable exceptions. However, it needs to be borne in mind that there were gaps in the available data returned to the evaluators. Hard-to-
reach groups may be less likely to complete the individual level data and the pilots differed in
the extent to which they documented and quantified their outreach activities.

6.10 Most staff thought that the pilots had been successful in achieving their locally
determined short term goals, but not the medium or longer term ones. A few reported that
their project had not achieved any of their goals due to insufficient time and the lack of
realistic project objectives.

6.11 We think it is possible that, as a result of WMS staffs’ push to try to achieve all the
WMS pilots aims at the same time, that the time spent developing community links may have
reduced capacity to undertake health assessments, or vice versa, and that the tensions
between different strands of the strategy had the net effect of diluting the overall (potential)
impact of the WMS initiative.

Contribution to Men’s Health Strategy

6.12 The men’s health strategy was built upon the key principles of establishing strong
community links; developing appropriate support mechanisms; and providing a
comprehensive health assessment. The projects with the strongest community links were
those where pre-existing partnership working was in place and the timescale of the pilots
provided limited opportunities for new community development work to establish results.
The second objective was partially achieved as was evidenced by referrals to GPs, practice
nurses and smoking cessation services. However, such referral pathways were already open
to men without the need for referral by another service or health professional. Other potential
interventions or support services were less well used, although a few pilots did set up their
own follow on services, e.g. weight management. As indicated above, all of the pilots
provided health assessments to a varying extent.

Policy learning

6.13 Despite the limited nature of the WMS pilot project, there are a number of emergent
findings about men’s health and men’s views about primary care services in Scotland that
could be used to inform any future men’s health work.

Factors that encouraged and inhibited WMS use

6.14 Men who used WMS pilots reported doing so for three reasons: first, curiosity about
the WMS as well as a motivation to seek information about their health (sometimes about a
pre-existing condition) from other health professionals was associated with service uptake.
Secondly spouses, partners or friends played an influential role in encouraging men to attend
and, thirdly, the perceived convenience and accessibility of the WMS services were factors in
service use. However, factors that encouraged some men, paradoxically, inhibited others;
e.g. services provided during the evening in some urban locations were considered
inappropriate by men because of concerns about being out in the evening in the areas in
which they lived.
No ‘one size fits all’

6.15  In general, men favoured services that were located in mainstream health care settings, offered more in-depth consultations and tests, and incorporated some form of follow up work. However, there was diversity in men’s preferences and we conclude that no one model or approach to addressing men’s health is suitable for blanket application across Scotland, and believe that the optimal standard for the development of men’s health services is one that should be dictated by needs of the target group, health topic, setting and local circumstances; a view which is consistent with the position advocated by Judd et al. (2001). In order to reach men, it may be necessary to offer a range of services in different settings. Direct targeting of specific groups of men was often successful; reaching homeless men in East Glasgow by taking the service to the heart of their community was a prime example. Other pilots achieved success in engaging with LGBT men and gypsy travellers by working directly with key stakeholder groups from these communities.

Men’s health: Scope for health improvement

6.16  As far as we are aware, this was the first attempt in Scotland to engage directly with men (in a comprehensive way) to explore their views about their health and well-being; what changes they feel they want or should be making to their lifestyles (to make them more health enhancing); and how and where they think primary health services should function to support their health seeking behaviour.

6.17  The health risks of smoking are clearly accepted amongst men, but there is a stark difference in their perception of other health behaviours, such as alcohol and physical activity, as health problems (see 3.29 Table 1). However, an encouraging proportion of men expressed a desire to change their behaviour, indicating that great potential for men’s health improvement exists. The experience of tackling smoking suggests that capitalising fully on this potential may require concerted action across government both to lower barriers to healthy behaviours and to discourage unhealthy behaviours, in addition to individualised health improvement interventions.

Testing and follow up

6.18  Men valued having physical tests and measurements taken, especially blood pressure (BP) and cholesterol, during their health assessments, and for many the prospect of these had encouraged them to come and use a WMS pilot. Yet it was clear that there was concern about (and resistance to) wholesale testing (BP and cholesterol) of WMS users amongst some health professionals. It is beyond the scope of this evaluation to suggest what appropriate clinical practice (for BP or cholesterol) should be in the context of well men services, but we recommend that there is further exploration and development of protocols that would meet both the expressed and felt needs of men and the clinical evidence base, in order that this ‘engagement opportunity’ is not squandered. Developing follow-up services would also enable men to have access to sustained support in addressing any health concerns identified.
Local interpretation and implementation of nationally determined initiatives

6.19 The WMS pilot programme was perhaps overambitious in attempting to (a) address a complex issue, such as men’s health, where there is no clear evidence base for interventions, and (b) contribute to the development of that evidence base. This pilot programme also encouraged a diversity of approaches to delivering WMS, with the intention of identifying which approaches were better than others, but it also had multiple objectives that projects interpreted in different ways. This was therefore a commendable attempt to commission health services developed with input from both the intended target groups and professional groups and organisations (a blend of so-called ‘top-down’ and ‘bottom-up’ approaches). While this is considered to be ideal health promotion practice, in reality, it is difficult to achieve, and tensions and misunderstandings are commonplace within this approach, as evident within this project.

Primary care

6.20 Primary care remains a key setting in which to reach a large proportion of men. WMS users were in the habit of consulting their GP, but were reluctant to raise lifestyle, prevention type queries with them. There are a number of strategies that would improve current practice in engaging with them about health promotion issues in this context. Mainstream primary care services could develop a ‘gender-friendly, health improvement’ ethos, that encourages men (and women) to raise all kinds of health concerns with their GP, not just those related to a current health concern or illness.

6.21 Concerns about the availability of, and referral to, follow on services other than smoking cessation also remain. Having successfully engaged men in considering their health, the low levels of further intervention with respect to alcohol and physical activity represented a missed opportunity. More attention should be given to identifying and putting in place appropriate interventions before general health promotion activities take place.

Project planning and evaluation: Twin challenges

6.22 Although project proposals indicated that staff had agreed to conduct or engage with evaluation work as a condition of the funding, there was a general lack of engagement with the evaluation processes during implementation, illustrated not only by the nature and quality of the data received from many of the pilots, but also through insights gained through the staff interviews. It was apparent that little formal planning for evaluation had taken place; most pilots had not identified additional resources or mechanisms (existing or otherwise) to collect information and the majority did not have the capacity to undertake this function. Having said that, the vast majority of staff did recognise the need to collect activity information.

6.23 The diverse range of perspectives (individual, professional and organisational) that emerged about the most appropriate ways to address men’s health ultimately influenced how staff viewed the intent of the WMS funding and, their notions about relevant criteria that should be used for evaluation. The commissioning process (of projects of this nature) needs to take account of this phenomenon and to ensure that adequate time is factored in to clarify such issues, and address any tensions that will inevitably arise during the bid development
stage. This is particularly important when dealing with diverse, multi-agency partnership groupings.

6.24 There was a lack of appreciation that this pilot project was effectively a ‘demonstration’ project, which was entirely different from previous projects in which staff may have been involved. Frontline staff could have been better informed about the nature and purpose of the evaluation. However, individual and organisational deficits associated with health promotion evaluation capacity are systemic throughout Scotland (NHS Health Scotland, 2006). Commissioners and programme planners may also wish to require or recommend that more time and resources are focussed on capacity building work for frontline staff employed on demonstration projects in the future.

6.25 Most projects also evolved and changed in order to engage more effectively with their intended target group. This level of project ‘instability’ presents evaluators with challenges in determining which particular aspects of a service should be linked with any of observable impacts or effects that might emerge.

6.26 There is a need for project planners intending to implement new complex, multi-agency, community-based projects (like the WMS) to develop partnership models of working that can be evaluated. Future funding should require all potential bidders to develop and submit proposals that include an evaluation plan, alongside the proposed project plan. This might encourage project planners to articulate the ‘theory’ of their project. None of the WMS pilots6 indicated any sort of theoretical basis; a persistent criticism of health improvement projects (Hawe et al. 1990; Tones and Tilford, 1994). More crucially, such proposals may also encourage planners to think in more detail about project and evaluation requirements, and consider all related resource implications. Evaluation plans should also be developed with external evaluators at a much earlier stage, particularly for larger scale projects. The use of planning models (e.g. logic models) may have assisted in addressing these points (Cooksy et al. (2001), WK Kellogg Foundation (2004)).

Further Research

6.27 The evaluation suggests that further investigation is required to explore the professional and organisational capacity, particularly within primary care, to deal with possible increased demand for health improvement work by men.

6.28 Due to the short operational time frame of many of the WMS pilots a question remains about how effective sustained community development can be in challenging men’s attitudes towards their health and health services use.

6.29 It is also important to identify effective ways of engaging with young men and men without partners with health improvement efforts. These groups emerged as hard-to-reach by the WMS pilots.

6.30 Lastly, the impact of the WMS on health outcomes over time could not be addressed in this study because of the time scales involved. However, some projects have the potential to follow up their clients and it should possible to explore this issue in the future.

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6 It is important to note however, that this question was not directly raised during interviews with staff.
REFERENCES


ANNEX 1: MAP OF SCOTLAND SHOWING HEALTH BOARD REGIONS AT THE TIME OF THE WELL MEN SERVICE PILOTS

NB. Circled health board areas are those which hosted WMS projects
## ANNEX 2: CHARACTERISTICS OF PILOT PROJECTS AS DEFINED BY THE EVALUATION TEAM

<table>
<thead>
<tr>
<th>Tayside</th>
<th>Topic</th>
<th>How</th>
<th>Who</th>
<th>Where</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>W; SC; C</td>
<td>C</td>
<td>D</td>
<td>U</td>
<td>General targets: D; R; W; D; H; T; E. Special methods: S; O</td>
</tr>
<tr>
<td>2</td>
<td>B; SM</td>
<td>C; follow-up</td>
<td>D</td>
<td>U</td>
<td>Special venues: football grounds; clubs; pubs.</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>D; W</td>
<td>R</td>
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<th>Where</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>CW; S</td>
<td>O; C</td>
<td>D; S; H</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CW; S; MH</td>
<td>C</td>
<td>D; S; MH</td>
<td>U</td>
<td></td>
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<tr>
<td>3</td>
<td>S; C; SH</td>
<td>M</td>
<td>S; MH</td>
<td>R</td>
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<tr>
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<th>Who</th>
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<th>Comments</th>
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<tr>
<td>1</td>
<td>HA</td>
<td>C</td>
<td>NGP; DU; SN; AU; E; H; U; G; BS; EM</td>
<td>R; U</td>
<td>HA will be offered in satellites.</td>
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<th>Glasgow</th>
<th>Topic</th>
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<th>Where</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>Health piloted</td>
<td>H; U; DI; E</td>
<td></td>
<td>U</td>
<td></td>
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<tr>
<td>2</td>
<td>Health</td>
<td>C</td>
<td>U; S; H; SN</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C; C</td>
<td>D; U</td>
<td>U</td>
<td>Special venues: football grounds; clubs; pubs.</td>
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<tr>
<td>4</td>
<td>C</td>
<td>C</td>
<td>E</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>C; SH</td>
<td>NGO</td>
<td>Hard reach</td>
<td>U</td>
<td>Hard-to-reach men not specified</td>
</tr>
<tr>
<td>6</td>
<td>C</td>
<td>C</td>
<td>D; U</td>
<td>U</td>
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<th>Highland</th>
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<th>Who</th>
<th>Where</th>
<th>Comments</th>
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<tr>
<td>1</td>
<td>HA; SC; MH</td>
<td>C</td>
<td>E; SN; T; MH; H; U; W; DI</td>
<td>R</td>
<td>User involvement service design</td>
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<td>1</td>
<td>HP; C</td>
<td>H; E; D</td>
<td>4x LHCC</td>
<td>User involvement service design</td>
<td>Hard-to-reach men not specified</td>
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<th>Shetland</th>
<th>Topic</th>
<th>How</th>
<th>Who</th>
<th>Where</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>C; A; MH; D</td>
<td>C</td>
<td>W; MH</td>
<td>R</td>
<td>Too small to target sub-groups Men’s health week planned</td>
</tr>
</tbody>
</table>

**Notes**

**Topic:** W=weight management; SC=smoking cessation; C=counselling; B=blood pressure; SM=Stress management; CW=community work; S=screening; MH=mental health; HA=health assessment; SH=self help group; HP=health promotion; A=alcohol; D=drugs

**How:** O=outreach; M=mobile bus; C=clinic; S=street work; RS=road show; NGO=non statutory service

**Who:** H=homeless; Y=young; E=ethnic minorities (BME); U=unemployed; W=workplace; D=deprived; T=travellers; S=socially excluded; MH=guyys with mental health issues; NGP=not in contact with GP; DU=drug users; AU=alcohol users; SN=special needs (e.g. learning disabilities); G=gay; BS=bisexual, EM=employed men; DI=disabilities

**Where:** U=urban; R=rural
## ANNEX 3: OVERVIEW OF EVALUATION OBJECTIVES AND RESEARCH METHODS

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Methods</th>
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<tbody>
<tr>
<td><strong>1. Implementation</strong></td>
<td></td>
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</table>
| Establish a baseline, which describes the characteristics of men and of practice in relation to men’s health in each of the pilot sites at the point when the pilots commence. | Systematic literature review  
Analysis of pilot project (PP) monitoring data - All projects  
Secondary analysis of routinely collected men’s health and health service use data |
| Develop with pilot partnerships a consistent framework for the collection of monitoring information on the operation and outcomes of the pilots. | Development of PP monitoring framework and database - All projects |
| **2. Operation of the pilots** |                                                                         |
| Describe and compare the development, implementation and operation of each of the pilots. | Visits and interviews with key service provider (SP) informants - All projects  
Case studies - Three selected projects |
| Describe and assess the impact of the partnership arrangements in each of the pilots, examining the management structure, senior management support, involvement of all key stakeholders including service users, inter-agency working, and individual cultures of different partners. | Visits and interviews with key SP informants - All projects  
Case studies - Three selected projects |
| Assess how local systems support and inform the development and delivery of effective services by examining local arrangements for monitoring and evaluation, quality of information, information flows and the use of information to inform further planning and service delivery. | Case studies - Three selected projects |
| Evaluate the community engagement strategies developed by the pilot partnerships. | Case studies - Three selected projects |
| Evaluate the extent to which pilots are developing and delivering services based on evidence of what works. | Case studies - Three selected projects  
Interviews with key SP informants - All projects  
Analysis of PP data - All projects  
Systematic literature review. |
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Methods</th>
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<tr>
<td><strong>3. Engaging with men</strong></td>
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<tr>
<td>Describe the ways in which pilots have</td>
<td>Focus Groups/Interviews - Users and non-users in three selected case study projects</td>
</tr>
<tr>
<td>informed and consulted men in the design,</td>
<td>Visits and interviews with key SP informants -All projects</td>
</tr>
<tr>
<td>delivery and implementation of the pilots,</td>
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<td>identifying any specific barriers encountered.</td>
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<tr>
<td>Describe and assess how the pilots track and</td>
<td>Focus groups/interviews - Users and non-users in three selected projects</td>
</tr>
<tr>
<td>maintain engagement with men using well men</td>
<td>Visits and interviews with key SP informants -All projects</td>
</tr>
<tr>
<td>services, considering why and at which points</td>
<td>Health economic methods (DCE) - All projects and three control health board areas</td>
</tr>
<tr>
<td>some men may drop out.</td>
<td>Analysis of PP data - All projects</td>
</tr>
<tr>
<td>Describe and assess the characteristics and</td>
<td>Case studies - Three selected projects</td>
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<tr>
<td>experiences of men who use well men services</td>
<td></td>
</tr>
<tr>
<td>and also those who do not engage with the</td>
<td></td>
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<tr>
<td>pilots.</td>
<td></td>
</tr>
<tr>
<td>Evaluate the effectiveness of the pilots’</td>
<td>Focus groups/interview - Users and non-users in three selected projects</td>
</tr>
<tr>
<td>approaches to engaging and targeting specific</td>
<td>Visits and interviews with key SP informants -All projects</td>
</tr>
<tr>
<td>groups of men, in particular those who might</td>
<td>Case studies - Three selected projects</td>
</tr>
<tr>
<td>be described as socially excluded or are “hard</td>
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<td>to reach”.</td>
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<td>Explore the ways in which pilots have</td>
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<td>Visits and interviews with key SP informants - All projects</td>
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<td>Identify and disseminate examples of good practice in the development and delivery of well men services.</td>
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ANNEX 4: PILOT PROFILES

Introduction

In the following section L1 refers to awareness raising activities; L2 to brief health checks; and L3 consists of a comprehensive health assessment.

Argyll and Clyde region

$Renfrewshire and Inverclyde:

Activities: Included largely L1 and L2 activities, as well as L3 assessments (n=521).

Target groups: Men in deprived areas and socially excluded men, unwilling/unable to engage with a fixed/mainstream service.

Delivery modes: Mixture of fixed clinics and outreach.

Characteristics of men seen: only 247 men (47%) provided a valid postcode, of whom 13% lived in DEPCAT 6 and 5% in DEPCAT 7 compared to 16% and 5% of the regional population. Men were generally older, more likely to be married, home owners, and were less likely to have no qualifications. Unemployment levels were similar to the regional average. This pilot was not more successful in recruiting from deprived areas than was to be expected given the regional average.

Health status and GP use: service users had relatively good physical health; only 5% had (very) bad physical health compared to 13% regionally and 35% had a long standing illness or disability (49% regionally). Fifty-seven percent of service users had visited a GP in the past year compared to 76% of local men. Only 19% WMS users were smokers (33% regionally); of these, 71% were concerned about their smoking. Twenty percent consumed over 21 units p/w (33% regionally). However, only 7% of drinkers thought their drinking was a problem.
Lomond:

**Activities:** L1 (e.g. info stalls at events) and L2 activities made up most of the work, however there were some L3 assessments (n= 82).

**Delivery modes:** Fixed clinics in urban settings and outreach work.

**Target groups:** Men living in deprived areas, socially excluded men and men with mental health problems.

**Characteristics of men seen:** L3 data were collected at urban fixed clinics, but only 39% provided a valid postcode. The pilot was successful in recruiting men from deprived areas (DEPCAT 6) but less successful in recruiting from very deprived areas (DEPCAT 7). Overall, this pilot recruited more men from deprived areas than expected. Service users were older, better educated and more likely to be employed, home owners and married than the regional population.

**Health status and GP use:** Fewer had visited a GP, but they had better physical health and health related behaviour than their regional counterparts.

Argyll and Bute:

**Activities:** L1 (e.g. awareness raising at rural events), L2 and L3 assessments (n= 38).

**Target groups:** Socially excluded men and those with mental health problems

**Delivery modes:** Mobile bus may have contributed to success in reaching disadvantaged men.

**Characteristics of men seen:** nearly all (97%) of the service users were aged 45 and over compared to 49% of regional men. They also had higher levels of education, were more likely to be married and a homeowner. However, unemployment was double the regional average (11% vs. 6%). This pilot was successful in reaching relatively socially disadvantaged men in the area. Service users lived in rurally deprived areas that are not identified by DEPCAT scores.

**Health status and GP use:** Service users had better physical health than the regional average and fewer had a longstanding illness, disability or infirmity, or had visited their GP in the last year. The proportion of users who were smokers was similar to the regional average (33%). Twenty-seven percent drank more than 21 units per week, compared to 33% local men, but only 12% of users perceived their drinking to be a problem.
Fife region

**Activities:** Mainly L3 assessments (n=481) and some L1 activities, e.g. local radio awareness raising.

**Target groups:** Drug and/or alcohol users, those with special needs, ethnic minorities, homeless, unemployed, homosexual and bisexual men, and those not in contact with a GP.

**Delivery modes:** A mixture of fixed health centre clinics and outreach clinics located in pharmacies and workplaces.

**Characteristics of men seen:** 30% provided a valid postcode. Service users were more likely to be 45 and over, married, and unemployed but less likely to have no qualifications compared to the regional average. This pilot recruited more men than would be expected from DEPCAT 6 areas; however none were from the most deprived areas (DEPCAT 7). The proportion of men from ethnic minority groups (1%) mirrored the regional figure, despite the project targeting this group.

**Health status and GP use:** Service users were less likely to be engaged in health damaging behaviours compared to their local counterparts. However, fewer had visited a GP in the last year. Service users had better physical health than all men locally, but an equal proportion had a long-term illness.

Greater Glasgow region

The majority of pilot projects were located in DEPCAT 6 and 7 areas; however the secondary data that is used to provide a context is only available at Greater Glasgow level. This may result in an inflated estimate of effectiveness in some circumstances. All Greater Glasgow pilots focussed on L3 comprehensive health assessments and gave less emphasis to conducting L1 and L2 activities, but all project areas indicated that they were engaged in community development work to a greater or lesser extent at the same time.

**Glasgow East:**

**Activities:** Mainly L3 health assessments, (n=478).

**Target groups:** All local men were targeted with a focus on homeless and unemployed men.

**Delivery modes:** Health clinics and community setting (homeless).
**Characteristics of men seen:** More men lived in deprived areas than the regional average. The majority of users (80%) provided a valid postcode. Service users were older than the regional average, more likely to be married and unemployed and less likely to be homeowners. Education levels were identical to the regional average (35% had no qualifications).

**Health status and GP use:** Fourteen percent reported having (very) bad physical health compared to 11% regionally, and slightly more reported having a longstanding illness, disability or infirmity (46%) compared to a regional average of 40%. A similar proportion had visited a GP in the last year (about 76%), and smoked (35%), whilst 73% viewed their smoking as a problem. Twenty percent consumed more than 21 units per week, less than the local rate (32%). However, only 13% of drinkers viewed this as a problem.

**Greater Pollock:**

**Activities:** L3 assessments (n=69).

**Target groups:** Men who were homeless, unemployed, socially excluded and those with special needs.

**Delivery modes:** Primary care clinics and outreach work.

**Characteristics of men seen:** Almost all (97%) provided a valid postcode. Twenty-one percent lived in DEPCAT 6 and 64% lived in DEPCAT 7 compared to regional proportions of 18% and 30% respectively. Service users were younger than their regional counterparts, and had similar education levels and a similar proportion was married, fewer were homeowners and just 2% were homeless. Service users were nearly three times as likely to be unemployed (18%),

**Health status and GP use:** Men were more likely to have (very) bad physical health and/or a longstanding illness/disability than the regional averages (11 and 40% respectively). The same proportion (77%) had visited a GP in the last year. Thirty-nine percent were recorded as smokers (and 71% of these viewed their smoking as a problem) compared to 35% of the regional population. Fifty-nine percent consumed alcohol, however only 14% reported that they drank more than 21 units per week, compared to 32% of the regional population. However, only 17% of drinkers were concerned about their alcohol consumption.
Greater Shawlands:

**Activities:** L3 assessments (n=135).

**Target groups:** Unemployed men and those living in deprived areas.

**Delivery modes:** Primary care clinics.

**Characteristics of men seen:** Virtually all men (99%) provided a valid postcode. Twenty-one percent lived in DEPCAT 6 and 20% lived in DEPCAT 7, compared to regional proportions of 18% and 30% respectively. Forty-one percent were aged 45 and over compared to 45% of regional men and 18% had no qualification compared to 35% regionally. Service users were more likely to be married, homeowners, and employed.

**Health status and GP use:** Only 5% reported having (very) bad physical health compared to 11% of the regional population and 29% had long-term illness or disability compared to 40% of regional population. Only 61% had visited their GP in the last year compared to a regional average of 77%. The pilot attracted fewer smokers (23% vs. 35%), but the majority (69%) of WMS smokers viewed their smoking as a problem. Nineteen percent reported using over 21 units per week compared to 32% in the regional population. However, only 9% of drinkers viewed their alcohol consumption as a problem.

Glasgow North:

**Activities:** L3 assessments (n=120).

**Target groups:** Hard-to-reach men living in deprived areas.

**Delivery modes:** Fixed clinics in an urban health setting.

**Characteristics of men seen:** Almost all men (96%) provided a valid postcode. Four percent lived in DEPCAT 6 and 66% lived in DEPCAT 7, compared to regional proportions of 18% and 30% respectively. Service users were younger, better educated, more likely to be married but less likely to be homeowners or employed than the regional population.

**Health status and GP use:** Service users had better physical health, less long-term illnesses and visited their GP less frequently than local men. An equal proportion (10% vs. 11%) had (very) bad physical health. Just under a third of WMS users were smokers (30%) compared to 35% regionally, but almost all were concerned about their smoking (91%). Twenty-one percent drank more than 21 units per week compared to 32% of the local population, but only 15% of the users were concerned about their alcohol intake.
Glasgow South East:

Activities: L3 assessments (n=145).
Target groups: Hard-to-reach men
Delivery modes: Fixed clinics in primary care settings.
Characteristics of men seen: Only half of the recorded WMS users (54%) provided a valid postcode. Eleven percent of these men lived in DEPCAT 6 and 43% lived in DEPCAT 7, compared to regional proportions of 18% and 30% respectively. Service users were older, more likely to be married and better educated than the local population, but were less likely to be homeowners. There were almost twice as many unemployed service users (11%) as the regional average (7%).
Health status and GP use: The same proportion (11%) of service users and local men had “(very) bad” physical health. However a higher proportion had a longstanding illness, disability or infirmity (49%) compared to the regional population (40%). Despite this, less had visited their GP in the last year (73% compared to 77%). Fewer were smokers (26%) compared to the regional population (35%), yet 69% of them viewed their smoking as a concern. Only 54% reported drinking alcohol and 12% of these drank more than 21 units per week compared to 32% of the regional population. Thirteen percent of drinkers were concerned about their alcohol consumption.

Glasgow Westone:

Activities: L3 assessments (n=121) and counselling.
Target groups: Unemployed men and men living in deprived areas.
Delivery modes: Urban fixed clinic.
Characteristics of men seen: Most (70%) provided a valid postcode. Fifteen percent lived in DEPCAT 6 and 11% in DEPCAT 7, compared to 18% and 30% respectively of the regional population. Service users were older, better educated and more likely to be married, however they were less likely to be homeowners or employed.
Health status and GP use: Service users had better physical health, fewer long-term illnesses and less had visited a GP in the last year. Twenty-four percent smoked compared to 35% of the regional population and 74% were concerned about their smoking. Eighteen percent consumed more than 21 units of alcohol per week compared to 32% of the regional population, but only 8% of the users were concerned about their alcohol intake.
Highland region

**Activities:** L1 activities (e.g. awareness raising events in non-NHS settings), and L2 activities in the form of a “5-minute MOT” comprised the bulk of their work. Two-thirds of users had a “5-minute MOT” and only a third of service users had a full L3 health assessment (n= 235).

**Target groups:** A wide range of hard-to-reach men, e.g. ethnic minorities (BME); men with special needs; travellers; homeless; (un)employed; disabled and men with mental health problems.

**Delivery modes:** Mobile service and some community or workplace activities.

**Characteristics of men seen:** Most (69%) provided a valid postcode. No one lived in DEPCAT 7 and only 2% in DEPCAT 6, compared to 0% and 0.3% respectively of the regional population. The service users were younger, better educated, more likely to be married, more likely to be homeowners and more likely to be employed than the regional population. Just 1% was homeless and the same proportion was unemployed (6%) as the regional population.

**Health status and GP use:** Four percent had “(very) bad” physical health compared to 6% of regional men. Twenty-three percent had a long-standing illness or disability compared to 42% of regional men. Lastly 56% had visited their GP in the last year compared to 78% of local population. A minority smoked (15%) compared to 26% regionally. However 72% perceived their smoking as a problem. Nineteen percent drank more than 21 units per week compared to 29% regionally; however only 4% perceived their drinking as a problem.
Lothian Region

**Lothian: Model 1**

**Activities:** L1 and L3 assessments (n=115).
**Target groups:** Local men.
**Delivery modes:** Fixed urban clinics.

**Characteristics of men seen:** Approximately 30% did not provide personal data, hence the results should be interpreted with caution. Fifty-eight percent provided a valid postcode. No one lived in DEPCAT 7 and only 5% in DEPCAT 6, compared to 3% and 5% respectively of the regional population. The service users were slightly older, better educated, more likely to be married and less likely to be unemployed than the regional population.

**Health status and GP use:** Service users had better physical health and used their GP less frequently than local men. Seventeen percent of service users were smokers compared to 21% regionally. Fifteen percent consumed more than 21 units per week compared to 29% of the regional population. However, only 7% perceived their drinking to be a problem.

**Lothian: Model 2**

**Activities:** L1 and L2 activities including awareness raising and networking with local agencies concerned with homeless men and their health. Some L3 assessments.
**Target groups:** Homeless men.
**Delivery modes:** Outreach.

**Characteristics of men seen:** Information was only returned on 23 men. Most of those were aged 45 and over, had some qualifications, were single and lived in rented accommodation. Twenty percent were homeless. Less than half were unemployed and a minority were gypsy travellers, ex-service men and ex-prisoners.

**Health status and GP use:** Nearly all reported adequate or good physical and mental health. Only one man reported having “bad” physical health and 2 reported having “bad” mental health. Over half had visited their GP in the last year, however this is lower than the regional average (80% (Scottish Executive, 2005a)). Over half smoked and all but one consumed alcohol.

**Lothian: Model 3**

**Activities:** L1 activities, e.g. awareness raising through word of mouth. L2 activities through e.g. men’s groups. L3 assessments in a non-NHS setting (n=105).
Target groups: Local men in a deprived urban area.

Delivery modes: Outreach

Characteristics of men seen: Only 30% of men provided data. Only 20% provided postcodes. A quarter of these men lived in DEPCAT 6 and 7 compared to 8% of the regional population. Men were older and less educated men than the regional population, but were more likely to be married and own their own residence. More than twice as many users were unemployed (11%) than the regional average (4%).

Health status and GP use: Less WMS users had visited a GP in the last year than the regional average and fewer smoked or drank more than the recommended limit.

Lothian: Model 4 pilot (n=2)

Activities: L1 and L2 activities, specifically peer education. Fifteen men were trained as peer educators, but the evaluation team received no data on the number of contacts made with the local community.

Target groups: Unclear

Delivery modes: Urban non-NHS locations.

Shetland Region

Activities: L1 and L3 comprehensive health assessments (n=166).

Target groups: Local men.

Delivery modes: Remote and rural fixed clinics.

Characteristics of men seen: Ninety-two percent provided valid postcodes. Shetland only has DEPCAT 3 and 4 rated areas. Half of WMS users lived in DEPCAT 3 rated areas and half in DEPCAT 4 rated areas compared to 63% and 37% respectively of the regional population. Men were younger, better educated, more likely to be married and own their own residence than the regional population. Reported unemployment was very low as it is in Shetland generally.

Health status and GP use: Service users had better physical health, less long-term illness and had visited their GP less frequently than their regional counterparts. Only 1% had “(very) bad” physical health compared to a regional of 8%. Similarly, only 22% had a long-standing disability, illness or infirmity compared to 39% of the regional population. Fewer had visited a GP in the last year and fewer smoked. Interestingly, a higher proportion heavily consumed
alcohol than their regional counterparts, yet they were generally unconcerned about their alcohol consumption.

**Tayside Region**

**Angus:**

**Activities:** L1 activities (awareness raising), L2 activities (e.g. drop-in-and-talk service for students), and L3 comprehensive health assessments (n=135),

**Target groups:** Men in deprived areas without access to health services.

**Delivery modes:** Fixed clinics in non-NHS settings

**Characteristics of men seen:** Most (86%) provided a valid postcode. Of these 8% lived in DEPCAT 6 and 4% lived in DEPCAT 7 compared to 15% and 7% respectively of the regional population. Service users were younger, more educated, more likely to be married and own their own residence than the regional population. Unemployment levels were very similar with 6% among users and 5% regionally.

**Health status and GP use:** Users had better physical health, less long-term illness and visited their GP less frequently than their regional counterparts and also smoked and drank less. Service users were generally unconcerned about their drinking levels.

**Dundee:**

**Activities:** L1 activities (e.g. Men’s Awareness Day) and L3 comprehensive health assessments (n=302).

**Target groups:** Marginalised and vulnerable men living in deprived areas without access to key local services.

**Delivery modes:** Fixed clinics mainly in workplaces

**Characteristics of men seen:** Most men (83%) provided a valid postcode. Thirty-two percent lived in DEPCAT 6 and 22% in DEPCAT 7, compared to 15% and 7% respectively of the regional population. Service users were older, more likely to be married and own their own residence than the regional population. Home ownership was the regional rate of (64%) of service users. Fewer of the service users were unemployed (1%) compared to their regional counterparts (5%).

**Health status and GP use:** Only 1% of users had “bad” or “very bad” physical health compared to a regional average of 8% (Scottish Executive, 2005a). Similarly 8% of users
had a long-standing disability, illness or infirmity compared to 37% of the regional population. Lastly just 41% of users had visited their GP in the last year compared to a regional average of 72%, and they smoked less and consumed less alcohol compared to the regional population. Service users were generally unconcerned about their alcohol consumption.

Perth:

Activities: L1 activities (awareness raising) and L3 assessments.
Target groups: Men on low income.
Delivery modes: Mobile bus